From: David Dickson
Sent: Saturday, September 5, 2020 9:32 AM
To: Redacted gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

One of seven.

Please treat as confidential.

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> Redacted *thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*

Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf

"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a ***confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether****. "*

As per Redacted *previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.

I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.

Thank you,

Dr. G. Redacted *MD MSc FRCPC*
Medical Officer of Health
Alberta Health Services – Edmonton Zone"

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.
    - Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.
- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**

        - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
    - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
    - When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order "*In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

> *"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."*
>
> *"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."*

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

> *"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."*

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively

impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275 residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life

changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

2020-07-05	Edmonton Zone	Female	80+ years	Died
2020-07-05	Edmonton Zone	Male	70-79 years	Died
2020-07-07	Edmonton Zone	Male	70-79 years	Died
2020-07-08	Edmonton Zone	Female	80+ years	Died
2020-07-12	Edmonton Zone	Female	70-79 years	Died
2020-07-14	Edmonton Zone	Female	80+ years	Died
2020-07-14	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Male	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-17	Edmonton Zone	Female	80+ years	Died
2020-07-17	Edmonton Zone	Female	80+ years	Died
2020-07-18	Edmonton Zone	Female	80+ years	Died
2020-07-18	Edmonton Zone	Female	80+ years	Died
2020-07-19	Edmonton Zone	Female	80+ years	Died
2020-07-19	Edmonton Zone	Female	70-79 years	Died
2020-07-21	Edmonton Zone	Female	80+ years	Died
2020-07-26	Edmonton Zone	Female	80+ years	Died
2020-07-27	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	70-79 years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	70-79 years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-29	Edmonton Zone	Female	70-79 years	Died
2020-07-29	Edmonton Zone	Female	80+ years	Died

We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

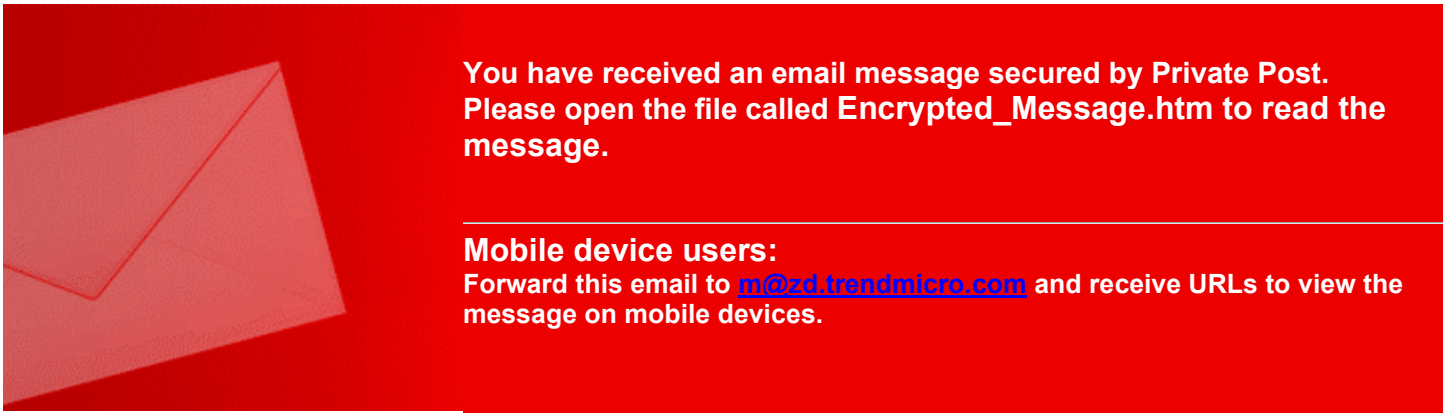
Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

David & Karen Dickson

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com)
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

Microsoft Partner

From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential



Attachments
1-CapitalCare 14072020.pdf
1-CapitalCare 16072020.pdf
1-health-cmoh-record-of-decision-cmoh-14-2020.pdf
1-health-cmoh-record-of-decision-cmoh-29-2020.pdf

Karen Dickson

From: CapitalCare <info@capitalcare.net>
Sent: Tuesday, July 14, 2020 4:16 PM
To: Karen Dickson
Subject: CapitalCare (CCD) Update July 14

Trouble viewing this email? Read it online

CapitalCare DICKINSFIELD

July 14, 2020

Dear Residents and Families:

On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines.

What are we doing?

The health and safety of all our residents, patients, and staff is our top priority.

We have taken immediate action on the appropriate Infection Prevention and Control measures required. Staff are wearing full Personal Protective Equipment (PPE) when they are caring for all residents in isolation, including taking extra precautions in donning and doffing their PPE when leaving and entering residents' rooms, and wearing masks continuously in other areas as well. We have been carefully cleaning any high and low-touch surfaces.

Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow. If your loved one tests positive, we will notify you as soon as we get the results.

Effective immediately, outdoor and window visitation has been suspended until further notice. We will continue to arrange virtual visits and phone calls. We understand this is difficult; however,

limiting visitation is one essential measure to prevent further spread of the illness.

Last month, CapitalCare responded immediately and effectively to two COVID-19 outbreaks at other centres. We are confident in our Pandemic Response Plan to manage this outbreak as well.

Our residents are always at the centre of everything we do and together we will get through this!

Updates on the status of Dickinsfield and all other CapitalCare centres sites will be posted to CapitalCare's website.

All other centres at CapitalCare continue to have no confirmed cases of COVID-19.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

If you have any further questions or comments please email us at info@capitalcare.net.

Sincerely,

Redacted Site Director
CapitalCare Dickinsfield

GET SOCIAL WITH US:

CapitalCare Dickinsfield
14225 - 94 Street
Edmonton, Alberta T5E 6C6
T 780.371.6500
F 780.371.6583

Karen Dickson

From: CapitalCare <info@capitalcare.net>
Sent: Thursday, July 16, 2020 3:08 PM
To: Karen Dickson
Subject: CapitalCare CCD Update - July 16, 2020

Trouble viewing this email? Read it online

CapitalCare DICKINSFIELD

July 16, 2020

Dear Residents and Families:

Since notifying you earlier this week of the outbreak at Capitalcare Dickinsfield, we have some additional information.

On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health. If your loved one tests positive, we will notify you as soon as we get the results.

Outdoor visitation has been suspended at Dickinsfield until further notice; however, window visits have resumed. Laundry drop-off and pick-up can continue.

Ongoing communication with you is a priority. We invite you to attend a virtual Town Hall on **Tuesday, July 21st from 5:30 – 6 p.m.** Although this is a video conference, you have the option of attending by phone. Please submit your questions ahead of time to info@capitalcare.net.

Topic: CapitalCare - Dickinsfield

Time: 5:30 p.m. – 6 p.m. Mountain Time

Join Zoom Meeting

Meeting ID: 969 5014 1538
Password: 617865

Join the meeting by phone

Ph: (587) 328-1099

Meeting ID: 969 5014 1538

Password: 617865

Updates on the status of Dickinsfield and all other CapitalCare centres will be posted to CapitalCare's website.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

If you have any further questions or comments please email us at: info@capitalcare.net.

Last week, CapitalCare Dickinsfield residents had a wonderful afternoon of outdoor musical entertainment, with back-to-back concerts so that many could enjoy the music without gathering in a large group.

Helping You Connect

CapitalCare FOUNDATION

FEAST RE-IMAGINED

At **CapitalCare Foundation**, we aim to build community in everything we do. Due to the ongoing COVID-19 pandemic, we are unable to hold what you have known as Feast on the Field at Commonwealth Stadium as we have in years past, but this hasn't stopped us from getting creative to bring you the re-imagined **Feast on YOUR Field!**

LEARN MORE

Did you know we've partnered with Skip The Depot , a bottle collection service that will let you donate your bottle refund directly to us! Click below to learn more.

SKIP THE DEPOT

The **Hearts for Healthcare** window decals are really making a difference. Send your messages in and give CapitalCare staff virtual gratitude through your inspiring messages!

SEND A HEART

CANADA HELPS

GET SOCIAL WITH US:

CapitalCare
6th Floor, 10909 Jasper Avenue
Edmonton, Alberta T5J 3M9
Ph: (780) 448-2421

Alberta Health

Office of the Chief Medical Officer of Health
10025 Jasper Avenue NW
PO Box 1360, Stn. Main
Edmonton, Alberta T5J 2N3
Canada

RECORD OF DECISION – CMOH Order 14-2020 which rescinds CMOH Order 09-2020

Re: 2020 COVID-19 Response

Whereas I, Dr. Deena Hinshaw, Chief Medical Officer of Health (CMOH) have initiated an investigation into the existence of COVID-19 within the Province of Alberta.

Whereas the investigation has confirmed that COVID-19 is present in Alberta and constitutes a public health emergency as a novel or highly infectious agent that poses a significant risk to public health.

Whereas under section 29(2.1) of the *Public Health Act* (the Act), I have the authority by order to prohibit a person from attending a location for any period and subject to any conditions that I consider appropriate, where I have determined that the person engaging in that activity could transmit an infectious agent. I also have the authority to take whatever other steps that are, in my opinion, necessary in order to lessen the impact of the public health emergency.

Whereas I made Record of Decision - CMOH Order 09-2020 on April 7, 2020.

Whereas having determined that it is necessary to balance the need to restrict the ability of persons to visit residents in health care facilities located in Alberta while ensuring residents' quality of life can be maintained to the greatest extent possible, I hereby make the following Order which rescinds Record of Decision - CMOH Order 09-2020:

1. Effective immediately, all operators of a health care facility, located in the Province of Alberta must comply with the visitation standards attached as Appendix A to this Order.

2. For the purposes of this order, a "health care facility" is defined as:

    (a) an auxiliary hospital under the *Hospitals Act*;

    (b) a nursing home under the *Nursing Homes Act;*

    (c) a designated supportive living accommodation or a licensed supportive living accommodation under the *Supportive Living Accommodation Licensing Act;* and

    (d) a lodge accommodation under the *Alberta Housing Act*.

3. Despite section 1 of this Order, an operator of a health care facility may be exempted from the application of this Order, by me, on a case-by-case basis.

4. This Order remains in effect until rescinded by the Chief Medical Officer of Health.

Signed on this 28 day of April, 2020.

Deena Hinshaw, MD
Chief Medical Officer of Health

Document: Appendix A to Record of Decision – CMOH Order 14-2020

Subject: Guideline regarding visitation in licensed supportive living and long-term care.

Date Issued: April 28, 2020

Scope of Application: As per Record of Decision – CMOH Order 14-2020

Distribution: All licensed supportive living (including group homes and lodges), long-term care (nursing homes and auxiliary hospitals).

***Amendments to previous orders are noted by highlighting**

Purpose:
This guidance supplements the application of CMOH Order 14-2020 (the Order), outlining the requirements for all operators[1], staff[2], residents[3], as well as the families and friends of those residents who live within the facilities to which the Order applies. The intent of this guidance is to protect the health and safety of residents and staff in these facilities.

Key Messages:

Individuals over 60 years of age and those with pre-existing health conditions are most at risk of severe symptoms from COVID-19. To prevent the spread of respiratory viruses, including COVID-19, among seniors and vulnerable groups:

- Visitors, **in the limited instances** when they will be allowed to **enter** any continuing care (licensed supportive living or long-term care), are limited to a single individual designated by the resident or guardian (or other alternate decision-maker).
- Each designated essential visitor must be verified and undergo a health screening prior to entering the facility. This includes a temperature check and a questionnaire.
- Facilities must have security staff or a greeter to conduct this screening and verify the visitor as the designate.
- As of this Order[4], **no visitors**, including those designated as essential, are allowed entry into these facilities, **except for visits**:
    - Where the resident's quality of life and/or care needs cannot be met without their assistance, or
    - When a resident is dying (see below).
- **Outdoor visits** with the designated essential visitor and one other person (maximum group of 3, including the resident) should be supported, when desired.
    - As per Order 12, residents who are not required to isolate may spend time outdoors while observing physical/social distancing requirements.

[1] Operator means any operator, service provider, site administration or other staff member responsible for areas impacted by these expectations.
[2] Any person employed by or contracted by the site, or an Alberta Health Services employee or other essential worker.
[3] A resident is any person who lives within one of these sites (sometimes called clients e.g., by group homes).
[4] This order rescinds and updates CMOH Order 09-2020.

- It is important for mental health to spend time outdoors. It is encouraged that residents be given an opportunity to spend time outdoors, where feasible and appropriate and have safe outdoor visits when desired.

Designated Essential Visitors

- One essential visitor must be designated by the resident, or their alternate decision-maker.
  - This means only a single individual is designated.
  - The designated essential visitor can be a family member, friend or companion.
  - The designated essential visitor cannot be under 18 years of age (see #2 below for exception).
  - The **site contact** (e.g. director of care, case manager, facility administrator) will confirm each designated essential visitor and ensure that they meet the criteria in this document.
  - The site contact can make exceptions, and allow the designated essential visitor to approve others to visit, in circumstances where a resident is dying (see #2 below).
  - A resident may identify a temporary replacement designated essential visitor for approval if the designated essential visitor is unable to perform their role for a period of time (e.g. self-isolation, other caregiving duties, or otherwise unable).
    - To clarify, the intent is not for this designate to change regularly or multiple times, but to enable a replacement, when required.
- Visits from the designated essential visitor are **permitted in the facility** within the following parameters**:**
  1. Visits where the resident's quality of life and/or care needs cannot be met without the designated essential visitor's assistance.
     - Designated essential visitors may carry out quality of life and/or care related activities, as appropriate, where **staff are unable to provide** those due to emergent pandemic impacts, and where the designated essential visitors have been provided appropriate guidance, if needed.
     - Operators are encouraged to be responsive to resident unmet needs (which may be identified in care plans, where relevant) and utilize this option when it is in the best interest of the resident (e.g., for someone who has a cognitive impairment or dementia who is **unable** to understand the restrictions currently imposed **and** where the person's quality of care and life are directly supported by the involvement of the known and supportive visitor).
  2. Visits in circumstances where a resident is at the end of their life.
     - Residents who are dying should have the opportunity to have their family/visitors at their side, while following the guidelines in place to ensure everyone's safety.
     - While it is difficult to be precise around when a resident is at the end of their end of life, in the context of COVID-19, visitation at end of life refers to the **last two weeks of life**.
       - The site contact (e.g. director of care, case manager, facility administrator) is expected to be reasonable and use their best judgement in making determinations about residents who are dying with consideration given to providing a quality end of life for the resident and their visitors.
     - The designated essential visitor may enter and can approve others, including the resident's family, their religious leader(s), a child (under 18 years of age), and their friends to enter, so long as **only one visitor enters the facility at a time**.
       - The exceptions to the requirement that "only one visitor enters the facility at a time," are:
         - if the approved visitor is a child. In those circumstances, the child must be accompanied by either the designated essential visitor or the child's parent/guardian; and

    - if the room is of a sufficient size to accommodate two visitors who can be two metres distant from each other, two visitors may attend at the same time.
3. Residents and visitors who meet the above parameters will not be restricted unnecessarily; however, resident and site circumstance may mean that not all desired visits are able to be accommodated.
4. When there is disagreement on permitted visitors, the designated essential visitor should first discuss the situation with the operator. If the situation cannot be resolved, and the visit is allowed as per this document, please contact Alberta Health Services Patient Relations (in the case of designated supportive living and long term care) or Alberta Health's Accommodation Licensing Inspector (asal@gov.ab.ca, in the case of non-AHS contracted sites) for direction.

- If several designated essential visitors meet this criteria in any one facility, it is acceptable for an operator to create a reasonable approach that responds to requests in a way that ensures both resident care needs and safe visitor presence (including consideration of operational feasibility and the availability of staff to facilitate the visits, as per requirements) to balance the needs of all. Operators must be transparent about their approach with residents and designated essential visitors.
    - This may include staggering visits, phasing visitors in on a unit-by-unit basis, or other creative approaches that ensure residents are receiving the essential quality of life and/or care they require in response to unmet needs.

- Designated essential visitors must:
    1. **Pre-arrange** visits with the operator (e.g., facility administrator or identified designate) and be expected.
    2. Be escorted by site staff to the resident's room and remain in the resident's room for the duration of the visit other than when assisting with required quality of life or care activities (e.g. meal time) or supporting an outdoor visit.
    3. Not visit with any other residents.
    4. Must wear a mask continuously throughout their time in the facility and shall be instructed how to put on and take off that mask and any other personal protective equipment (PPE) that might be required (by staff/operator).
    5. Perform hand hygiene (including hand washing and/or use of hand sanitizer) on entry and exit from rooms, when leaving and returning to the facility and as directed.

- Operators must:
    1. Ensure that only the designated essential visitor is allowed into the site at any time.
    2. Ensure that the Health Assessment Screening (see below) is conducted on every visit.
    3. Instruct any visitors permitted to enter the site to wash their hands often with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer (greater than 60% alcohol content).
    4. Prior to caring for, or entering the room of, a symptomatic resident, ensure that any designated essential visitors or family members are provided with the required PPE, are trained, and have practiced the appropriate use of PPE.
        - This may be done in partnership with Public Health and includes (but may not be limited to) the correct choice of, application (putting on) of and removal of the PPE (e.g., preventing contamination of clothing, skin, and environment).
    5. Provide any other visitor (permitted only in circumstances when the resident is at the end of their life) with the appropriate PPE, including a mask that covers the visitor's mouth and nose, and instruct the visitor on how to safely put on and take off the mask as well any additional PPE (if it is required).

6. Ensure that all visitors wear the mask continuously while in the facility.

- Any individual who has had direct contact with a person who has a confirmed case of COVID-19, without wearing recommended PPE (i.e., before they are aware that the person has a confirmed case of COVID-19), is required to self-isolate as per direction from Public Health.

Operators who determine that they need to further restrict the above guidelines must consult with AHS Continuing Care Zone Executive Director, or relevant designate (e.g. Alberta Health Accommodation Licensing Inspector, Seniors and Housing, or Community and Social Services).

Outdoor Visitors

- As per **Order 12**, residents who are not required to isolate may spend time outdoors while observing physical/social distancing requirements.
- It is important for mental health to spend time outdoors. It is encouraged that residents be given an opportunity to spend time outdoors, where feasible and appropriate and have safe outdoor visits when desired.
- Outdoor visits with the **designated essential visitor plus one other person** (total group size of 3, including the resident) should be supported, when desired. There is no age restriction for the other person (e.g. minors should be permitted) and the visit may include, as appropriate for the resident, going beyond the property (e.g. community walks).
    - Arrangements for the outside visit (including scheduling, frequency, feasibility, etc.) should be made by the designated essential visitor, or the resident, directly with the operator.
        - Operators must not unreasonably deny requests for an outdoor visit, however resident and site circumstance (and the requirements for physical distancing and other protective measures ordered) may mean that not all desired visits are able to be accommodated.
    - All outdoor visitors must continuously mask during the visit and follow appropriate physical distancing requirements, as appropriate (e.g. considerations for pushing wheelchair, being hard of hearing). Any type of mask (e.g. non-medical) should be permitted.
    - Up to three or fewer people (including the resident) may be permitted at an outdoor visit. The maximum number of visitors will be determined by the operator, based on the amount of space, the number of visit groupings happening, and the ability to maintain physical distance.
    - Visitors, other than the designated essential visitor, will be asked to remain outdoors at all times (i.e. entry to the facility will not be permitted).
        - If the only suitable outdoor space is solely accessible through access to the facility, and an outdoor visit is considered essential to quality of life, only a designated essential visitor is permitted and must follow all requirements for entering visitors. Staff must escort the visitor using the most direct path through the facility.
    - All Chief Medical Officer of Health Guidance must be followed.
    - Residents must, with staff assistance where necessary, wash their hands or use hand sanitizer immediately upon re-entry to the building and be screened per **Order 12.**

Health Assessment Screening for Visitors

Any visitor who intends to enter a facility, and/or who cannot maintain physical distancing during an outdoor visit must be screened. This screening must be completed every time the designated essential visitor enters the site. Visitors who do not enter (i.e. outdoor visits) and follow all physical distancing during the outdoor visit are not required to be screened. Screening shall involve the following:

1. Temperature screening

2. COVID-19 Questionnaire (see **below**)
3. Confirmation of identity and "designated essential visitor" status (only if entering the building)
4. Documentation of arrival and exit times (only if entering the building)

COVID-19 **Visitor** Screening[5]

1.	Do you have any of the below symptoms:		
	• Fever (**38.0°C** or higher)	**YES**	**NO**
	• Any **new** or **worsening** symptoms:		
	○ Cough	**YES**	**NO**
	○ Shortness of Breath / Difficulty Breathing	**YES**	**NO**
	○ Sore throat	**YES**	**NO**
	○ Runny Nose	**YES**	**NO**
	○ Feeling unwell/Fatigued	**YES**	**NO**
	○ Nausea/Vomiting/Diarrhea	**YES**	**NO**
2.	Have you, or anyone in your household travelled outside of Canada **in the last 14 days**?	**YES**	**NO**
3.	Have you had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with cough and/or fever **in the last 14 days without** the use of appropriate PPE?	**YES**	**NO**
4.	Have you had close contact (face-to-face contact within 2 meters/6 feet) **in the last 14 days** with someone who is being investigated or confirmed to be a case of COVID-19 **without** the use of appropriate PPE?	**YES**	**NO**

- If any visitor answers **YES** to any of the screening questions, they will not be permitted to enter the facility.
- Visitors must be directed to self-isolate and complete the AHS online assessment tool to arrange for testing.

Operators are encouraged to visit Alberta Health's website to www.alberta.ca/COVID19 for updated information. If there are any questions, please contact asal@gov.ab.ca.

[5] Operators must be aware of, and follow, any applicable privacy legislation (e.g., Freedom of Information and Protection of Privacy Act, Health Information Act, Personal Information Protection Act, etc.), should they document/retain the Health Assessment Screening completed with residents and staff (or others).

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10025 Jasper Avenue NW
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Edmonton, Alberta T5J 2N3
Canada

RECORD OF DECISION – CMOH Order 29-2020 which rescinds CMOH Order 14-2020

Re: 2020 COVID-19 Response

Whereas I, Dr. Deena Hinshaw, Chief Medical Officer of Health have initiated an investigation into the existence of COVID-19 within the Province of Alberta.

Whereas the investigation has confirmed that COVID-19 is present in Alberta.

Whereas under section 29(2)(b)(i) of the *Public Health Act*, I may take whatever steps I consider necessary

(A) to suppress COVID-19 in those who may have already been infected with COVID-19,

(B) to protect those who have not already been exposed to COVID-19,

(C) to break the chain of transmission and prevent spread of COVID-19, and

(D) to remove the source of infection.

Whereas I made Record of Decision – CMOH Order 14-2020 on April 28, 2020.

Whereas having determined that it is desirable to allow for further visitation to take place within certain health care facilities.

Therefore, effective July 23, 2020 Record of Decision - CMOH Order 14-2020 is rescinded and I am taking the following steps to protect Albertans from exposure to COVID-19 and to prevent the spread of COVID-19:

1. All operators of a health care facility located in the Province of Alberta must comply with the requirements of this Order. For greater certainty, unless otherwise indicated in this Order, Appendix A to this Order represents the leading practices that Alberta Health expects operators of health care facilities to follow while carrying out the requirements of this Order.

2. For the purposes of this Order, a "health care facility" is defined as:

   (a) an auxiliary hospital under the *Hospitals Act*;

   (b) a nursing home under the *Nursing Homes Act;*

   (c) a designated supportive living accommodation or a licensed supportive living accommodation under the *Supportive Living Accommodation Licensing Act;*

   (d) a lodge accommodation under the *Alberta Housing Act*; and

(e) any facility in which residential hospice services are offered or provided by Alberta Health Services or by a service provider under contract with Alberta Health Services.

3. All operators of a health care facility must develop and implement a safe visiting policy that enables visitors to attend to residents within the health care facility during the COVID-19 pandemic.

4. Every attendance of a visitor must be prearranged with the staff of the health care facility in which the resident is located.

5. Before allowing a visitor to attend to a resident within the health care facility, the staff of a health care facility must:

   (a) record the individual's visit, including the date, time and information required to be collected under section 4(b);

   (b) conduct a health assessment of the individual, including taking the individual's temperature and requiring the individual to answer a questionnaire;

   (c) confirm that the individual does not have a temperature over 38 degrees Celsius or any illness identified under the heading *COVID-19 Designated Family/Support Person and Visitor Screening* of Appendix A to this Order;

   (d) discuss and explain to the individual the *Safe Visiting Practices* guidance set out in Appendix A; and

   (e) ensure the individual has any necessary personal protective equipment and instruct the individual as to how to use the personal protective equipment.

6. If an operator permits a visitor to attend to a resident within the health care facility, in an area other than a resident's room, the operator must

   (a) post signage visible to individuals entering the area, informing individuals that the area is a shared visiting space; and

   (b) limit the number of visitors and residents that are able to access the area, to ensure that 2 metres distance can be maintained between every person accessing the area, at all times.

7. Despite section 1 of this Order, an operator of a health care facility may be exempted from the application of this Order, by me, on a case-by-case basis.

8. This Order remains in effect until rescinded by the Chief Medical Officer of Health.

Signed on this 16 day of July, 2020.

Deena Hinshaw, MD
Chief Medical Officer of Health

Alberta

Document: Appendix A to Record of Decision – CMOH Order 29-2020

Subject: Guidance for safe visiting in licensed supportive living, long-term care and hospice settings.

Date Issued: July 16, 2020

Scope of Application: As per Record of Decision – CMOH Order 29-2020

Distribution: All licensed supportive living (including group homes and lodges), long-term care (nursing homes and auxiliary hospitals), and facilities offering or providing a residential hospice service model.

Summary of Changes		
Concept	**CMOH Order 14-2020 (Previous Requirements)**	**CMOH Order 29-2020 (New)**
Scope	• Licensed supportive living • Long-term care	• Licensed supportive living • Long-term care • Hospice (in continuing care and stand-alone)
Approach	• 'Restricted Access'	• 'Safe Access' • Resident-directed, site level approach
Types of Visits Permitted	• Unmet Care/Quality of Life • End of Life • Outdoor	• No restrictions based on type of visit
Who is permitted to visit	• 1 designated essential visitor • Others in end of life • One other for outdoor visits	• 2 designated family/support persons • Other visitors in extenuating circumstances and, where agreeable, social visits
Location of indoor visit	• Resident Room • Care Area	• Resident Room • Shared Care Area • Designated Indoor Space
Outdoor visit parameters	• Maximum three, including designated essential visitor and resident	• Maximum 5, including resident
Operator Approach	• 'Reasonable'	• Minimum expectations, including consideration of resident needs, preferences and assessment of risk
Restricted Access	• Consult with relevant authority	• Clear parameters, based on assessment of risk • Dispute resolution expectations
Other	• n/a	• Pets, Gifts • Guidance for safe physical touch and use of PPE when a barrier to communication

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Purpose

This Appendix supplements the application of CMOH Order 29-2020 (the Order), outlining the requirements for all operators[1], staff[2], residents[3], as well as the families, friends and support persons of those residents who live within the facilities to which the Order applies. The intent of this guidance is to protect the health and safety of residents and staff in these facilities while ensuring safe and meaningful connection with the persons that support them.

Key Messages

- Individuals over 60 years of age and those with pre-existing health conditions are most at risk of severe symptoms from COVID-19. One of the key measures for protecting residents and staff in congregate living settings against COVID-19 exposure is limiting the number of people on site at any one time.
- Strict limitations to visitor access were necessary in earlier stages of the pandemic. Severe outbreaks in congregate care settings are now less likely because we now know more about COVID-19 and the protections that have been put in place to date have worked. It is critical that all public health safety measures continue to be implemented and observed by all persons impacted by this Order to prevent the spread of COVID-19.
    - Temporary limitations will still occur in situations where threat of COVID-19 is imminent. All restrictions must be determined in collaboration with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate.
- To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions.
- Furthermore, safe access to visitors (other than designated persons) helps support family caregivers and provides vital social interaction for residents.
- As of this Order[4], visiting restrictions are as follows:
    - Indoor access for **designated family/support person(s)**
        - Residents may name up to two individuals for this role
    - Access to **visitors** in extenuating circumstances:
        - End of life (last 4-6 weeks, except in the case of hospice)
        - Change in health status (due to medical/social/spiritual crisis)
        - Pressing circumstances (including financial or legal matters, family crisis)
    - Outdoor visits in designated spaces:
        - Up to 5 individuals, including the resident, are permitted if feasible
    - Where desired and if determined safe, indoor social visits with **visitors** in designated indoor spaces.
- It is imperative that all persons entering these settings:
    - Understand the risk of exposure to COVID-19 (for self and others);
    - Follow all related site policies and public health measures in place; and
    - Remain vigilant in protecting themselves and others both while on site as well as off site.
- To recognize the threat of COVID-19, all operators must develop, maintain, implement and continuously evaluate a principle-based policy and process for safe visiting, informed by the needs and preferences of residents.

[1] Operator means any operator, service provider, site administration or other staff member responsible for areas impacted by these expectations.
[2] Any person employed by or contracted by the site, or an Alberta Health Services employee or other essential worker.
[3] A resident is any person who lives within one of these sites (sometimes called clients e.g., by group homes).
[4] This order rescinds and updates CMOH Order 14-2020.

- Individual site capacity for safe visiting varies. All operators must assess risk tolerance in developing a policy and process. This includes consideration of both individual and collective resident[5] perception of risk as well as site configuration and ability to maintain physical distancing.

Designated Family/Support Persons

- An **operator** must proactively and collaboratively work with residents, or alternate decision makers, to confirm up to two (2) **designated family/support persons**[6] per resident, ensuring each resident has the level of support they desire and/or require.
- These persons may be a family member, friend, companion (privately paid or volunteer), support worker (privately paid or volunteer), power of attorney/trustee, agent, legal guardian, or any other person identified by the resident or alternate decision maker.
- These persons cannot be under 18 years of age.
  - In rare circumstances, and if the most suitable individual is younger, individuals 16 years of age or older may be supported to be a designated family/support person.
- A resident or their designated family/support persons may identify a temporary replacement designated family/support person if a designated family/support person is unable to perform their role for a period of time (e.g. self-isolation, out of town, or otherwise unable).
  - To clarify, the intent is not for the designate to change regularly or multiple times, but to enable a replacement, when required, for a reasonable period of time depending on the circumstance.
- It is possible for multiple residents to have the same designated family/support persons.
- All designated family/support persons must be supported as essential to maintaining the resident's mental and physical health.
- Indoor and outdoor in-person access to the resident by designated family/support persons can be for any reason and all persons should be verified by the operator upon entry for indoor visits.
  - To clarify, designated family/support persons should contact the facility to coordinate[7] the time of their visit to ensure the operator has the opportunity to manage the number of people on site at a given time.
  - It is recommended that designated family/support persons establish a standing schedule (a schedule that is consistent week after week) based on resident needs and preferences for resident room visits or in shared care areas to ensure operators expect their presence.
  - Designated family/support persons shall not be subject to restrictive pre-arranging or scheduling requirements (including duration or frequency limitations) unless the visit is intended to be in a designated shared space (indoors, including shared resident rooms, or outdoors).
- An **operator** must educate all designated family/support persons on *Safe Visiting Practices* and related site policies.

Visitors

- An **operator** must permit visitors (i.e. those other than designated persons) access to indoor and outdoor visits with a resident (as specified in Table 1 summary of indoor and outdoor visit parameters).

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[5] When residents who share a room have differences in their desire for visits within their space (i.e. one resident does not want to take the risk of accepting visits), alternative options must be considered and provided. This may include providing alternative space for the visits, cohorting residents who do not wish to have visitors, etc.

[6] As of this Order, the term Designated Essential Visitor is replaced by Designated Family/Support Person. All existing designated essential visitors will now be referred to as designated family/support person.

[7] Should the requested time of visit not be agreeable to the operator (i.e. already have many other visitors at that time), a mutually agreeable alternative should be arranged.

- Access to indoor visitors shall be determined either by resident circumstance, in the case of extenuating circumstances or by the site's risk tolerance assessment, in the case of social visits.
- Access to outdoor visitors shall be permitted, when desired by the resident, their alternate decision maker, or designated family/support persons.

- Visitors (other family, friends, accompanied minors, support persons, professionals, etc.) **must** be permitted entry in circumstances identified as extenuating:
  - End of Life:
    - Within the context of supportive living and long-term care: While it is difficult to be precise around when a resident is at the end of their life, end of life in this context refers to the last four to six weeks of life.
      - The **operator** must be reasonable and use their best judgement in making determinations about residents who are at end of their life with consideration given to providing a quality end of life for the resident and their visitors.
      - Once there has been an end of life determination, increased access under this parameter will continue, beyond the four to six week timeframe, if a resident has not died.
      - To clarify, a physician's note is not required for the determination of end of life.
    - Within the context of hospice: Increased access under end of life parameters above apply from the time of admission to hospice.
  - Significant change in health status: Any instance of sudden change in physical/mental/cognitive/ spiritual health status, extreme loneliness or depression, or other situation where resident health has been or is suddenly compromised.
    - The **operator** must be reasonable and use their best judgement in making determinations about residents having a significant change in health status, in consultation with the resident and designated family/support person(s).
  - Pressing circumstance: Any life event where on site access to someone other than the designated family/support persons might be necessary (e.g. financial or legal matters, family crisis, etc.).
    - The **operator** must be reasonable and accommodate visitors in a pressing circumstance.

- An **operator** must not restrict entry to visitors in these three above instances. All visits must be coordinated with the operator.
- To clarify, these visitors shall not be subject to duration or frequency limitations in place by the operator to manage visitors.
- Visits in these situations are subject to *Indoor Visit* requirements regarding number of people at one time (Refer to Table 1 for summary).

- Other visitors (including accompanied minors) **may** be permitted for indoor visits in circumstances identified as social visits.
  - In settings where the assessed risk of COVID-19 exposure is low and site and resident directed risk tolerance is high (refer to *Risk Tolerance Assessment*), visitors may be permitted for indoor social visits.
    - Access to social visits may be based on site ability to accommodate more people (i.e. maintain physical distancing) and subject to operator approach (i.e. scheduling frequency and duration limitations).
    - Visits in these situations are subject to *Indoor Visit* requirements regarding number of people at one time (Refer to Table 1 for summary).
- Other visitors (including minors) **must** be permitted for outdoor visits.

- Access to outdoor visits may be based on site ability to accommodate more people (i.e. maintain physical distancing) and subject to operator approach (i.e. scheduling frequency and duration limitations).
- Visits in these situations are subject to *Outdoor Visit* parameters regarding number of people at one time (Refer to Table 1 for summary).

- An **operator** must educate all visitors on *Safe Visiting Practices* and related site policies.

Operator Requirements

- An **operator** must:
  1. Develop, implement, maintain, and communicate a principle-based policy and process for safe visiting during the COVID-19 pandemic. This policy and process must be developed in collaboration with residents and families, consider all guidance provided in within this Order and, at minimum:
     a. Consider the needs and preferences of residents and families;
        i. Parameters for visits must be flexible and supportive and reflective of the voice of the resident[8], where they are able to express their preferences regarding visiting.
        ii. Unless otherwise compromised due to health status, residents should be supported to identify their own perceived risk tolerance.
     b. Outline the method of coordinating visits to ensure safe presence and movement of people and equitable access to visits for all residents;
        i. Develop a standing schedule (if desired) for designated family/support persons based on the needs and preferences of the resident.
        ii. Develop a method for scheduling visits in shared spaces (indoor and outdoor) where applicable.
     c. Identify the assessed risk tolerance[9] of the site, in consultation with residents, families, and staff, with consideration of risks and mitigation plans for changes to resident or site circumstance;
     d. Identify the criteria for restricted access;
     e. Outline process for restricting visits due to non-complying persons;
     f. Outline dispute resolution process, including method of documentation;
        i. Refer to *Dispute Resolution* for minimum expectations for this process.
     g. Be evaluated regularly, at minimum every three weeks or as risk conditions change or when residents or families indicate a need to re-evaluate; and
     h. Be regularly communicated to residents, staff, and designated family/support persons, at minimum every time it is updated.
  2. Proactively and collaboratively work with residents, or alternate decision makers, to confirm up to two (2) designated family/support persons per resident, ensuring each resident has the level of support they desire and/or require.
  3. Keep a list of all designated family/support persons for verification purposes.
  4. Ensure that the *Health Assessment Screening* is conducted on every person upon entering the site under this Order and instruct persons to proceed directly to the expected location of visit (resident room, shared care area or designated indoor space).
  5. Discuss and explain *Safe Visiting Practices* and related site policies all residents, designated family/support persons and visitors and instruct all persons to adhere to them.
  6. Designate outdoor spaces for outdoor visits and, where applicable, indoor spaces for indoor visits and mark them as such with signage.

[8] Where there is a difference in desire for visits between a resident and their family/visitors, the resident's preferences will be paramount.
[9] Refer to *Risk Tolerance Assessment* for guidance

7. Ensure residents, designated family/support persons and/or visitors have or are provided with the required PPE (based on precaution required), have been trained to use, and have practiced the appropriate use of the PPE.

- Operators are encouraged to consider the following principles in the development of a site-based policy and process for safe visiting during the COVID-19 pandemic:
    - Balanced: Respecting the physical, mental, social, cultural and spiritual needs of the resident alongside the risks to the collective of more people on site.
    - Risk-informed: Perceived or actual risk factors are recognized and considered alongside the needs and preferences of residents (at an individual and collective level).
    - Respectful: Recognition that access to loved ones and supportive persons is deeply personal and contextual, often difficult for individuals to articulate and generalize.
    - Responsive: Recognition that site characteristics and resident circumstances change.
    - Transparent: Decisions or adjustments to an approach must be communicated in an immediate and timely manner with residents, families and other impacted persons.
    - Collective responsibility: All impacted parties have a duty to minimize risks to self and others and ensure safety both in on-site and off-site activity.
- Operators may use off-site volunteers (or on site if a resident volunteer) on a case-by-case basis for specific tasks to help support the implementation of CMOH Order 29-2020 (e.g. remote virtual/telephone training and education support to designated family/support persons and visitors; remote scheduling support; etc.).

Designated Family/Support Persons and Visitor Responsibilities

- All designated family/support persons and visitors must be instructed to:
    1. Undergo Active *Health Assessment Screening* at entry and self check for symptoms throughout visit.
    2. Coordinate all visits with operator, unless done by the resident.
    3. Be educated on and adhere to *Safe Visiting Practices* and related site policies.
    4. Only visit with the resident(s) they are supporting.
    5. Wear a mask continuously indoors; and, if physical distancing cannot be maintained, outdoors.
    6. Notify the operator of any symptoms that arise within 14 days of visiting with a resident.
- Entry may be refused if there is reason to believe an individual is not abiding by these responsibilities.

Indoor Visits

- An **operator** must not limit residents from visiting with each other.
    - Residents who are not required to isolate (e.g. not symptomatic nor required to isolate in the case of outbreak protocols, etc.) or quarantine (e.g. not a close contact of someone symptomatic) are permitted to visit indoors with other non-isolating or non-quarantining residents of the same site. If a site is under investigation for an outbreak, or in an outbreak, these visits should occur with physical distancing requirements in place.
    - Visits between residents may be in a resident room or in a designated shared space (see below).
- At minimum, an **operator** must permit visits from designated family/support persons and visitors in extenuating circumstances in resident rooms and shared care areas within the following parameters[10] (Refer to Table 1 for summary):
    - Resident Room[11]: **Up to two at one time**, space permitting.

[10] Subject to *Restricted Access*

[11] In the case of a semi-private room, physical distancing from the other resident(s) must be maintained. If this cannot be maintained, the operator must do their best to make accommodations to support the residents (e.g. temporary relocation of resident, etc.)

        - At a minimum, visitors other than the designated family/support persons shall have access to a resident room in end of life, change in health status or pressing circumstance situations.
        - The only exception to "up to two at one time" is in the case of end of life**, where three persons at one time** are permitted, unless all persons are from the same household in which case there is **no maximum**.
    - Shared care areas (where direct care, such as assistance with eating, rehabilitation support, bathing support, is provided): **One at a time** (designated family/support person only)
        - Semi-private resident rooms should be considered a resident room and not a shared care area.
- Social visits from others (not designated family/support persons or visitors in extenuating circumstances) may occur in resident room.
- An operator may designate shared indoor space(s) for indoor visits.
    - Designation of indoor visiting spaces should be informed by the site's risk tolerance assessment, including consideration of location of space, size of space and ability to safely accommodate more people (e.g. maintain physical distancing).
    - Visits in designated indoor spaces may be restricted to designated family/support persons only or can include other visitors if building design/space makes this feasible. All visits must occur in spaces where physical distancing is possible between all persons and groupings.
        - Limit of **3 people per grouping** (including the resident), unless the site can safely accommodate more.
- A designated family/support person is not required to be present for an indoor visit.

Outdoor Visits

- It is important for mental health to spend time outdoors. An **operator** must not restrict access to outdoors for residents who are not required to isolate (e.g., not symptomatic nor required to isolate in the case of outbreak protocols, etc.) or quarantine (e.g., not a close contact of someone symptomatic, etc.). When desired, residents must be supported to spend time outdoors and have outdoor visits, while observing physical distancing requirements.
- While residents who are not required to isolate (i.e. symptomatic) or quarantine (i.e. close contact of someone who is symptomatic) are encouraged to stay on site property, they are not required to do so.
    - For visits that go beyond the property (e.g. community walks), arrangements with the operator are only required if the resident requires staff support to prepare for or be transported to the visit.
        - For greater clarity, if a resident requires a designated family/support persons', or visitors' (when permitted) assistance to be transported to the visit, arrangements with the operator should not be required beyond the existing operator policy for social leaves for notification.
- An **operator** must support outdoor visits with **up to five people** (including the resident), when desired.
    - An operator may determine a lesser maximum number of people based on the amount of space, the number of groupings, and the ability to maintain physical distance between all persons and groupings (with the exception of those from the same household).
    - **Operators** must designate suitable outdoor space(s) for visits.
    - A designated family/support person is not required to be present for the outdoor visit.
    - Outdoor visitors, other than the designated family/support persons, will be asked to remain outdoors at all times (i.e. entry to the site will not be permitted), unless otherwise indicated by operator.
    - Operators are encouraged to designate indoor space if feasible for instances where weather conditions make outdoor visits not appropriate.

Table 1. Indoor and Outdoor Visit Summary

Indoor Location	Requirements[12]
Resident Room (private rooms)	**<u>At Minimum</u>** Up to two people at one time (not including resident): o Designated Family/Support Person(s); and/or o Visitor(s) in change in health status or pressing circumstance situations Up to 3 people at one time in <u>end of life</u> circumstances, unless all persons are from the same household in which case there is <u>no maximum</u> o Designated Family/Support Person(s); and/or o Visitor(s) **<u>Where permitted, based on site's risk tolerance assessment</u>** Social visits, up to two people at one time (not including resident); designated family/support person not required
Resident Room (semi- private rooms)	Same as private rooms, but physical distancing from the other resident(s) must be maintained If this cannot be maintained, the operator must do their best to make accommodations to support the residents (e.g. temporary relocation of resident, etc.)
Shared Care Area (where direct care is provided)	**<u>At minimum</u>** One designated family/support person at a time only
Designated Indoor Spaces (not care areas)	**<u>Where permitted, based on site's risk tolerance assessment</u>** Limited to a maximum of 3 people (including the resident) per grouping, unless the site can safely accommodate more
Designated Outdoor Spaces	**<u>At minimum</u>** Up to five people (including the resident) per grouping if physical distancing can be maintained

Extended Visits

- As per CMOH Order 23-2020 (which amends CMOH Order 10-2020):
    - An **operator** must advise residents of their responsibilities regarding Resident Outings.
    - Residents returning from off-site outings of less than 24 hours are not required to isolate, unless they fail the Health Assessment Screening.
    - Residents returning from off-site outings of more than 24 hours are required to isolate for 14 days following their return.
    - Modification to isolation requirements in specific situations may be granted by zone Medical Officers of Health, on a case-by-case basis, for the resident.

<u>Off-Site Overnight Stays</u>

- An **operator** must support residents in leaving the site for recreational extended stays (over 24 hours) off-site (e.g. visits to family cabin, weekends at family house, etc.), when desired.

[12] Numbers subject to *Restricted Access*

- Where a resident is immunocompromised or medically fragile, they should involve their care team, physician, at-home supports and any alternate decision maker to make a decision about leaving on an extended stay off-site.

On-Site Overnight Stays

- In extenuating circumstances (i.e. end of life; change in health status or pressing circumstance), when requested and where feasible, an operator may implement a process for overnight stays for one or more designated family/support persons and/or other visitors.
    - Prolonged overnight stays (i.e. night after night) should be supported, following all *Safe Visiting Practices* and related site policies, in hospice situations.
- An **operator** must instruct the designated family/support person(s) and/or visitors(s) to follow all additional site protocols that may be in place above and beyond this Order to ensure a safe overnight visit on-site.

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.
    - Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.
- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration[13] with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate[14].
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.
        - For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
    - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.

[13] An operator's safe visiting policy and process, developed in collaboration with residents and families, must identify criteria for restricted access.

[14] As per CMOH Order 23-2020, Once the AHS Coordinated COVID-19 Response team has been informed and a COVID-19 outbreak has been declared, the AHS zone Medical Officers of Health (or designate) will be the contact going forward.

- When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Risk Tolerance Assessment

- Risk tolerance, in the context of this Order, is the ability of a site, as an entity (physical accommodation and the collective of residents and staff), to accept increased potential of exposure to COVID-19 to inform situations where restricted access may be necessary and where more visits (e.g. social) are desired. Risk tolerance is fluid (i.e. is not constant; will continuously change) and will depend on many factors, outlined in Table 2.
    - It is important to recognize that risk factors are not mutually exclusive. It is the consideration of the combination of them that will ultimately inform a site's risk tolerance.
        - For example, a site could be small with minimal space, where the residents are active and healthy and assess their own risk tolerance as high. In this situation, social visits in designated indoor spaces or resident rooms, if desired, may be permitted.
- Per CMOH Order 29-2020, an **operator** must identify the risk tolerance for the site based on conversations with their residents, families and staff. Risk tolerance will vary between sites for many reasons including site designation (e.g., a group home may have a greater risk tolerance than a long-term care facility) and perception of risk tolerance by each resident or alternate decision maker.

Dispute Resolution

- An **operator** must document all disputes as per existing concern/complaints processes under the Accommodation Standards and/or Continuing Care Health Service Standards (where relevant).
- An **operator** must develop a process for dispute resolution that includes the following escalation, at minimum:
    1. An **operator** must work with the resident and designated family/support person(s) to address any concerns that arise regarding the site policy and process for safe visiting, and the interpretation and implementation of this Order. This may include addressing through the Resident and Family Council, where a Council is established and representative of the collective.
    2. Should concerns not be resolved at site level, **organizational/agency executive level position** (where applicable) support shall be sought.
    3. Should the concern still be unresolved after speaking with the operator and an executive of the organization/agency, Alberta Health Accommodation Standards and Licencing or Alberta Health Services AHS Patient Relations (only for designated supportive living or long-term care) may be contacted for support.

Table 2. Risk Tolerance Assessment Table

Risk Factors	Description and Site Assessment
Number of People on site and Layout of Site	To ensure safe movement of people, operators may assess the site in terms of layout and number of people on site at any one time. For example: ▪ Spacious hallways, common areas and rooms may indicate a higher risk tolerance ▪ Prevalence of semi-private rooms may indicate a lower risk tolerance ▪ The number of floors may mean increased use of access points (e.g. elevators) which may indicate a lower risk tolerance
	Site Notes:
Collective Health Status of Residents, where known	This may be actual or perceived health status. If the majority of residents have complex health conditions, this may indicate a lower risk tolerance
	Site Notes:
Number of residents actively leaving site for outings	Consider essential and non-essential outings. The number of residents actively leaving the site for outings may indicate a lower risk tolerance (as there is already increased potential of exposure)
	Site Notes:
Any disclosed resident directed assessment of risk tolerance	Though it is recognized not everyone will assess themselves the same way, residents will have a sense of their health and the risks they would be willing to take for more visitors on site. Though this is a subjective measure, the risk tolerance of the site should be directed by the risk tolerance of the residents, where disclosed.
	Site Notes:
Any disclosed staff directed assessment of risk tolerance	Though this is a subjective measure, the risk tolerance of the site should be informed by the risk tolerance of the staff, where disclosed.
	Site Notes:
Mechanism for ongoing assessment of risk designation of region	Up to date understanding of the incidence of COVID-19 in the community is important *Note: Where a facility is located with respect to risk designation of region* ***does not itself*** *constitute the need to adjust risk tolerance of site.* • Open: Low level of risk, no additional restrictions in place • Watch: The province is monitoring the risk and discussing with local government(s) and other community leaders the possible need for additional health measures • Enhanced: Risk levels require enhanced public health measures to control the spread
	Site Notes:
Other:	
Other:	

Safe Visiting Practices

Risk of Unknown Exposure to COVID-19

- It is important for all persons to understand their risk of unknown exposure to COVID-19, based on their behaviour in the last 14 days, prior to entering the site and modify their behaviour accordingly (Refer to Table 3).
    - It is particularly critical that active *Health Assessment Screening* is completed at entry, is answered completely and accurately, and anyone with symptoms or recent known exposure to COVID-19 not enter the site at all.
    - While individuals do not need to disclose their assessed risk of unknown exposure to the operator, they must ensure the resident or alternate decision maker is aware of it and behave accordingly.
    - Individuals should limit the number of different sites they enter and provide in-person visits to only one site per day to the greatest extent possible.

Table 3. Risk of Unknown Exposure Assessment Guidance

Low Risk	**Medium Risk**	**High Risk**
To be considered at low risk of unknown exposure, all the following conditions must be met: • Does not work or live in an area of high COVID-19 exposure (refer to Risk designation of region) • Works from home • Part of a small cohort (15 or less) who consistently practices physical distancing and masks when cannot maintain distance • Not have had guests at home in the past 14 days • Visits resident(s) in one site in a day • Makes essential outings only • Uses own vehicle • Consistently maintains 2 metres of distance from those outside household in all activities • Mask worn when cannot maintain physical distancing • Consistent hand hygiene • No interprovincial travel within the last 14 days	*There will be many variations that arise between the extremes of high and low risk of unknown exposure* *Individuals must use their best judgement to determine risk of unknown exposure where neither low nor high is appropriate.*	To be considered at high risk of unknown exposure, any one or more of the following may be met: • Works or lives in an area of high COVID-19 exposure (refer to Risk designation of region) • Works outside home in settings where distancing is not consistently maintained and masking is not consistently used • Worked at or visited a location with a declared COVID-19 outbreak in last 14 days • Part of a large cohort (more than 15) • Cohort inconsistently practices physical distancing and use of masks when cannot maintain distance • Have had guests in home in last 14 days • Visits resident(s) in multiple sites in one day • Outings where contact with others outside household is likely • Use of public transit or carpooling where distancing is not consistently maintained and masking is not consistently used • Does not maintain physical distancing and does not wear a mask • Infrequent or inconsistent hand hygiene • Interprovincial travel within the past 14 days

Hand Hygiene

- All persons visiting, including residents, must wash their hands often with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer (greater than 60% alcohol content) before, during as appropriate, and after all visits.
    - An operator may require the visiting person to provide their own hand sanitizer.

Use of PPE – General Practices

- All designated family/support persons and visitors are required to wear a mask continuously throughout their time indoors and be instructed how to put on and take off that mask and any other PPE that may be required. A mask may be provided by the operator, designated family/support persons or visitors.
    - Single-use masks may be removed (and immediately disposed of) for indoor visits in a resident room if physical distancing can be maintained. A new mask must be worn in transit through the site.
    - Public Health Guidelines for use of masks must be followed.
- Continuous use of a mask is not required for outdoor visits unless physical distancing cannot be maintained.
- When visiting a newly admitted resident or a resident on isolation precautions, operators must ensure that the designated family/support persons and/or visitors have or are provided with the required PPE (based on precaution required), have been trained to use, and have practiced the appropriate use of the PPE.

Use of PPE to Enable Safe Physical Touch

- The risk of transmission of COVID-19 increases with close proximity. If a resident and their designated family/support person(s) or visitor(s) understand this and they wish to include physical touch in their visits, this may be done by following the additional guidance:
    - Stop close contact with the resident and inform staff immediately for further direction if they are or become symptomatic during the visit.
    - Continuously wear a mask that covers the nose and mouth while within 2 metres of the resident.
    - Though a resident does not need to also wear a mask, they may choose to do so based on their own risk of unknown exposure from off-site activity (refer to Table 2).
    - Perform hand hygiene (hand washing and/or use of alcohol based hand sanitizer) both before and after direct physical contact with the resident.
    - If resident is isolated due to symptoms of COVID-19:
        - Operators must ensure that the designated family/support persons and/or visitors have or are provided with the required PPE (based on precaution required), are trained, and have practiced the appropriate use of the PPE.

- Individuals at low risk of unknown exposure may engage in safe physical touch.
- Individuals at medium risk of unknown exposure may engage in safe physical touch, where resident risk tolerance is high.
- **Individuals at high risk of unknown exposure are not recommended to physically touch the resident** unless providing direct resident care wearing all appropriate PPE.
- Refer to Table 3 for guidance on risk of unknown exposure to COVID-19.

Use of PPE for those with Cognitive/Sensory Impairments or Traumatic Experiences

- Residents who have sensory deficiencies or cognitive impairment must be supported to have safe and meaningful visits that support their health and wellbeing. This includes creative strategies to overcome barriers in situations where the use of PPE by the visiting person is inappropriate or disrupts communication, where physical distancing cannot be maintained.
    - For greater clarity, where use of PPE is disruptive, it is acceptable to remove the PPE if physical distancing can be maintained.
- Where the use of facial PPE (such as a face mask) by a designated family/support person or a visitor is distressing due to a cognitive or sensory impairment or traumatic experience, and physical distancing cannot be maintained, adaptation of facial PPE may be considered as described below:
    - Facial PPE must provide respiratory droplet source control (e.g. if face shields are being considered, they must provide protection that wraps under the chin).
    - Adaptations must be discussed/approved by the operator and facility medical director, if applicable, or zone Medical Officers of Health on a case-by-case basis.

Visiting Animals

- Subject to precautions and ability of the operator to accommodate animals, one animal is permitted to accompany a staff member, designated family/support person or other visitor for both indoor and outdoor visits.
- The animal must meet the individual operator policy regarding animal visits, where established, and operators must require visiting animals to be well (i.e. not displaying signs of illness, such as diarrhea or vomiting) and not come from a household with individuals at high risk of unknown exposure to COVID-19.

Gifts

- Designated family/support persons and visitors should be permitted to bring gifts, including homemade or purchased food or flowers/plants.
- Depending on the risk level of the individual, and at the discretion of the operator, some items may be required to be cleaned and disinfected by the individual or quarantined for a period of time (when disinfection is not possible).

Health Assessment Screening

Active Health Assessment Screening for Designated Family/Support Persons and Visitors

Any designated family/support person or visitor who intends to enter a facility, and/or who cannot maintain physical distancing during an outdoor visit must be screened. This screening must be completed every time the individual enters the site. Persons who do not enter (i.e. outdoor visits) and follow all physical distancing during the outdoor visit are not required to be screened. Screening shall involve the following:

1. Temperature screening
2. COVID-19 Questionnaire (see **below**)
3. Confirmation of self assessment of risk of unknown exposure to COVID-19 and understanding of *Safe Visiting Practices*
4. Confirmation of identity and designated status (only if entering the building)
5. Documentation of arrival and exit times (only if entering the building)

COVID-19 **Designated Family/Support Person and Visitor** Screening[15]

1.	Do you have any of the below symptoms:		
	• Fever (**38.0°C** or higher)	**YES**	**NO**
	• Any **new** or **worsening** symptoms:		
	○ Cough	**YES**	**NO**
	○ Shortness of Breath / Difficulty Breathing	**YES**	**NO**
	○ Sore throat	**YES**	**NO**
	○ Chills	**YES**	**NO**
	○ Painful swallowing	**YES**	**NO**
	○ Runny Nose / Nasal Congestion	**YES**	**NO**
	○ Feeling unwell / Fatigued	**YES**	**NO**
	○ Nausea / Vomiting / Diarrhea	**YES**	**NO**
	○ Unexplained loss of appetite	**YES**	**NO**
	○ Loss of sense of taste or smell	**YES**	**NO**
	○ Muscle / Joint aches	**YES**	**NO**
	○ Headache	**YES**	**NO**
	○ Conjunctivitis (commonly known as pink eye)	**YES**	**NO**
2.	Have you, travelled outside of Canada **in the last 14 days**?	**YES**	**NO**
3.	Have you had close unprotected* contact (face-to-face contact within 2 meters/6 feet) with someone who has travelled outside of Canada in the last 14 days and who is ill**?	**YES**	**NO**
4.	Have you had close unprotected* contact (face-to-face contact within 2 meters/6 feet) in the last 14 days with someone who is ill**?	**YES**	**NO**
5.	Have you been in close unprotected* contact in the last 14 days with someone who is being investigated or confirmed to be a case of COVID-19?	**YES**	**NO**
6.	Have you assessed your risk of unknown exposure based on your last two weeks of activity (refer to Risk of Unknown Exposure Assessment CMOH Order 29-2020 Appendix A)?	**YES**	**NO**
7.	Do you understand *Safe Visiting Practices* and related site policies (refer to CMOH Order 29-2020 Appendix A)?	**YES**	**NO**

- If any individual answers **YES** to screening questions 1-5, they will not be permitted to enter the site.
  - Individuals must be directed to self-isolate and complete the AHS online assessment tool to arrange for testing.
- If any individual answers **NO** to screening questions 6-7, they will work with the operator to understand their responsibilities before being permitted to enter the site.

[15] Operators must be aware of, and follow, any applicable privacy legislation (e.g., Freedom of Information and Protection of Privacy Act, Health Information Act, Personal Information Protection Act, etc.), should they document/retain the Health Assessment Screening completed with residents and staff (or others).

* 'Unprotected' means close contact without appropriate personal protective equipment

** 'ill' means someone with COVID-19 symptoms on the list above

Operators are encouraged to visit Alberta Health's website to www.alberta.ca/COVID19 for updated information. If there are any questions, please contact Alberta Health Accommodation Standards and Licensing at asal@gov.ab.ca.

CMOH Order 29-2020 Tables

Table 1. Indoor and Outdoor Visit Summary

Indoor Location	**Requirements**[16]
Resident Room (private rooms)	**<u>At Minimum</u>** Up to two people at one time (not including resident): o Designated Family/Support Person(s); and/or o Visitor(s) in change in health status or pressing circumstance situations Up to 3 people at one time in <u>end of life</u> circumstances, unless all persons are from the same household in which case there is <u>no maximum</u> o Designated Family/Support Person(s); and/or o Visitor(s) **<u>Where permitted, based on site's risk tolerance assessment</u>** Social visits, up to two people at one time (not including resident); designated family/support person not required
Resident Room (semi- private rooms)	Same as private rooms, but physical distancing from the other resident(s) must be maintained If this cannot be maintained, the operator must do their best to make accommodations to support the residents (e.g. temporary relocation of resident, etc.)
Shared Care Area (where direct care is provided)	**<u>At minimum</u>** One designated family/support person at a time only
Designated Indoor Spaces (not care areas)	**<u>Where permitted, based on site's risk tolerance assessment</u>** Limited to a maximum of 3 people (including the resident) per grouping, unless the site can safely accommodate more
Designated Outdoor Spaces	**<u>At minimum</u>** Up to five people (including the resident) per grouping if physical distancing can be maintained

[16] Numbers subject to *Restricted Access*

Table 2. Risk Tolerance Assessment Table

Risk Factors	Description and Site Assessment
Number of People on site and Layout of Site	To ensure safe movement of people, operators may assess the site in terms of layout and number of people on site at any one time. For example: ▪ Spacious hallways, common areas and rooms may indicate a higher risk tolerance ▪ Prevalence of semi-private rooms may indicate a lower risk tolerance ▪ The number of floors may mean increased use of access points (e.g. elevators) which may indicate a lower risk tolerance
	Site Notes:
Collective Health Status of Residents, where known	This may be actual or perceived health status. If the majority of residents have complex health conditions, this may indicate a lower risk tolerance
	Site Notes:
Number of residents actively leaving site for outings	Consider essential and non-essential outings. The number of residents actively leaving the site for outings may indicate a lower risk tolerance (as there is already increased potential of exposure)
	Site Notes:
Any disclosed resident directed assessment of risk tolerance	Though it is recognized not everyone will assess themselves the same way, residents will have a sense of their health and the risks they would be willing to take for more visitors on site. Though this is a subjective measure, the risk tolerance of the site should be directed by the risk tolerance of the residents, where disclosed.
	Site Notes:
Any disclosed staff directed assessment of risk tolerance	Though this is a subjective measure, the risk tolerance of the site should be informed by the risk tolerance of the staff, where disclosed.
	Site Notes:
Mechanism for ongoing assessment of risk designation of region	Up to date understanding of the incidence of COVID-19 in the community is important *Note: Where a facility is located with respect to risk designation of region **does not itself** constitute the need to adjust risk tolerance of site.* • Open: Low level of risk, no additional restrictions in place • Watch: The province is monitoring the risk and discussing with local government(s) and other community leaders the possible need for additional health measures • Enhanced: Risk levels require enhanced public health measures to control the spread
	Site Notes:
Other:	
Other:	

Risk of Unknown Exposure to COVID-19

- It is important for all persons to understand their risk of unknown exposure to COVID-19, based on their behaviour in the last 14 days, prior to entering the site and modify their behaviour accordingly (Refer to Table 3).
    - It is particularly critical that active *Health Assessment Screening* is completed at entry, is answered completely and accurately, and anyone with symptoms or recent known exposure to COVID-19 not enter the site at all.
    - While individuals do not need to disclose their assessed risk of unknown exposure to the operator, they must ensure the resident or alternate decision maker is aware of it and behave accordingly.
    - Individuals should limit the number of different sites they enter and provide in-person visits to only one site per day to the greatest extent possible.

Table 3. Risk of Unknown Exposure Assessment Guidance

Low Risk	**Medium Risk**	**High Risk**
To be considered at low risk of unknown exposure, all the following conditions must be met: • Does not work or live in an area of high COVID-19 exposure (refer to Risk designation of region) • Works from home • Part of a small cohort (15 or less) who consistently practices physical distancing and masks when cannot maintain distance • Not have had guests at home in the past 14 days • Visits resident(s) in one site in a day • Makes essential outings only • Uses own vehicle • Consistently maintains 2 metres of distance from those outside household in all activities • Mask worn when cannot maintain physical distancing • Consistent hand hygiene • No interprovincial travel within the last 14 days	*There will be many variations that arise between the extremes of high and low risk of unknown exposure* *Individuals must use their best judgement to determine risk of unknown exposure where neither low nor high is appropriate.*	To be considered at high risk of unknown exposure, any one or more of the following may be met: • Works or lives in an area of high COVID-19 exposure (refer to Risk designation of region) • Works outside home in settings where distancing is not consistently maintained and masking is not consistently used • Worked at or visited a location with a declared COVID-19 outbreak in last 14 days • Part of a large cohort (more than 15) • Cohort inconsistently practices physical distancing and use of masks when cannot maintain distance • Have had guests in home in last 14 days • Visits resident(s) in multiple sites in one day • Outings where contact with others outside household is likely • Use of public transit or carpooling where distancing is not consistently maintained and masking is not consistently used • Does not maintain physical distancing and does not wear a mask • Infrequent or inconsistent hand hygiene • Interprovincial travel within the past 14 days

Two of seven.

Please treat as confidential.

From: David Dickson
Sent: August 12, 2020 10:46 AM
To: Dane.Lloyd@parl.gc.ca; SpruceGrove.StonyPlain@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca
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Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Thank you yet again Dane for another 'pass the buck' response, dismissing the concerns of your constituents. I have now included the MLA's as you suggested. I also added in all the MP's as this is a local, provincial and federal matter as regards Long Term Care. Maybe one of them, unlike you, has the moral fortitude to step up and do more than send out lip service emails. I know they have been talking at caucus about the items in my research for many months but are continually shut down by our Premier and Deena Hinshaw.

Please note, the issues raised here are happening everywhere in Canada as you well know and concede in your email. That makes this a FEDERAL ISSUE, not just a provincial one.

The boilerplate response again about treatments and testing is getting tiring. You really should get another script or have someone actually read the research. To do any less is nothing less than gross negligence. "caring [sic] out testing with clinically and scientifically proven methods" (or even carrying) is completely incorrect. As indicted below, the testing is widely inaccurate and unfit for purpose. This has even been admitted on camera by Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health on July 31st, 2020. (https://youtu.be/bbwMo7IbXbw). Long Term Care Centers are being shut across the country for isolated asymptomatic voluntary tests in a sea of negative results i.e. where there is no COVID. Why is this not something you are raising in Parliament and beyond? Is that not a FEDERAL MATTER?

Maybe even talk to Doctors who are being threatened daily for trying to treat cases early instead of forcing patients into isolation to get too sick to treat. Maybe you could look into where all millions of FEDERALLY donated doses of Hydroxychloroquine have gone? If it doesn't work, why have all the governments stock piled these donations? That is an actual FEDERAL matter!

On long term care facilities, our mother has been in this one for 10 years without incident. It is not the facility that is the issue but the protocols handed down from Dr Tam and the Federal Government that have been adopted in lockstep across each province. That again IS A FEDERAL MATTER.

So, on the FEDERAL MATTERS, what are you doing? What have you done? What questions have you asked since I provided the material that was of FEDERAL INTEREST?

How many more will die on your watch while you regurgitate this government approved drivel?

And yes we are mad at your lack of response. We voted for you and we WILL hold you accountable. Note that these comments are not just those of two sole voters but of a growing number in Alberta and beyond who are disgusted by responses such as this.

David

David T. Dickson
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From: Dane.Lloyd@parl.gc.ca <Dane.Lloyd@parl.gc.ca>
Sent: August 12, 2020 9:30 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

Dear Mr. Dickson,

Thank you for reaching out.

We receive hundreds of emails a day so it can take more than a week to receive a reply.

Testing for COVID-19 and quarantine procedures in the province of Alberta falls under the jurisdiction of the provincial government. As, the federal government representative I do not have a say of influence in their procedures and methods. As I stated in a previous email to you, public health officials are caring out testing with clinically and scientifically proven methods. If you would like to discuss the Alberta operating procedures I would encourage you to reach out to your MLA. If your require assistance in determining who that is my staff would be more than happy to assist you.

There are some opinions out which are exceptionally critical regarding the treatment of COVID-19; many of these statements have not been proven in a scientific or peer reviewed manner so we cannot operate of these assumptions until they have been thoroughly proven. IT is the responsibility of all government officials to ensure the health and safety of its citizens. Other treatment and testing options and research projects are being funded by the federal government, but this research doesn't happen overnight. As research progresses we will have a deeper understanding of COVID-19 and be able to expand our treatment options and procedures.

With regards to long-term care facilities, this is a very serious matter. It would be a very stressful situation for you to have a family member residing in a care facility during this time.

It is unfortunate that it took a pandemic to bring to light some of the appalling conditions that seniors and those who require specialized care had been living in. I find it disturbing that the situation got so bad that the military was called in

to take-over the operations of these facilities. The entire experience is completely unacceptable, and it must be addresses in a swift manner.

The oversight of long-term care facilities in Canada mainly falls under the jurisdiction of the provincial governments, however, I do believe that there is a place for the federal government. We need to work together to form guiding principles which will create a system that provides safe and reliable care of some of our country's most vulnerable.

I also whole-heartedly support a joint federal and provincial investigation into the state of long-term care facilities across the country. I feel that this type of investigation is necessary for us to fully understand where the issues lie and where services need to be improved.

Any governments primary responsibility, be it federal or provincial, is to ensure the health and safety of all Canadians. In this situation, all levels of government failed these vulnerable persons and we need to ensure that a catastrophe like this never happens again. I would encourage you to reach out to your MLA to discuss this matter further as well.

Once again, thank you for taking the time to reach out and discuss this very serious matter and please feel free to contact me in the future.

Kind regards,

Dane Lloyd, M.P.
Sturgeon River – Parkland

From: David Dickson <david.dickson@dksdata.com>
Sent: August 11, 2020 7:00 PM
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Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

To all above and all your colleagues,

It has now been almost a week and not a single response from our member of Parliament (Dane Lloyd) or the two other members of Parliament included below who have been contacted on multiple occasions. Also, no response from the Alberta Health Advocate who is also aware of the many concerns regarding the handling of the below and the larger matter around the COVID response by the Alberta Government.

Today we were informed of another staff created outbreak at Capital Care Dickinsfield (CCD) putting this facility on another 2 week "outbreak" and subjecting the residents to a fourth (and who known how many more) high risk and questionable RC-PCR testing. Note that the same exact fact pattern as in our complaint below was used to extend another Capital Care facility (sudden gastric issues in residents on the day the lockdown should end). How many coincidences make a pattern? Now we assume this latest lockdown at CCD will be under the same incompetent management as before putting the health of residents in further jeopardy. As days pass, it is hard to believe that these processes are not designed to actually hurry along the deaths of these most precious members of society.

You ALL have a duty of care to the citizens of Alberta and none more so than the residents in long term care. Protocols put in place by Deena Hinshaw which have never been enacted before are responsible for avoidable deaths far outnumbering those from this virus. Your inaction is actively contributing to this. You may well remember Jerry Dunham who died unnecessarily in Medicine Hat. I am currently in contact with his family. Avoidable deaths will soon be front and centre, leaving deaths from this virus in the distance. It is a duty of office to ensure accountability and responsibility for actions taken which have life changing consequences for so many on a scale never witnessed before in history.

At what point will you come out of the shadows and stand up for the citizens of this province? There are Albertans dying due to these barbaric and unquestioned protocols that have no scientific basis whatsoever. People are terrified everyday with growing 'cases' but there is no mention that almost all are voluntary asymptomatic tests that have no value other than the fear mongering factor for the daily updates. Speaking of 'Cases' again. This short video explains how cases were being used to manipulate the public in March. Here we go yet again. https://youtu.be/dLWwSYTjiBA

Note that the current rate of positive tests ('Cases') is 1.85% of all tested. The number of reported deaths per test in the province is 0.0337%. False positive error rates are confirmed to be up to 50% putting the number of positive cases as within the margin of error of zero. Tests, even serology tests, can come back positive months after any infection has passed. Deaths are marked as COVID no matter the true cause. This, along with all the facts used to petrify the population, is not even being hidden. Yet it is ignored by ALL of you. Why is that?

At no time in history (since Nuremburg) have we been subject to experiments in public health at this level. Isolation/quarantine of healthy individuals removes, indeed negates, all human rights and restricts access to required health care (mental and physical) that has already resulted in many avoidable deaths. Many more will follow if this continues without challenge. The public is told that known treatments are either dangerous or don't work, when doctors are told that the real reason for withholding treatment is a lack of medication availability. Yet at the same time over 4 million doses of HCQ in Canada alone have been donated by the manufacturers specifically for COVID treatment. Where did those doses of medication go? Worldwide, this number of donated doses of medication exceeds 250 million. More than enough to have treated every person who has died multiple times over. Yet the treatment would have been useless as Deena Hinshaw and AHS deliberately force people to stay home until too sick to be treated properly. Then patients quite literally gasping their last, are consigned to the deadly ventilator after a mere 5 litres of O2 (10 in the Misericordia). No BPAP machine in hospitals was offered for fear of aerosolising the virus (despite protocols available in every hospital for MRSA patients that would negate that risk). Yet CPAP machines are still in use by paramedics in ambulances… I guess their lives are not worth as much as nurses and doctors… or is it something else? My own cardio thoracic surgeon assured me that this barbaric procedure would never happen in Alberta and certainly not in his hospital. He said it only happened for a short time in NY and Italy and no Doctor would ever do this here. Then I pointed out Dr. Darren Markland's tweets boasting about the use of ventilators for people with a respiratory disease. My doctor has not spoken to me since. Why is that?

I have spoken to doctors and nurses in Alberta who have been threatened to keep them quiet. People have died as a result. How is this not under investigation? And all this time, the prerequisite report that Deena Hinshaw quotes on all her Orders as justification for everything that has transpired from the initial lockdown on is yet to be produced to the citizens of this Province. Why is that?

To Glen Motz (Retired Medicine Hat Senior Police Officer), Derek Sloan (Candidate for Leadership), Dane Lloyd, (Member of Parliament for my family and I here in Spruce Grove), and Janice Harrington, (Alberta Health Patient Advocate), we are adding onto this list… Kerry Diotte, (member for Edmonton Griesbach), the area covered by Dickinsfield Long Term Care facility where our mother is currently incarcerated once more… it is time for you to do something and question what is really happening here. As we move back to hearing about cases, just like at the beginning in March, how many of these are from the voluntary asymptomatic testing and how many are 'spontaneous' with no apparent cause or subsequent case?

Consider that all the 'cases' related to Dickinsfield were staff members, not residents. In the Southside Good Samaritan's Care Centre in Edmonton we have 67 cases (26 deaths) in residents and 19 cases in staff. All carers were wearing full PPE at all times and following strict protocols. All of the deaths are in those over 70 years with multiple life threatening co-morbidities. In fact, we have not had a reported death 'with' not 'of' COVID under the age of 70 since April 23rd, 2020. Yet we now require children over the age of 2 to be forced into masks in most cities. I have arrested people during my time as a police officer for less abusive behaviour to children. Yet now we follow the order of politicians who have admitted the decision was rendered based on a survey of 6,000 citizens where 51% opted for mandatory masks. This is nothing less than gross negligence on the part of politicians, police and health professionals.

As with every case in this self described 'most deadly virus in the history of the world', AHS forces people to stay home until the symptoms get too serious for any useful treatment protocols. When did we ever do that before? Are we actually trying to kill people? Where has all common sense gone? Note that compared to SARS and MERS, this mortality of this virus is not even close to the hype it has been given, even assuming the statistics were even close to true. Compared to TB, Ebola and other contagious viruses, it hardly registers at all. In fact, in March of 2020, the UK specifically dropped COVID from being listed as a Highly Contagious Infectious Disease because it was not deadly enough! Yet Canada and Alberta locked down anyway and continue to expand measures that become more bizarre by the day. It appears that Deena Hinshaw and the Government are trying to test the intelligence of people and continue to be surprised at how compliant these citizens will be no matter what they are asked to do.

Note, the average age of a person dying 'with' not 'of' COVID in the province is 83 as of today. Last week it went up to 84 years just for a week. The average life expectancy in the province is 81. Denna Hinshaw has even used the death of a 105 year old with more than three life threatening co-morbidities as a COVID death statistic to justify her actions. Although any death is sad, the most surprising part of the death of a 105 year old right now is the fact that they were 105!

Due to the inane, insane and immoral protocols under the direction of Deena Hinshaw et al, many Albertans have died on intubated ventilators which have NEVER been used for the treatment of a respiratory disease before - for good reason. Ventilators misused in this way are known to cause significant lung damage and death even in those with healthy lungs. How do I know? It happened to me, as Glen Motz is well aware from when I worked with him on the largest Police Project ever undertaken in this province.

As regards this and more, I am attaching my research AGAIN for Mr. Diotte and as a reminder to those who have already had it. Maybe now some of this will resonate more clearly with recent events. It should be noted that most of you have had my research for months, some without even an acknowledgement let alone a response.

This government and Deena Hinshaw never were competent to manage any health crisis. It is clear that their actions have resulted in the deaths of many Albertans and so much more besides. For anyone continuing to ignore this and hide behind politics, in the words of Dante Alighieri "The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

I hope one or more will take up the mantel for the sake of us all. Please contact me for further information. Note that all I have presented is verifiable, been peer reviewed by colleagues and other professionals worldwide along with those here at home in Alberta. There is so much more to this story. It is way beyond time to start asking questions rather than blindly following 'Orders'.

David

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Privacy and Cybersecurity Expert.
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my LinkedIn profile Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.

(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: August 5, 2020 9:20 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>; Derek.Sloan@parl.gc.ca; Dane.Lloyd@parl.gc.ca; health.deputy-minister@gov.ab.ca; info@albertahealthadvocates.ca; Glen.Motz@parl.gc.ca; premier@gov.ab.ca
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; deena.hinshaw@ahs.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Dr. Redacted

The fact that you consider this was a matter for your sole attention, dismissing all others on the email, is indicative of the reason for the complaint. Add to that the fact that you appear to consider it so minor an irritation to you that you can swat it off as a patient complaint to be lost while the chaos under your direction continues, boggles the mind. I assure you that the residents and families do not consider this matter so irrelevant to be dismissed out of hand. Further, as you are well aware, the AHS patient relations department is absolutely not equipped to address such concerns.

The gravity of these concerns warrants more than a summary dismissal by the person who is the very subject of the concerns. This is even more concerning as the actions are indictive of violations of the health act.

I would appreciate some response from the Members of Parliament, Health Advocate's Office, Premiers Office, Health Minister and the office of the CMO, all of whom are included in this email and are directly responsible for the lives of Albertans impacted by this behavior.

David

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my Linked in profile Microsoft Partner

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From: Redacted albertahealthservices.ca
To: david.dickson@dksdata.com, deena.hinshaw@gov.ab.ca, janice.harrington@albertahealthadvocates.ca, jason.kenney@gov.ab.ca
CC: dane.lloyd@parl.gc.ca, derek.sloan@parl.gc.ca, dksdata@gmail.com, glen.motz@parl.gc.ca, health.deputy-minister@gov.ab.ca,

info@albertahealthadvocates.ca, karen.dickson@dksdata.com, premier@gov.ab.ca

Sent: Thursday, August 06, 2020 12:52:36 AM (GMT)

Subject: RE: RE: Visitation for Redacted

Mr. and Mrs. Dickson,

I regret to hear that you are not satisfied with the management of the Capital Care Dickinsfield outbreak and discussions with our AHS team were not able to resolve your concerns.

If you wish to request further investigation into these concerns, please contact our AHS Patient Relations Department: https://www.albertahealthservices.ca/about/patientfeedback.aspx

•Telephone: 1-855-550-2555
•Fax:1-877-871-4340
•Mailing address only:
c/o Patient Relations
10030 107 Street NW, Edmonton, AB T5J 3E4

Sincerely,

Dr. Redacted MD MSc FRCPC
Medical Officer of Health
Alberta Health Services – Edmonton Zone

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> *Redacted thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*
>
> *Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf*
>
> *"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a **confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether**. "*
>
> *As per Redacted previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
> *Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.*
>
> *I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.*
>
> *Thank you,*
>
> *Dr. RedactRedacted MD MSc FRCPC*
> *Medical Officer of Health*
> *Alberta Health Services – Edmonton Zone"*

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.

- Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.

- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
  - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
    - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
  - Any restrictions must not exceed 14 days without re-evaluation.
  - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**
    - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
    - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
  - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
  - When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order *"In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."

"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the

previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275 residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

2020-07-05	Edmonton Zone	Female	80+ years	Died
2020-07-05	Edmonton Zone	Male	70-79 years	Died
2020-07-07	Edmonton Zone	Male	70-79 years	Died
2020-07-08	Edmonton Zone	Female	80+ years	Died
2020-07-12	Edmonton Zone	Female	70-79 years	Died
2020-07-14	Edmonton Zone	Female	80+ years	Died
2020-07-14	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Female	80+ years	Died
2020-07-15	Edmonton Zone	Male	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-16	Edmonton Zone	Female	80+ years	Died
2020-07-17	Edmonton Zone	Female	80+ years	Died
2020-07-17	Edmonton Zone	Female	80+ years	Died
2020-07-18	Edmonton Zone	Female	80+ years	Died
2020-07-18	Edmonton Zone	Female	80+ years	Died
2020-07-19	Edmonton Zone	Female	80+ years	Died
2020-07-19	Edmonton Zone	Female	70-79 years	Died
2020-07-21	Edmonton Zone	Female	80+ years	Died
2020-07-26	Edmonton Zone	Female	80+ years	Died
2020-07-27	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	70-79 years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	70-79 years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-28	Edmonton Zone	Female	80+ years	Died
2020-07-29	Edmonton Zone	Female	70-79 years	Died
2020-07-29	Edmonton Zone	Female	80+ years	Died

We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

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From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

You have received an email message secured by Private Post. Please open the file called Encrypted_Message.htm to read the message.

Mobile device users:
Forward this email to m@zd.trendmicro.com and receive URLs to view the message on mobile devices.

Attachments

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The Best Laid Plans. COVID-19

A SARS-COV-2 Story.

First published on March 28, 2020

"The wolves knew when it was time to stop looking for what they'd lost, to focus instead on what was yet to come." Jodi Picoult, Lone Wolf

Contents

Executive summary.

Before we start, let me ask... is COVID 19 so deadly as to necessitate a full lockdown, one that requires biocontainment protocols that put MRSA to shame in all health facilities, even those without a single case? If so, why have we shut down emergency rooms across the province and emptied half the wards for a pandemic that appears to have never arrived, despite being here since December at the latest?

We have never in the history of man, quarantined the healthy. From the black plague to SARS and MERS, this current plan is unprecedented. However, there is a plan that locked up the healthy, sick and injured alike, but it is a plan that should never have seen the light of day after the cold war ended.

As a result of these 'protocols' and plan, health workers are stressed to the point that PTSD will be a significant factor in the coming months and years. Yet hospitals are empty, workers furloughed rural ER centers closed. So, if it is that deadly, why have we not implemented full martial law? We require such protocols for anyone that walks through the hospital doors and appears sick, yet people can circulate freely when outside the hospital without any supportable protocols that would have any impact for such a deadly disease. The contradictions in directions right now are incomprehensible.

How can we have just opened long-term care facilities for unsupervised outdoor visits where the residents can be taken from the property and mix with anyone before being taken back? Would that not be highly negligent if it is this deadly?

The reality is we never should have locked down and should have followed all the protocols we already had in place for the more deadly H1N1, SARS and MERS. SARS had a 9.6% mortality rate and MERS a 34% mortality rate, based on actual deaths, not the current guidelines of AHS and CDC. This virus was declassified in Europe from a Highly Infectious Contagious Disease before the UK locked down due to its low mortality rate, yet we all remain locked down.

The following document is a collection of ongoing articles that attempt to explain the reality of the COVID 19 story. The story of a 'novel' (new) coronavirus, something which we experience each year with every newly mutated strain of flu and colds. In addition to the many strains of flu we experience each year (currently 10 separate strains being tracked by the CDC in the 2019/2020 flu season), we

have seen a number of flu epidemics in the last 100 or so years. From Spanish Flu (H1N1) to Swine Flu (H1N1) to the current dominant strain of seasonal flu (H1N1), yes, all the same flu. This isn't even the first SARS-CoV strain. That would have been SARS-CoV-1 in 2003. COVID 19 is the new and improved SARS 2.0, officially designated as SARS-CoV-2.

We have never closed the world in previous years. Most don't even notice the regular flu seasons despite hundreds of thousands of deaths worldwide.

What changed this time? Two words, PANIC followed by FEAR.

This time something or someone triggered the global emergency management protocols designed for much worse than a global pandemic. China, at ground zero, showed the world a scene of panic whilst reporting infection and death rates no more concerning than SARS or MERS before them. Numbers were produced by WHO and others and plugged into models that have failed to produce reliable figures in almost every previous outbreak scenario. These models were presented suggesting millions of deaths would imminently occur unless drastic action was taken, with no facts or reason, no peer reviews or supporting evidence for these conclusions. These models have yet again failed at every hurdle despite the constant revisions dropping the predicted deaths by orders of magnitude each time. For the UK, the projected body count decreased rapidly from millions dead to hundreds of thousands to now 20,000 as of writing. Yet still we remain locked down and listen to these same scientists who got everything wrong.

Scientists and doctors became celebrities presenting ever more frightening and equally deceptive figures on the screen in their now daily briefings. World and local leaders bowed to the almighty doctors and mad scientists, terrified to question them for fear of political suicide if the doctors proved to be right. In addition, the politicians suddenly seized on unchecked power as emergency orders and laws were enacted in haste and modified in ways that had nothing to do with health or welfare.

A compliant public retreated to their houses without a complaint, receiving their regularly scheduled micro 'programming' push through social media and television 24 hours a day. If they went out shopping, they would be greeted with the reinforcing PWA messages plastered as far as the eye could

see. Standing on their little round circles, not speaking and barely making eye contact, the public scouring the aisles for the ever-elusive toilet roll. Scared to approach anyone for fear of catching COVID 19, they hid behind masks, silent like drones. Yet, the mystic virus hangs unseen in the air around for hours and on every surface we touch for days. It spreads with every shared touch and movement through the infected air and is taken back to each and every family lair.

We sit at home and receive our guaranteed basic income handout while our vehicles sit idly in the garage. Addicted to the next COVID 19 update in between binge episodes on Netflix and Amazon Prime, lives on hold to the sound of the ever recurring 'just two weeks more' loop. We 'look but don't touch' our 'new normal' family on little screens as their lives 'Zoom' by. The 'brave' venture to the end of driveways or wave through windows at their grandchildren. Never again will the friendly handshake or hug return to society in the 'new normal'. All this in a few short weeks. Whatever happened to the human race, barely crawling on its belly at best or curled in a ball in the corner at worst? Don't dare speak out and ask what is happening, for fear of your fellow neighbour, family member or even your best friend turning on you in a heartbeat to ensure the 'new normal rules are followed.

What about the avoidable casualties of COVID 19 such as suicides, domestic violence, heart attacks, drug and alcohol abuse, child molestations, cancer, diabetes and other critical follow ups, unreported numbers that are now spiking out of control. Pay no attention to these forgotten victims. Now people only die of COVID 19.

Hospitals are half empty (but fully bio contained) in the middle of a global pandemic. Doctors and nurses 'furloughed' the 'new normal' for 'let go'. And yet in the 'hot spots' the full bio containment protocols reduce efficiency and increase stress resulting in more deaths. We don't treat these coronavirus victims with safe and common anti-viral/autoimmune medications as we have in the past. Safe and commonly prescribed, these medications are now deemed dangerous and not to be talked about. That is unless you are in an area with malaria, have lupus or rheumatoid arthritis. In that case, go ahead take it for decades without supervision or a care. Just remember the annual eye exam, if only the opticians were still open.

Don't worry though. There is a way out. Just a mandatory DNA test, COVID 19 passport to verify you are a virus survivor and a new app on your phone to track your every movement. Just in case you pass by someone infected with the dreaded COVID 19. But aren't I immune now? Maybe not says WHO. So, hold on those passports and get back into the house. Unless of course you have to go shopping, are an 'essential worker' (from fast food to hardware) then you can go out. But not in groups of more than 5 or is that 10 or 15. But then again, if there are hundreds of people in your 'essential' workplace, any number is fine. The economy will be opening soon. But maintain your social distance and ensure you are safe from this deadly virus, the one that requires biowarfare protocols in a hospital but no more than a homemade cloth mask (or not) when outside or at home. So what essential services are deemed safe under the 'new normal rules'? Opticians, restaurant patios and parks? No, hairdressers, nail salons and tattoo parlors. Oh of course that makes complete sense, at least we will look good as the virus spreads.

Sill make sure you follow all the rules, or they will come for your house by bankruptcy proxy. From a $100 fine in the past to potentially $500,000 or jail time, just for breaking that 2-meter rule or gathering in a dangerous crowd of 6 or more.

So, in a few short weeks, we gave up our freedoms to all-powerful governments on the whim of a scientists' models with all the accuracy of a 20-year weather forecast. A cascading series of events led to governments gaining powers that they were never meant to have outside of an Armageddon type scenario.

Now what do we really know about this virus?

1. *It started in the most populous area of the world during one of the highest travel periods (Christmas, New Year and Chinese New Year).*
2. *It was left unchecked by the world for 4-5 months while it expanded at an R_0 rate of 3.4 to 5.7. That is one person infecting anything from 3.4 to 5.7 people in an exponential growth. This was never going to be controlled. (Note that the CDC suddenly change the R0 to 2-3 recently. WHO knowns why?)*

3. *Yet, it never killed in quantities until we started testing in late February or March, at which point it started killing by the tens of thousands.*
    a. *Where are all the bodies from before that, if it is so infectious and deadly?*
4. *It was not safe to go out with a handful of infections that would spread exponentially but may be safe with tens of thousands as a starting point.*
    a. *Flatten the curve they said… with this sort of starting point we will spike into millions of infections and deaths in days, if it is as deadly as they say.*
5. *Lockdown steps have at best had no impact on the spread and at worst have increased the spread due to the 'partial' closure. How can a virus that requires biowarfare protocols as soon as it crosses the hospital doors, be slowed or stopped unless those protocols expand beyond the hospital?*
6. *The original models projected millions of deaths that never came but we continue to stay locked away.*
7. *People have been plunged into poverty, depression, abuse, suicide and left frightened to go to the doctors or hospital. Some are now dying at home from ever increasing heart attacks and more. All because they are told to 'STAY HOME to SAVE THE' health workers.*
8. *We have a safe, cheap treatment that was endorsed by the experts for SARS, MERS and many others. It is used in billions of doses dispensed every year in an almost over the counter mentality, to holiday makers, lupus and rheumatoid arthritis patients. It has been clinically tested and documented as effective in treating coronavirus in various forms as far back as the 1940's but now is now the drug 'that shall not be named'.*
9. *We have to blame China for the initial deception. But from point that our leaders took charge, we need to look closer to home for those to be held accountable.*
10. *We should stop being dependent on China. Yet we watch helpless as it picks over the carcasses of our society torn asunder. And our leaders' response is to buy us out of debt, with our very own money. But make sure you get those 'quality' orders for masks, gloves, COVID 19 tests and more from China, before we go, as no-one else is making them. Just make sure you keep the receipts for the faulty returns.*

11. *Ventilators kill if not used appropriately, and for COVID 19 - there is never an appropriate time. But let's buy more ventilators especially from those experts in the medical equipment field such as vacuum cleaner and car manufacturers… Will they go through years of double-blind studies to make sure they are safe?*
12. *Deaths are now almost exclusively the domain of COVID 19, no matter the cause, as per the official guidelines. And there is a financial benefit to adding COVID 19 to the death certificate in many locations. Moreover, no-one questions that cause of death. Take a number, next patient please!*
13. *The fallout from this manufactured crisis is yet to come. From poverty, to the PTSD that will follow. And the tsunami of backlogged treatments and surgeries that will overwhelm a health system now ill prepared for a rush. The longer we wait, the harder it will be.*

The reality is that this was no more deadly than flu. This was known from the beginning. SARS, MERS and every other 'test run' pandemic in the last 30 or more years never triggered this response. Yet somehow this ever less deadly outbreak did. No-one appears willing to say 'sorry' and let's start over. Better to let people suffer in silence. And God help them if they speak up with anything but the government and social media talking points.

Unlike flu, COVID 19 has a tried and tested, cheap and safe treatment if used early enough. Yet this virus was used as an excuse to remove all civil rights throughout the world. It was weaponized to plunge us into the darkest times we have seen in modern history. And there appears to be no light at the end of this tunnel.

Time to end the insanity. Treat the sick. Remove the lockdown and 'social distancing' that are preventing herd immunity from protecting us all. Stop the tracking and get back to work.

Hold the guilty to account and never let this happen again.

And those guilty of taking advantage of a manufactured crisis;

From a Knight's Tale (RIP the inimitable Heath Ledger)

Wat: You have been weighed.

Roland: You have been measured.

Kate: And you have absolutely...

Chaucer: Been found wanting.

William: Welcome to New World. God save you, if it is right that he should do so.

The Best Laid Plans. COVID-19

A SARS-COV-2 Story – Chapter 1.

First published on March 28, 2020

We need a better Plan.

Before I start, I should mention I fall into four of the top five risk categories for COVID-19. I have family who are particularly at risk also. To be blunt, I have skin in the game. But this isn't about me or you. It is about us all.

Updated May 17th, 2020: Please check out this daily blog being maintained by a Swiss Doctor on what is happening globally. It contains many links to support the below and the comments in the blog[1]. (Swiss Doctor, 2020)

We are currently dealing with the largest global stressor ever experienced in modern history. Note I didn't say pandemic or crisis. That would have been anything from World War I, II, Spanish Flu or countless other scenarios that have killed many millions. This has now developed the appearance of an uncontrolled pandemic. However, it had all the reasoning and information never to have become one. Was it ever really a pandemic? The panic and fear are real, but is the information used to create that fear and panic really all it is made out to be?

Right now, it is hard to rationalize what actions to take, but it is important to stop, think and realize that we need a better plan next time (and there **will** be a next time). This is now the fifth pandemic that is directly connected in just over two decades. This ignores many other global health threats that we have faced and overcome in the same time period.

[1] https://swprs.org/a-swiss-doctor-on-covid-19/

- *All years – Seasonal Flu - (Influenza-A) and (Influenza-B)[2] [3] (CDC, 2020)*
- *1918 H1N1 (Spanish Flu) (Influenza-A)[4] (CDC, 2020)*
- *1957 H2N2 ("Asian Flu") (Influenza-A) [5] (CDC, 2020)*
- *1968 H3N2 (Influenza-A)[6] (CDC, 2020)*
- *1997 H5N1 (Highly Pathogenic Asian Avian Influenza) (Bird flu) (Influenza-A)[7] (CDC, 2020)*
- *2003 - SARS (Severe Acute Respiratory Syndrome) - Coronavirus (SARS-CoV-1)[8] (CDC, 2020)*
- *2009 - H1N1 (Swine Flu) (Influenza-A)[9] (CDC, 2020)*
- *2012/2015 - MERS (Middle East Respiratory Syndrome) – Coronavirus (EMC/2012)[10] (CDC, 2020)*
- *2019 - COVID-19 (SARS-CoV-2) - Coronavirus[11] (CDC, 2020)*

We appear not to have learnt from how these previous pandemics were handled in the recent past. This is an occasion though where the saying, *"Those who cannot remember the past are condemned to repeat it." (George Santayana)*, is ironically turned on its head. Instead of following the lessons of previous outbreaks, we triggered a worst-case scenario plan.

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[2] https://www.cdc.gov/flu/about/index.html

[3] https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm

[4] https://www.cdc.gov/flu/pandemic-resources/1918-pandemic-h1n1.html

[5] https://www.cdc.gov/flu/pandemic-resources/1957-1958-pandemic.html

[6] https://www.cdc.gov/flu/pandemic-resources/1968-pandemic.html

[7] https://www.cdc.gov/flu/avianflu/

[8] https://www.cdc.gov/sars/

[9] https://www.cdc.gov/flu/pandemic-resources/2009-h1n1-pandemic.html

[10] https://www.cdc.gov/coronavirus/mers/

[11] https://www.cdc.gov/coronavirus/2019-ncov/

There are people in the world from First Responders to Government to Armed Services, who will recognize the 'break glass in case of emergency' plan that has been implemented by Governments at all levels globally. However, this plan was never designed for what we are dealing with now. It was designed to deal with a global emergency of catastrophic proportions and with it came government powers that should never be taken lightly.

We need a better plan

There are also professionals who deal with Business Continuity Planning (BCP) and Disaster Recovery Planning (DRP) who will recognize that this plan appears to have no nuances or layers. Those people understand that there can never be a 'one size fits all' for disaster planning.

- ***What is different this time?***
- ***Why is it so much worse?***

Before we answer the first question, we must touch upon the second.

Why is it so much worse?

The real question is, "Is this virus worse?" The answer to that, as regards the virus itself, is NO. How can that be you ask? This has caused a global collapse the likes of which has never been seen before.

It is the reaction and impact to society that is worse, not the actual virus. This reaction is causing a feedback loop that is actually making the impact of the virus and loss of life worse. However, no-one is asking how many people (outside of COVID-19) are dying in hospital or waiting for treatment due to the stress these new protocols have placed on the system. People didn't suddenly stop getting sick or requiring treatment for other just as deadly (and worse) ailments. Why are they being ignored?

The media says that regular flu has a mortality rate of 0.1% and COVID-19 is 2%-3%. That number for COVID-19 changes every day for each country from less than 0.1% to over 20%.

This study suggests that COVID-19 infection rates are already widespread which would put the mortality rate well below that of seasonal flu. Coronavirus may have infected half of UK population —

Oxford study [Link][12] (FT, 2020). This study also correlates with the massive, uncontrolled movement of people in and out of ground zero for months before countries went into partial lockdown. More recent studies on wider spread antibody testing suggest that even this Oxford study may underestimate the actual spread and therefore bring down the overall mortality rate below seasonal flu. This is backed up by the known and well-studied expectations of the spread of a highly infectious virus such as COVID 19.

Where did those numbers come from?

Seasonal Flu

These are long term statistics gathered over decades. This does not come from testing every person who has flu though. This 0.1% number is also based on millions of people contracting the flu seasonally, despite over 50% of the population being inoculated (think the ultimate in self-isolation). By the definition we are using for COVID 19, the flu is a far more serious perpetual global pandemic![13] (Flu Hospital Rates, 2020)

COVID-19

These are rapidly changing numbers associated with testing people who appear to be symptomatic or who have had direct contact with a person who has tested positive. This assumes only the people exhibiting symptoms and being tested have it. Even with this, it is widely acknowledged that over 80% of people infected have minimal symptoms and recover with no issues. Further, more than 90% recover in this small sample group.

[12] https://www.ft.com/content/5ff6469a-6dd8-11ea-89df-41bea055720b

[13] https://gis.cdc.gov/GRASP/Fluview/FluHospRates.html

What is really overwhelming the health system?

Extensive testing and new protocols impact the ability for the health system to deal with existing patients and other illnesses. Essential medical personnel are being redirected to full time testing. In the meantime, their regular work is handed off or shelved temporarily. Remember the health system is not dealing with just COVID-19.

Protocols have been escalated in health care to almost biowarfare levels, way beyond that of the protocols for far more deadly and infectious diseases. Unlike anything before, family members are separated at the doors of hospitals placing strain on health workers, family and the sick and dying. The strain this puts on the health system is creating a self-fulfilling prophecy. Have you ever been to a hospital treating MRSA (Methicillin-Resistant Staphylococcus Aureus), the 'Super Bug'? Imagine that scaled to every aspect of the health system and then double it for the new protocols. Even without a single case of COVID-19, these protocols are unsustainable.

Now remember that this outbreak started in one of the most populous areas on the planet. It was highly contagious and had a long incubation period (before and after infection) with minimal to no symptoms. It started no later than mid November 2019 (maybe earlier) and travel was not restricted globally until almost 5 months later. During that time, millions of travelers moved in and out of that area at high levels due to Christmas, New Year, Chinese New Year etc.

How many people have really come into contact with COVID-19 as a result?

How did China manage to keep the deaths to 4,634 out of 82,995 infections in a population of 1.4 **B**illon over a period of five months of reported outbreak in the region? Note that actual figures on testing are not available (as is most information on China).

Thursday, May 28, 2020			
	China		
Population	**Tests**	**Positive**	**Deaths**
1,439,323,776	0	82,995	4,634
Per Capita	0.00%	0.006%	**0.00032%**
Per Test		0.00%	0.0000%
Per Positive Test			**5.58%**

With so few deaths, why did China need sixteen large temporary hospitals for such a long time, on top of their existing medical infrastructure? How many people moved in and out of that highly infected area in the months before the world locked down? Something doesn't add up.

Anyone who understands statistics will see a few glaring issues with what is currently being reported.

What are the real statistics?

The CDC just published seasonal flu stats for the US. Up to 56 million infected and up to 62,000 deaths in the same November to April period[14]. (CDC, 2020)

Why is this relevant?

1. *People are not regularly tested for seasonal flu unless they are hospitalized. By contrast, there is mass (but targeted) testing worldwide for COVID-19.*
2. *CDC, WHO and Governments don't report flu numbers on a daily basis with announcements from World Leaders, feeding a panic narrative, unlike COVID 19.*
3. *Seasonal flu maintains those numbers despite a large part of the population being inoculated.*
4. *A smaller group of high-risk individuals have also received 5-year pneumococcal inoculation, protecting against most forms of pneumonia.*
5. *COVID-19 has mild to zero symptoms in more than 80% of people (in current testing) unlike seasonal flu.*

[14] https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm

6. *We have no statistics on the people who have contracted COVID-19 and were asymptomatic, untested and untreated.*
7. *Many people with no symptoms of COVID-19 have tested positive.*

Flu transmission is controlled by a large number of the population being inoculated. The spread of flu has been controlled this season by the exact same steps as those implemented for COVID 19. However, it still killed up to 63,000 people in the US alone in the same 2019/2020 period as COVID-19.

As testing increases for COVID-19, the numbers continue to change. More people appear to have contracted COVID-19 daily, or have they? More people are tested daily as tests roll out. Testing turn-around time has been reduced from 6 days to 15 minutes or less, so we see another spike in reported cases. This doesn't mean COVID-19 is necessarily growing exponentially despite the numbers growing as testing increases.

We need to be careful when referring to the terms 'Cases' and 'Confirmed Deaths' as they do not mean what many people think. As such, they, should be used with caution (unlike John Hopkins University, Bing COVID 10 map, The MSM and daily government updates). Note: The actual definitions and criteria are available from the CDC, WHO and many Government sources (as is shown in this document).

As of April 29th, 2020, the latest Canadian Medical Association Journal (CMAJ) guidelines state that COVID 19 has an overall mortality rate in tested positive cases as 0.1% (1 in 1000)[15] (Zhikang Ye, 2020). CMAJ quote this low mortality rate as a reason not to use any proven safe, cheap and effective medications for the treatment of mild to moderate cases. For COVID 19 (SARS-CoV-2) we are using a confusing mechanism in a clear attempt to artificially inflate the presumed actual mortality rate of the virus i.e. risk of death. All reporting now uses [Positive] 'Case Fatality Rate' (CFR) as an indicator of how likely it is for you to die of COVID 19. However, this is the percentage of the tested (not currently infected or recovered) positive cases. This is the 'numerator' (the number at the top of the equation). This is placed over the number of deaths presumed to also include COVID 19. Note this isn't a death

[15] https://www.cmaj.ca/content/early/2020/04/29/cmaj.200648

were COVID 19 is the primary cause or primary contributory factor in the death. In fact, it isn't even something that may have been tested for and is, as per CDC guidelines, acceptable to assume COVID 19 in some cases. This then forms a very questionable 'denominator' in the equation. We are therefore reporting the most significant piece of information ever reported in the history of the world based on two very questionable numbers.

A true risk of mortality (as calculated in every other pandemic is the actual rate of infection (number of people who caught the disease) over the people who actually died **of** the disease. This is a much lower number than is being reported.

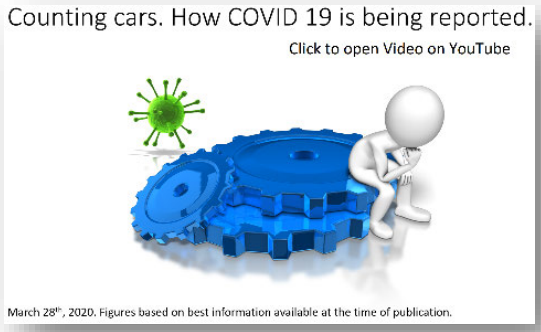
- For SARS-CoV-1 (SARS in 2003/2004) the actual mortality rate was 9.6%. We did not close a single country for that.
- For MERS-CoV (MERS in 2012/2015) the actual mortality rate was 34%. We did not close a single country for that.
- For COVID 19 (SARS-CoV-2), the actual mortality rate appears to close to or less than 0.1%, the same as seasonal flu. Yet we closed most of the world for this.

'Cases' are not the spread of the virus, but rather the targeted testing of a grouping of people expected to test positive. This has been consistently around 20% in the US. As this is targeted testing, the low rate of positive numbers in a group expected to be positive should be worrying. However, this results in a lower numerator ('Cases') which will increase the mortality percentage. This would not normally be an issue if you know how the numbers are derived, but many don't.

The denominator ('Deaths') are, as per the WHO and CDC guidelines, any person with or suspected of having COVID 19, where COVID 19 may have been a contributing factor. As there are many contributory causes of death, this number must not be assumed to be the only or primary cause of death. However, this is not clear in most reporting. Clarity is critical when you consider the impact of the decisions being taken in this scenario worldwide.

When misused as a reason to close the world, putting many lives in jeopardy from the consequences of a global lockdown, this is beyond negligent. ***It constitutes a crime against humanity!***

As an analogy to how these numbers are being reported, let's consider the way that governments justify everyone's favourite selfie moment, '**Photo Radar**' for speeding**.**



Counting cars. How COVID 19 is being reported.[Video Link][16] (Dickson, Counting Cars, 2020)

That being said, it is likely the numbers are growing. Sadly, partial self-isolation may be making the situation worse not better. We have taken a population with an unknown but likely high infection risk and **partially** isolated them. Inside these family or social isolation 'pods', 'social distancing' does not exist. If one person contracts the virus, all are likely to be infected. This isolation has increased stress, reduced time outdoors, created an unhealthy and sedentary lifestyle, all leading to many avoidable risks to our physical and mental health. As such the impact of this unnecessary lockdown will be felt for decades, if not generations to come.

We have allowed one or more of these 'pods' of people to go to small, concentrated and now more heavily frequented locations such as grocery stores, gas stations and fast food drive throughs. Each of these locations has a number of common use hard surfaces made of plastic and metal that we handle without a thought. This isn't just about COVID-19. Gas pump handles for example are as filthy as a toilet seat[17] (Selyukh, 2011). As COVID-19 is primarily transmitted by droplets from our breath (coughing, sneezing and even just breathing in some cases), it is these commonly handled surfaces that pose a potential risk of infection. These locations are not cleaned between visitors as an operating theatre would be.

[16] https://www.youtube-nocookie.com/embed/QM79ybr7Y18

[17] https://www.reuters.com/article/us-usa-health-filth/gas-pump-handles-top-study-of-filthy-surfaces-idUSTRE79O0G820111025

Although no specific cases of hard surface transfer have been cited yet, it is a known risk for virus and other communicable disease transfer in general. Every hard surface can hold the virus for up to 4-5 days (or longer)[18] (Moriarty LF, 2020).

"SARS-CoV-2 RNA was identified on a variety of surfaces in cabins of both symptomatic and asymptomatic infected passengers up to 17 days after cabins were vacated"

Soft surfaces 1- days. None of these surfaces, outside the health system, are being regularly or appropriately disinfected. There are a growing number of cases with no apparent source which could easily be common surface transfer cases. Further, in the same study, COVID 19 has even been found to be stable in the air for 3 hours.

Doctor Marc G. Wathelet, the distinguished virologist in charge of a team studying SARS stated;[19] [20]

"An aerosol, literally a solution in air, consists of micro-droplets, which are so small that they stay suspended in the air or fall much slower than small droplets. They are produced during normal breathing and this production is accelerated by speaking or even more by singing, shouting."
(Doremalen, 2020) (Roberts, 2020)

[18] https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e3.htm

[19] https://www.paulcraigroberts.org/2020/03/09/covid-19-and-aerosol-transmission-some-thoughts/

[20] https://www.nejm.org/doi/full/10.1056/NEJMc2004973

" The presence of more cases where the first symptoms are pulmonary for COVID-19 is a clear indication that transmission also occurs by aerosol." (Doremalen, 2020) (Roberts, 2020)

All the data seems to suggest that COVID 19, while highly infectious, is relatively low risk for all but the most vulnerable in society. Yet we have locked up everyone. This was a necessary part of the plan that was triggered, but is criminal to have been misused as it has been.

As transmissible by fomites (hard surfaces such as water bottles) or direct contact (mucous membranes) and being airborne, COVID 19 qualifies as a *"High consequence infectious diseases (HCID)"* in the UK. In fact, it was classified as such until four days before their lockdown.

Four days **BEFORE** the UK locked down it declassified COVID 19 as a HCID because[21]; (UK Government, 2020)

"...more information is available about mortality rates (low overall)..." (UK Government, 2020)

Since the lockdown in the UK, COVID 19 has been found to be orders of magnitude less deadly than it was thought even then. **Yet the lockdown continues worldwide.**

Why is that?

What is on this list?

- *Avian influenza A H7N9 and H5N1*
- *Avian influenza A H5N6 and H7N7*
- *Middle East respiratory syndrome (MERS)*
- *Severe acute respiratory syndrome (SARS)**

[21] https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#classification-of-hcids

*Note that SARS-CoV-1 (the original SARS) is on this list and yet there hasn't been a case since 2004.

There is also NO vaccine** for the original SARS*.

** The common cold is a coronavirus (OC43). Coronaviruses account for 10%-30% of respiratory infections worldwide (as per Dr. Fauci) but have never locked down the world.[22] (CDC, 2020)

There has never been a vaccine created for any human coronavirus.[23] (CDC, 2020)

Less than 2,000 'cases' (not 'deaths') in China alone, & drug makers 'rushed' to create a vaccine. This, despite no-one ever developing such a vaccine before. A cure for the common cold - Woo Hoo (or is that Wuhan). 50 years trying with no success for any coronavirus!

January 23rd, 2020 (Wall Street Journal article on rush to create a vaccine).[24] (McKay, 2020)

Canada clamoring to cure the new 'common cold'.[25] (D'Amore, 2020)

Thanks Dr. Fauci for suddenly jumping on the vaccine money train. Maybe you will cure the common cold as well!!![26]

We should stop comparing COVID 19 to the flu as H1N1 etc. have a vaccine.

COVID 19 - the new & improved 'Common Cold'.**

No other country (outside of China) has ever locked down its healthy citizens for any of these more deadly highly infectious diseases. So, why have we locked down the world for COVID 19?

In our new isolated way of life, we touch the same gas pump, shopping trolley or pay terminal (and more). The users and operators of these locations are not sanitizing (gloved or ungloved) between

[22] https://www.cdc.gov/coronavirus/types.html

[23] https://www.cdc.gov/coronavirus/general-information.html

[24] https://www.wsj.com/articles/drugmakers-rush-to-develop-vaccines-against-china-virus-11579813026

[25] https://globalnews.ca/news/6466954/coronavirus-outbreak-vaccine-research/

[26] https://jamanetwork.com/journals/jama/fullarticle/2759815

every surface touched. How is this controlling the spread and enforcing isolation? In effect, it is merely giving the appearance of isolation and control.

In fact, grocery stores have now decided that single use bags are a transmission risk. We have moved from banning single use plastic bags to not allowing re-usable bags. How times change in such a short period. In Alberta, the initial spread of infection coincided with most grocery stores banning single use plastic and requiring re-usable bags.

Each of the designated shoppers now come back to their family pods with an increased likelihood of exposure putting at risk the very people they are striving to protect.

This example touches on three 'essential services' that our partial isolation puts us in direct contact with daily. None of these are running with biohazard protocols.

Recently, the Government of Ontario published a list of 74 groups of essential services. It is hard to find a service that doesn't fall into one of these 74 categories. How many people are now moving in and out of high infection risk areas each day?

How are we controlling COVID-19 with partial isolation?

This might explain how Italy deteriorated so quickly when they went into partial isolation first. Note that there is no such thing as **full** isolation that does not result in many more deaths. The only full isolation is in a plastic bubble in a hospital. Think of the movie 'The Boy in the Plastic Bubble' starring John Travolta. That is not possible with a population needing food, medicine and any of the other basics of today's life. Additionally, northern Italians have an apparent genetic trait that increases the impact of an infection such as COVID-19[27] (Sala C1, 2008). As of April 11th, 2020, most of the cases in Italy are still focused in the northern region. Out of 17,127 deaths in Italy, only 1,083 have been in southern Italy. In addition, they have one of the oldest average populations in the world.

[27] https://www.ncbi.nlm.nih.gov/pubmed/18603552

Why didn't the other pandemics spread like this?

The late notice of the disease and increased global travel within China in recent years allowed the virus to spread throughout the world unchecked. China's borders have not been as relaxed as in recent years, so previous spread may have been more contained. Secondly, the prior outbreaks were managed through regular infectious disease protocols (not global lockdowns). Lastly, prior outbreaks were treated with a known prophylactic and treatment at the time. Effects of chloroquine on viral infections: an old drug against today's diseases [Link][28] (Savarino D. A., 2003). This is the very same medication and treatment protocol suddenly being tentatively 'trialed' by doctors and questioned daily by the media. The use of Hydroxychloroquine along with antibiotics is not a new miracle cure for a Coronavirus such as COVID-19. It was used to treat Avian Flu (1997), SARS (2003), MERS (2012/2015) and many other diseases that cause a cytokine storm (such as lupus) for decades. This is why Australia, France, Canada the US and many others are now testing it. As of April 11th, 2020, WHO were apparently expanding testing globally for this decades old drug. However, the obvious push back on this drug, but not others is noticeable.

One question must therefore be asked. Why did it take it taken five months, over twenty one thousand confirmed deaths (by April 11th, 2020) and a global economic meltdown before this was openly discussed and used to save lives? Why are the FDA suddenly suggesting it is dangerous and should not be used, only in the case of COVID 19? Why is it now being shut down in favour of riskier untested and expensive treatments?[29] (Dickson, Articles, 2020)

It is a drug that was invented in 1934 and has been used to treat malaria, lupus and rheumatoid arthritis for many decades. It is cheap, freely available and even the manufacturers are offering millions of free doses to get through this crisis. This is something Governments have been ignoring until one world leader, The US President, Donald J. Trump, pushed back. He forced the FDA to allow

[28] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(03)00806-5/fulltext

[29] https://www.linkedin.com/pulse/how-humble-gin-tonic-may-save-world-from-covid-19-dave-dickson-

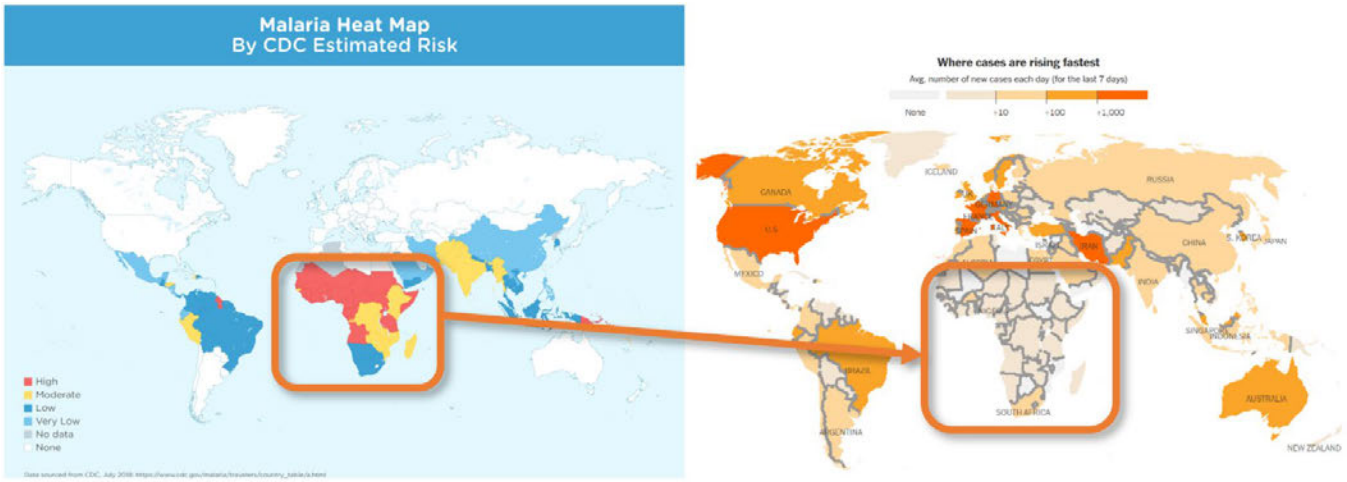
the drug to be used, which, up to that point, was apparently being held back by red tape. Whether you love or loath President Trump, we are now seeing the dam break. Global testing is now in full swing.

Speaking of malaria. Take a look at the malaria world maps and overlay the coronavirus maps. It is interesting to compare the areas of COVID-19 and malaria prone countries.

Although there are pockets of COVID-19 in areas with malaria, the incidence is very small in comparison to the surrounding countries. Africa, for instance, has a population of 1.3 billion. As of April 11th, 2020, Africa had 412 deaths and 9,079 confirmed cases out of 1.3 **B**illion people. Of that, 40% of the reported cases came from one areas in a tight cluster, Egypt, Tunisia and Algeria. If there were no incidences reported, it would suggest a lack of data as not everyone is taking the medication all the time.

What makes Africa so different from Italy and its 60 **M**illion population with over 17,127 deaths and over 135,586 infections in 45 days from the first reported death?[30] (Treated.com, 2018)

https://www.treated.com/malaria/world-map-risk

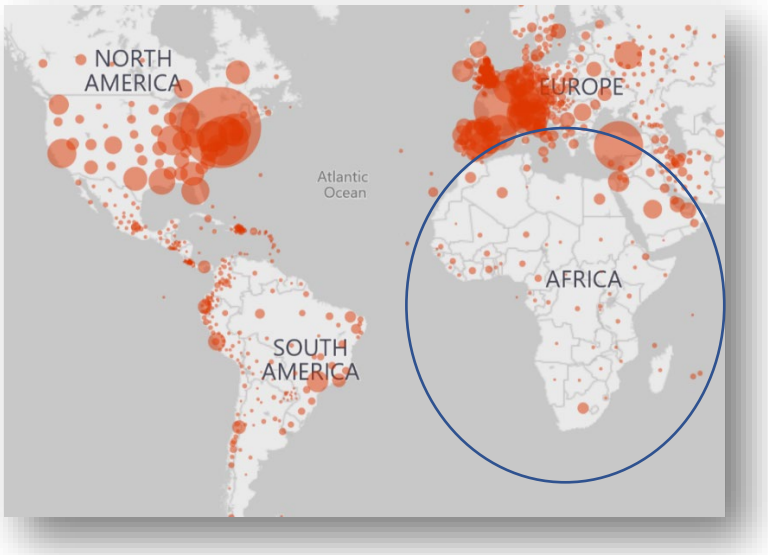


[30] https://www.treated.com/malaria/world-map-risk

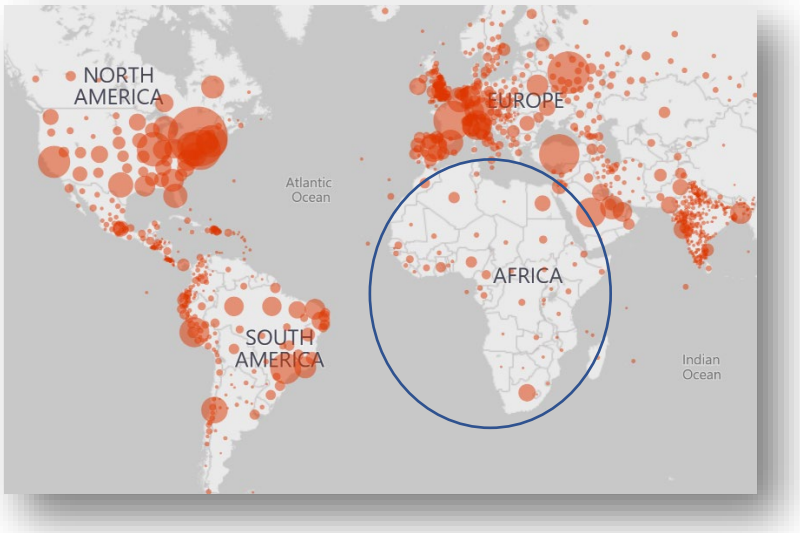
In these maps, we see two things.

Lack of travel/population and high risk of malaria coincide with low numbers of infection and mortality. Is this really just a coincidence?

What about the spread of COVID 19. Here is the map of the COVID 19 spread as of April 19th, 2020.



Here is the same map of the COVID 19 spread as of May 28th, 2020.



What is different this time?

Countries have implemented the only global disaster plan they have. It was designed for nuclear war and similar global scenarios where deaths were guaranteed in the millions. We have essentially implemented globally a 'break the glass' plan where the expectation is casualties and deaths due to the extreme nature of the crisis. The plan is designed to deal with an incident that would kill millions, so 'the casualties of war' position makes sense. This plan was never designed to deal with the type of scenario we are now facing.

We need another plan!

Controlling the population was critical in the plan for nuclear war. That can only be achieved if the population is contained. There are not enough Police or Armed Forces to contain a moving population. In prisons, guards don't try and control prisoners in the exercise yard. They lock them down. It takes a lot less manpower to control a population that is already contained.

Why did Governments across the globe implement their 'break the glass' plan? Because it is the only one they had. The larger question is why did they implement this plan this time and not before?

For SARS and MERS, countries quickly implemented localized infectious disease protocols. They also started the use of anti-malaria and other drugs early. Information globally was sparse and both travel and communication in and out of ground zero (China) was limited.

China tightly controls information flow in and out of their country. In past outbreaks, the Chinese reaction remained hidden from sight. This time, the information coming out of China due to global communications, social media etc. fed into panic protocols being implemented, one Government after the next. One Government (China) implemented this process, let other Governments observe it and boom, everyone is metaphorically 'panic buying toilet paper'. The mentality is, right or wrong, *'we can't be blamed for doing what everyone else does*'.

Back to the comments on a DRP and BCP. Organizations from small business to Governments sadly ignore these plans and very rarely update them. The belief is what they plan for doesn't 'normally' happen!

Yet, disasters do happen. These plans have to be living documents with layers for many scenarios. When the current global threat plans were created in the 60's-80's, there was only one scenario to plan for. Global Thermonuclear War. That risk still exists (with North Korea, China, Iran etc.), but now there are other risks, from 9/11 to the 2008 financial collapse, to SARS, MERS, H1N1, H5N1 etc.

We need a better Plan!

This exact scenario wasn't just predicable; it has happened four times already in just over two decades (SARS, MERS, H1N1, H5N1). Yet, the people who advise Government and manage these plans either did nothing or were not heard. Most of the lack of action and planning, as we know, is due to budgets and the mentality of 'BCP/DRP, what's that?'. This has to change.

We need a better Plan!

The only hope is to learn from this. It is a fact that *"those who fail to plan, plan to fail"*. Or as DNA (Douglas Noel Adams) said,

> "Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so." *(Adams, Last Chance to See, 1989)*

What is the answer right now? The world has gained momentum. We are on a course where it is hard to slow down and almost impossible to stop. The iceberg is here, the Titanic is sinking and we do not have enough boats (or ventilators, doctors, nurses or beds).

However, this is not 1912. We have more lifeboats coming along with every resource available to us. The Hydroxychloroquine trials are a start, as long as the media's worry mongering doesn't scupper the plans. Already we have had the media blaming the US president for three people in Nigeria overdosing

on an over the counter drug! They also blamed him for a couple taking Chloroquine Phosphate from their aquarium supplies, despite it being clearly not for human consumption. Why did the media not blame the Australian, French and US researchers that published the information in the first place? If the US President said Acetaminophen was good for headaches, would he be blamed for the many overdoses that happen every day? People have said if Donald J. Trump found the cure for cancer, people would ask why it took so long. I guess they were right.

However, this is not a left, right or any other type of political discussion. This is not about me, or you, it is about us all.

We have to learn from this. We have to change our response to this type of crisis in the future. This **will** happen again.

We need a better Plan!

"Fool me once, shame on you. Fool me twice, shame on me. Fool me three times, shame on both of us." *(King, 2000)*

1. *1997 H5N1 Highly Pathogenic Asian Avian Influenza (Bird flu) (Influenza-A)*
2. *2003 - SARS (Severe Acute Respiratory Syndrome) - Coronavirus (SARS-CoV-1)*
3. *2009 - H1N1 (Swine Flu) (Influenza-A)*
4. *2012/2015 - MERS (Middle East Respiratory Syndrome) – Coronavirus (EMC/2012)*
5. *2019 - COVID-19 (SARS-CoV-2) - Coronavirus*

In just over 20 years, we are now up to five!!! Shame on everyone if we do not learn and adapt our plans this time.

Maybe next time we need to stop, think and ask;

1. *Is this virus (not the reaction) like any other outbreak? - YES*
2. *Have we successfully dealt with this type of virus pandemic before? - YES*
3. *What did we do that worked?*
4. *Wash (literally) and repeat.*

We can't blame anyone right now. This is not the time for the distraction of a postmortem deep dive looking for blame. There will plenty of time for that, if we survive the current plan. The body (the human race), is still warm and breathing unassisted. We are slowly being smothered though. So, for humanity's sake, we have to learn from this tragedy. We didn't devolve into panic with SARS, MERS, H1N1 and H5N1 some of which, show higher mortality rates.

We need a better Plan!

By the numbers.

In the current crisis, we have an apparent abundance of information. Yet are we really seeing the true story? Right now, the facts being presented are based on targeted testing of likely 'Positive Cases' to misleadingly demonstrate inflated mortality rates. Typically, mortality rates are based on per capita or widespread random sample numbers.

We are continually being told we need to flatten the curve. However, the curve can be artificially manipulated when the figures are based on the number of tests performed and CDC guidelines have almost eradicated any other cause of death.

The US and Italy are prime examples of this misinformation. It should be noted that due to an aging population and other factors, Italy has one of the world's highest mortality (death) rates from seasonal flu in the world.

- *On average, **15%** of the **US** population contract seasonal flu. **0.02%** of that group die annually.*
- *On average, **9%** of the **Italian** population contract seasonal flu. **0.1%** of that group die annually.*

Based on this, you are **50%** more likely to catch flu in the US than Italy. However, you are **600%** more likely to die of flu in Italy than the US. Maybe the death rate from COVID-19 in Italy makes sense after all[31]. (Rizzoac, 2019)

[31] https://www.sciencedirect.com/science/article/pii/S1201971219303285

As on the beginning of April, 6 weeks into their full lockdown, Italy had a reported mortality rate (deaths) for COVID-19, per active case, of about 19.42%. This is the number used to frighten the population. But this is a number with no value whatsoever, other than to induce fear. If you are only looking for horses, you will never find a zebra, even if it is there. If you only test those most likely to have COVID 19, what else would you expect to find?

Digging deeper[32] (Our World Data, 2020), we find that deaths per tested individual is 0.9%. This hasn't changed much. However, this is another number with minimal value as testing is on those most likely to have caught COVID-19. The likelihood of death should be based on the per capita number in absence of widespread random sample testing. As of May 28th, 2020, the mortality rate in Italy was 0.055%. That is the only supportable statistic to show the actual chance of dying right now. Italy's mortality rate is something above but closer to 0.055%, not up to 20% (or 14.3% as of May 28th, 2020) as the media and others have pushed.

Thursday, May 28, 2020			
	Italy		
Population	**Tests**	**Positive**	**Deaths**
60,461,826	3,683,144	231,732	33,142
Per Capita	6.09%	0.383%	**0.05481%**
Per Test		6.29%	0.8998%
Per Positive Test			**14.30%**

For the same day in the US, well into the 'social distancing' and lock downs, these numbers were 5.85% based on positive tests. For each person tested, it was 0.64% (and dropping as testing increases). However, per capita, the unreported rate again was 0.031%. You can't control a population with those numbers though. So, the media pushes the escalating positive test results as if people are catching it at this same escalated rate with a false mortality of 5.85% at that time. In other locations around the

[32] https://ourworldindata.org/coronavirus-testing-source-data

world (as we move through each area), we see similar numbers. Again, the push is on the skewed numbers that cause panic.

Even here the reported numbers by the CDC themselves depend on what page you look at;

The main splash page for COVID 19 from the CDC shows 99,031 deaths as of May 28th, 2020 (up from 62,406 since May 2nd, 2020, despite the lockdown). Interesting that this is the figure the press, John Hopkins, Bing and government report[33]. (CDC, 2020)

Then there is the Respiratory disease reporting page with flu, COVID and 'all cause' mortality based on provisional death certificates (the most accurate data) that shows 81,372 deaths 'from' COVID19 on May 28th, 2020[34]. (CDC, 2020). This is significantly up from the 37,308 deaths 'from' COVID 19 on that same page as of May 2nd, 2020.

To make this worse, on May 2nd, 37K deaths were combined with other causes of death, plus not necessarily confirmed to even have COVID 19. Now that same page as of May 28th, 2020 shows 35,602 combined deaths. Did 2,000 people suddenly get better from 'death' of one form or another?

"Deaths with confirmed or presumed COVID-19, coded to ICD–10 code U07.1"

This artificial inflation of the 'death' count is by design and according to CDC and WHO directives. The one thing we can be assured of throughout this 'pandemic' is that the numbers have been constantly skewed to deliberately cause panic.

[33] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

[34] https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm

Thursday, May 28, 2020			
United States			
Population	**Tests**	**Positive**	**Deaths**
331,002,651	16,002,557	1,751,970	102,476
Per Capita	4.83%	0.529%	**0.03096%**
Per Test		10.95%	0.6404%
Per Positive Test			**5.85%**

Thursday, May 28, 2020			
Brazil			
Population	**Tests**	**Positive**	**Deaths**
212,559,417	871,839	414,661	25,697
Per Capita	0.41%	0.195%	**0.01209%**
Per Test		47.56%	2.9474%
Per Positive Test			**6.20%**

Thursday, May 28, 2020			
Russia			
Population	**Tests**	**Positive**	**Deaths**
145,934,462	9,701,280	379,051	4,142
Per Capita	6.65%	0.260%	**0.00284%**
Per Test		3.91%	0.0427%
Per Positive Test			**1.09%**

Thursday, May 28, 2020			
Spain			
Population	**Tests**	**Positive**	**Deaths**
46,754,778	3,556,567	283,849	27,118
Per Capita	7.61%	0.607%	**0.05800%**
Per Test		7.98%	0.7625%
Per Positive Test			**9.55%**

Thursday, May 28, 2020			
United Kingdom			
Population	**Tests**	**Positive**	**Deaths**
67,886,011	3,918,079	269,127	37,837
Per Capita	5.77%	0.396%	**0.05574%**
Per Test		6.87%	0.9657%
Per Positive Test			**14.06%**

Thursday, May 28, 2020			
France			
Population	**Tests**	**Positive**	**Deaths**
65,273,511	1,384,633	182,913	28,596
Per Capita	2.12%	0.280%	**0.04381%**
Per Test		13.21%	2.0652%
Per Positive Test			**15.63%**

Thursday, May 28, 2020			
Germany			
Population	**Tests**	**Positive**	**Deaths**
83,783,942	3,952,971	182,202	8,552
Per Capita	4.72%	0.217%	**0.01021%**
Per Test		4.61%	0.2163%
Per Positive Test			**4.69%**

Thursday, May 28, 2020			
India			
Population	**Tests**	**Positive**	**Deaths**
1,380,004,385	3,362,136	164,936	4,673
Per Capita	0.24%	0.012%	**0.00034%**
Per Test		4.91%	0.1390%
Per Positive Test			**2.83%**

Thursday, May 28, 2020			
Canada			
Population	**Tests**	**Positive**	**Deaths**
37,742,154	1,559,280	88,467	6,873
Per Capita	4.13%	0.234%	**0.01821%**
Per Test		5.67%	0.4408%
Per Positive Test			**7.77%**

Speaking of Canada. Drilling down on these numbers into Alberta paints a picture that is not being told anywhere.

Thursday, May 28, 2020			
Alberta			
Population	**Tests**	**Positive**	**Deaths**
4,345,737	223,771	6,926	141
Per Capita	5.15%	0.159%	**0.00324%**
Per Test		3.10%	0.0630%
Per Positive Test			**2.04%**

The average age of an Albertan that has died 'with' (or possibly with) COVID 19 is over 80 years of age. This is a story repeated in every country. In most places, the average age of death 'with' COVID 19, exceeds the overall life expectancy for that area. Effectivlely, on average, people are living longer 'with' COVID 19 that without it!

Alberta Population = 4,345,737	Alberta tested 223,771			Total deaths = 141		Per Capita = 0.0032%			05-28-2020
	1-4 years	10-19 years	20-29 years	30-39 years	40-49 years	50-59 years	60-69 years	70-79 years	80+ years
Tested Positive	140	599	935	1,414	1,558	1,010	523	238	321
Died ('WITH' not 'OF')	-	-	1	1	1	2	10	28	98
Mortality (with co-morbidities)	0.00%	0.00%	0.11%	0.07%	0.06%	0.20%	1.91%	11.76%	30.53%
Mortality (without co-	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Mortality percentage	UNDER 5 *0.00%*	UNDER 20 *0.00%*	UNDER 30 *0.71%*	UNDER 40 *1.42%*	UNDER 50 *2.13%*	UNDER 60 *3.55%*	Over 60 *96.45%*	Over 70 *89.36%*	Over 80 *69.50%*

Thursday, May 28, 2020			
Belgium			
Population	**Tests**	**Positive**	**Deaths**
11,589,623	818,807	57,849	9,388
Per Capita	7.07%	0.499%	**0.08100%**
Per Test		7.07%	1.1465%
Per Positive Test			**16.23%**

Thursday, May 28, 2020			
Denmark			
Population	**Tests**	**Positive**	**Deaths**
5,792,202	583,052	11,512	568
Per Capita	10.07%	0.199%	**0.00981%**
Per Test		1.97%	0.0974%
Per Positive Test			**4.93%**

Notice how the 'Mortality' rate being reported (per positive test, not per capita) is widely changing daily (up and down). Notice how it does not align between any country, even though that share similar demographics such as the Scandinavian countries.

Thursday, May 28, 2020			
Switzerland			
Population	**Tests**	**Positive**	**Deaths**
8,654,622	385,822	30,796	1,919
Per Capita	4.46%	0.356%	**0.02217%**
Per Test		7.98%	0.4974%
Per Positive Test			**6.23%**

Thursday, May 28, 2020			
	Sweden		
Population	**Tests**	**Positive**	**Deaths**
10,099,265	238,800	35,727	4,266
Per Capita	2.36%	0.354%	**0.04224%**
Per Test		14.96%	1.7864%
Per Positive Test			**11.94%**

Add in Norway to this mix and you have half the population of Sweden but apparently 94.5% less chance of dying in Norway than Sweden. In the per capita testing that number becomes an order of magnitude lower. Sweden has over 18 times more reported deaths than Norway. Switzerland, just over 8 times the deaths.

Thursday, May 28, 2020			
	Norway		
Population	**Tests**	**Positive**	**Deaths**
5,421,241	239,864	8,406	236
Per Capita	4.42%	0.155%	**0.00435%**
Per Test		3.50%	0.0984%
Per Positive Test			**2.81%**

Yet, the regular life expectancy of all three countries is almost identical. In Norway that life expectancy is about 83 years old. The median age of a COVID 19 death in Norway as of May, 28th, 2020 is 85 years old. So, in Norway on average, you will live two years longer with COVID 19, than without it.

Also note that the reported COVID 19 deaths on May 2nd, 2020 for Norway was 211 on the John Hopkins and Bing Maps (and ECDC data sources). However, the only official source of data for Norway

comes from the National Institute of Public Health (NIPH), where the actual number is 205[35]. (NIPH, 2020). This ongoing anomaly in reporting appears to have been addressed by the week of 24th, May 2020.

In other locations around the world (as we move through each area), we see similar numbers. Again, the push is on the skewed numbers that cause panic.

Lies, damn lies and statistics at their best.

Have world leaders been fed these apparent false narratives? Why are the Swedish and US leaders the only ones pushing back against the continuing lockdown narrative? For everyone else, is this just a reaction based on a panic implementation of the only plan they had?

WE NEED A BETTER PLAN!

[35] https://www.fhi.no/en/id/infectious-diseases/coronavirus/daily-reports/daily-reports-COVID19/

COVID 19 – Is the lock down working?

Published on April 3, 2020

A SARS-COV-2 Story – Chapter 2.

Update: May 2nd, 2020.

Dr. Mike Ryan, head of health emergencies at the World Health Organization **(WHO)**.

"Due to lockdown, most of the transmission that's actually happening in many countries now is happening in the household at family level,". (Ryan, 2020)

"Now we need to go and look in families and find those people that may be sick and remove them and isolate them in a safe and dignified manner." (Ryan, 2020)

- ***Question:*** *How is the rate of deaths and people with COVID 19 linked in ways that no-one is reporting?*
- ***Answer: Test kits (testing), test kits (positive), test kits (deaths).***

We don't have accurate (or reliable) information for China other than this started sometime in late 2019. What we do know is that from the first outbreak in China until the start of global lock down, many millions of people had moved in and out of that area of infection unhindered. Each of these people interacted with many others at airports, work, public places and at home. Each of these interactions most likely spread the virus even further.

As each country locked down, something else also happened. Each country, state or local government started to roll out exponentially growing testing. Unlike most other countries, Sweden did not follow the rigid lock down protocols implemented across the globe. However, Sweden did implement the same testing and their curve, in cases and deaths, aligns with that testing.

The lock down and its date are important **only** in that they trigger the testing. If we had not rigidly locked down, as Sweden didn't, we would see the same exponential curve and glowing red maps.

The current scientific consensus is that the virus can be spread as easily as breathing, hangs in the air for hours and on surfaces for many days.

- ***Question:*** *How then have we contained this virus?*

8. *The real question is, 'Have we contained the virus?'. The answer would appear to be* ***NO****!*

- ***Question:*** *If we haven't contained the virus and it has an incubation period of up to two weeks, why did we not see many deaths outside of China starting in December of 2019?*
- ***Answer: We were NOT tracking test kits.***

- ***Question:*** *What is the connection between escalating deaths and reported cases?*
- ***Answer: We are NOW tracking test kits.***

- ***Question:*** *If we haven't contained the virus and a lock down is not effective, then why are we not going back to work and following the normal practices of good hygiene to keep safe, clean and secure as we do every flu season?*
- ***Answer: We are ONLY tracking test kits.***

Some of the facts from the CDC on initial cases, lock downs and deaths - morning of April 26th 2020.

Day Zero to 5/28/2020 = 194 days.						
The spread of virus	First Positive Case	First Recorded Death	Lockdown day	Reported Deaths Lockdown	Reported Deaths 5/28/2020	Reported Deaths After Lockdown
United States	1/22/2020	2/6/2020	3/26/2020	1,050	102,476	101,426
Canada	1/25/2020	3/10/2020	3/18/2020	8	6,873	6,865
France	12/27/2019	2/15/2020	3/17/2020	148	28,596	28,448
Italy	1/31/2020	2/23/2020	2/23/2020	2	33,142	33,140
United Kingdom	1/31/2020	3/6/2020	3/23/2020	281	37,837	37,556
Sweden	2/1/2020	3/12/2020			4,266	4,266
Belgium	2/4/2020	3/12/2020	3/18/2020	5	9,388	9,383
Switzerland	2/26/2020	3/6/2020	3/13/2020	4	1,919	1,915
Norway	2/27/2020	3/13/2020	3/12/2020	-	236	236
Denmark	2/27/2020	3/16/2020	3/11/2020	-	568	568

(ECDC, 2020)

The first reported case of COVID 19 in China was December 1st (recently revised from December 31st). This puts the minimum earliest date of infection, in one of the most internationally traveled densely populated areas on the planet as November 16th, 2019. With an initial R_0 of 3.4 (WHO), now increased to 5.7, how was the virus controlled when, at that rate, the virus infections would double every 3 days. The first confirmed US death, from community transfer i.e. not travel related, was on February 6th, 2020. This changes the date for the most likely first case in the US to before January 22nd, 2020.

From the day of the first infection in China until the first lockdown in Northern Italy, a total of 99 days passed with only 2 recorded deaths. From that lockdown in northern Italy to April 26th,2020, a total of 63 days passed and reported deaths increased to 26,384. That meant that at the time of lockdown, there had been an average of 0.02 deaths per day in Italy from breakout to lockdown, but an average of 419 deaths per day since the lockdown. Did the virus suddenly get more deadly after the lockdown? If not, then there should have been up to 41,000 COVID 19 deaths in Italy between November 16th, 2019 to the date of the first lockdown on February 23rd, 2020. **Where are all the bodies?** After all, overall mortality in Italy has not really changed, COVID 19 apparently has a unique presentation unlike flu and COVID 19 is highly infectious and very deadly.

For the US, in the first 132 uncontrolled days a total of 1,050 deaths were reported. From that lockdown to May 2nd, 2020, a total of 37 days, reported deaths increased to 65,570. That meant that at the time of lockdown, there had been an average of 7.95 deaths per day in the USA from breakout

to lockdown, but an average of 1,772 deaths per day since the lockdown. Again, did the virus suddenly get more deadly after the lockdown? Now we know that the virus was spreading exponentially so it is not this simple. However, in the US we know that the virus had been spreading since the beginning of January 2019 (based on the first confirmed US, non-travel/community infection death). Since testing started in the US the test to positive case ratio has maintained a steady level of 20%. Based on this there could have been up to 234,000 COVID 19 deaths in the US from November 16th, 2019 to the date of the first lockdown on March 26th, 2020. **Where are all the bodies?**

Day Zero to 5/28/2020 = 194 days.						
Days Past	Days before first case	Days before first Death	Days before Lockdown	Days from Lockdown to 5/28/2020	Reported Deaths in days BEFORE Lockdown	Reported Deaths in days AFTER Lockdown
United States	67	82	131	63	1,050	101,426
Canada	70	115	123	71	8	6,865
France	41	91	122	72	148	28,448
Italy	76	99	99	95	2	33,140
United Kingdom	76	111	128	66	281	37,556
Sweden	77	117				4,266
Belgium	80	117	123	71	5	9,383
Switzerland	102	111	118	76	4	1,915
Norway	103	118	117	77	-	236
Denmark	103	121	116	78	-	568

(ECDC, 2020)

How is it safer to go out today than when the world locked down?

	Belgium	Canada	Switzerland	Denmark	France	UK	Italy	Norway	Sweden	USA
Locked Down	3/18/2020	3/18/2020	3/13/2020	3/11/2020	3/17/2020	3/23/2020	2/23/2020	3/12/2020		3/26/2020
Deaths on Lockdown	5	8	4	0	148	285	2	0		1050
Average Deaths Per Day (lockdown)	130	94	21	7	390	555	345	3	59	1557
Average Deaths per day (1 week)	76	134	10	5	187	432	209	1	63	1477

(ECDC, 2020)

We know these numbers are excessively large and unsupportable, but then again, so are the reported deaths **of** COVID 19. The figures above are based on the same calculations and base numbers used to justify the lockdowns, so why do they look so strange, but the numbers reported everyday don't?

If the reporting of deaths **from** (as opposed to with or possibly with) COVID 19 and COVID 19 infection spread has been accurate since the lockdown, **where are all the excess bodies?**

The reality is there are no excess bodies. The infection is widespread, and the mortality rate is not as high (or even close) to what is being reported. The vast majority of reported COVID 19 deaths have been due to significant co-morbidities, not COVID 19. So, what is the real reason for these scary red maps and excessively large numbers? Dr. Artin Massihi and Dr. Dan Erickson might have the answer[36] [37] (Erickson, 2020). If you don't read another word, just watch this video all the way through. They don't have all the answers, but the answers are out there if you know where to look. At the end I guarantee you will come back and you will want to know more.

You can wash and repeat for the numbers for each in the charts above (or any country, outside of China).

As you can see. Based on the reported deaths, allegedly minimized by the lockdown, there should have been an order of magnitude of deaths in the prior 131 days before lockdown in the US. Yet overall mortality in every country remains fairly static.

The spread of a virus.

We have all seen the ever-glowing red maps of reported cases and death exponentially predicting an almost 'end of days' scenario. But what are the facts behind these images?

We have all been told we have to lock down and isolate to get this under control.

However, what if this is based on a false assumption of the spread rather than a true tracking of the virus?

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[36] https://www.lifesitenews.com/blogs/two-california-emergency-room-covid-doctors-may-start-a-revolution-with-calm-science-data-based-press-conference-questioning-of-extreme-measures

[37] https://www.aier.org/article/open-up-society-now-say-dr-dan-erickson-and-dr-artin-massihi/

- ***Question:*** *Are we really tracking the spread of the virus?*
- ***Answer: No, we are tracking test kits.***

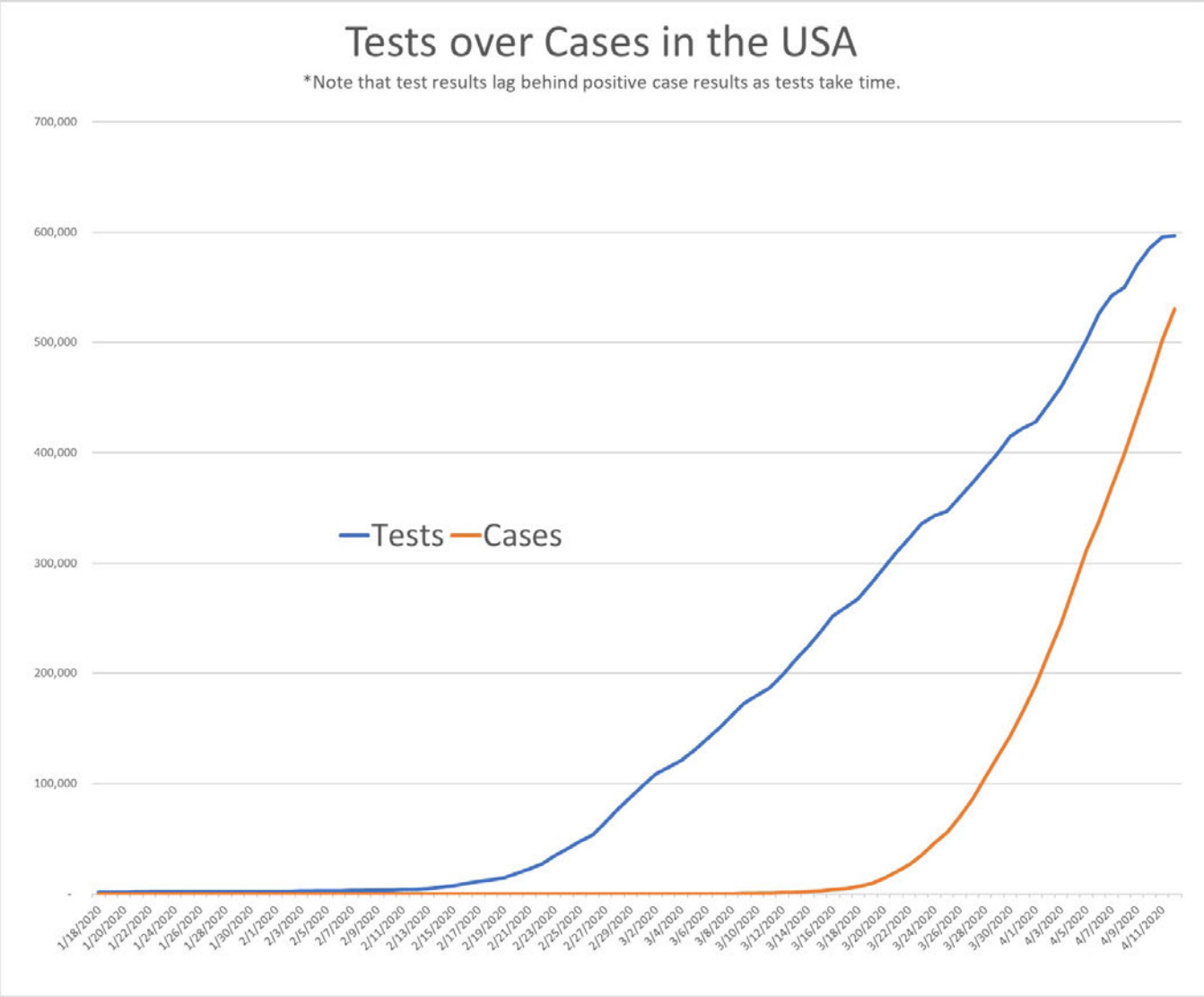
Positive Cases

The chart below shows the trend of 'Positive Cases' climbing in line with tests performed. Note that as the tests takes time to be confirmed, there is some lag from one to the other.

Notice something else... as tests are increased, positive numbers increase. So why are we using Positive Cases as an indication of exponential growth of the spread of the virus?

Current numbers show that 20% of the people tested in the USA have been positive for COVID 19. This has been a relatively steady percentage as testing became widespread.

If 20% of the population of the USA (331,002,651) already had the virus, we would see the same results. That would also put the estimates of those already infected to over 67 million people. That is beyond that of seasonal flu. Yet seasonal flu has already killed up to 62,000 people in the USA with less than 55 million infections this flu season alone.


Tests over Cases in the USA
*Note that test results lag behind positive case results as tests take time.
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
Tests
Cases
1/18/2020
1/20/2020
1/22/2020
1/24/2020
1/26/2020
1/28/2020
1/30/2020
2/1/2020
2/3/2020
2/5/2020
2/7/2020
2/9/2020
2/11/2020
2/13/2020
2/15/2020
2/17/2020
2/19/2020
2/21/2020
2/23/2020
2/25/2020
2/27/2020
2/29/2020
3/2/2020
3/4/2020
3/6/2020
3/8/2020
3/10/2020
3/12/2020
3/14/2020
3/16/2020
3/18/2020
3/20/2020
3/22/2020
3/24/2020
3/26/2020
3/28/2020
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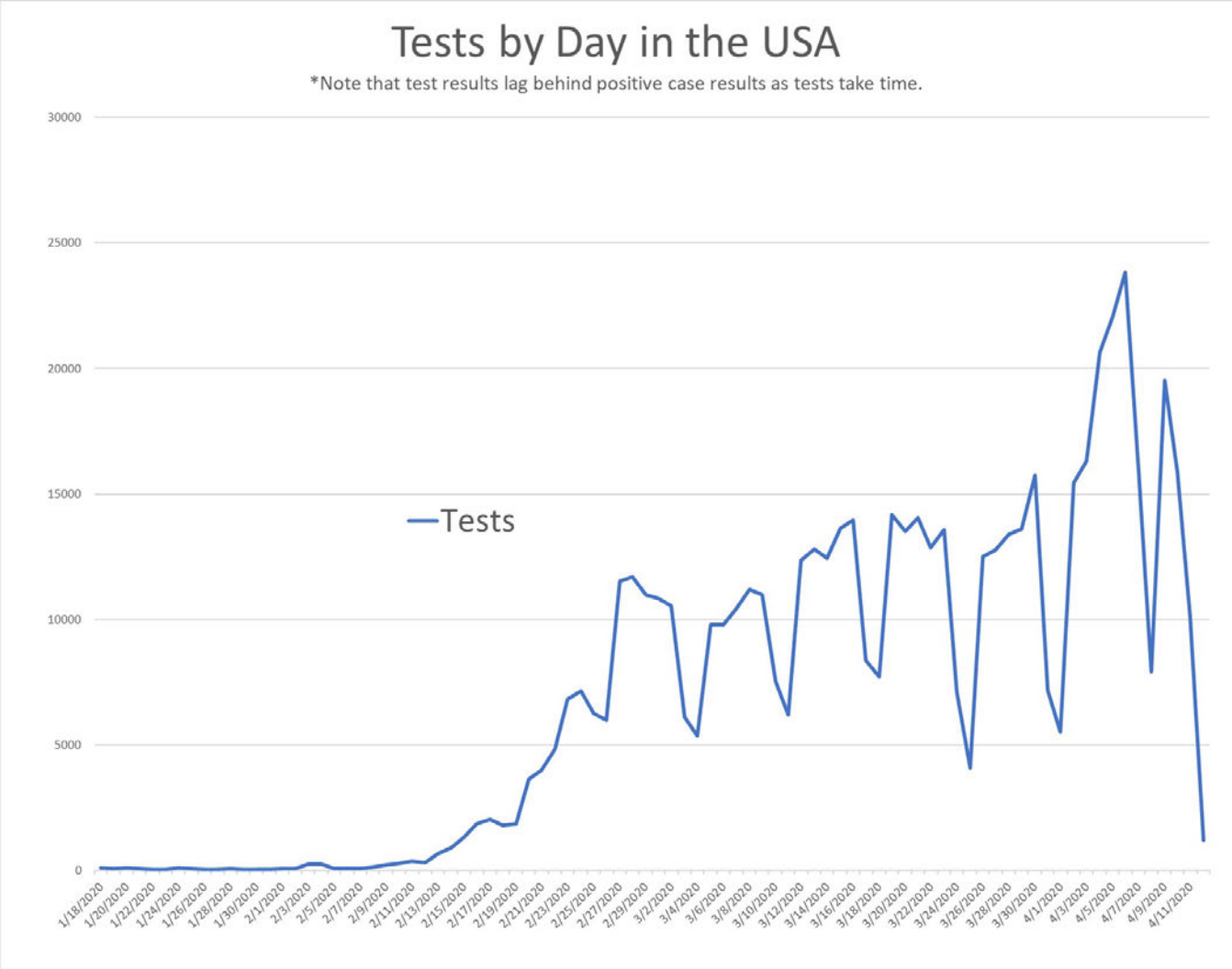
4/3/2020
4/5/2020
4/7/2020
4/9/2020
4/11/2020

(CDC, 2020)



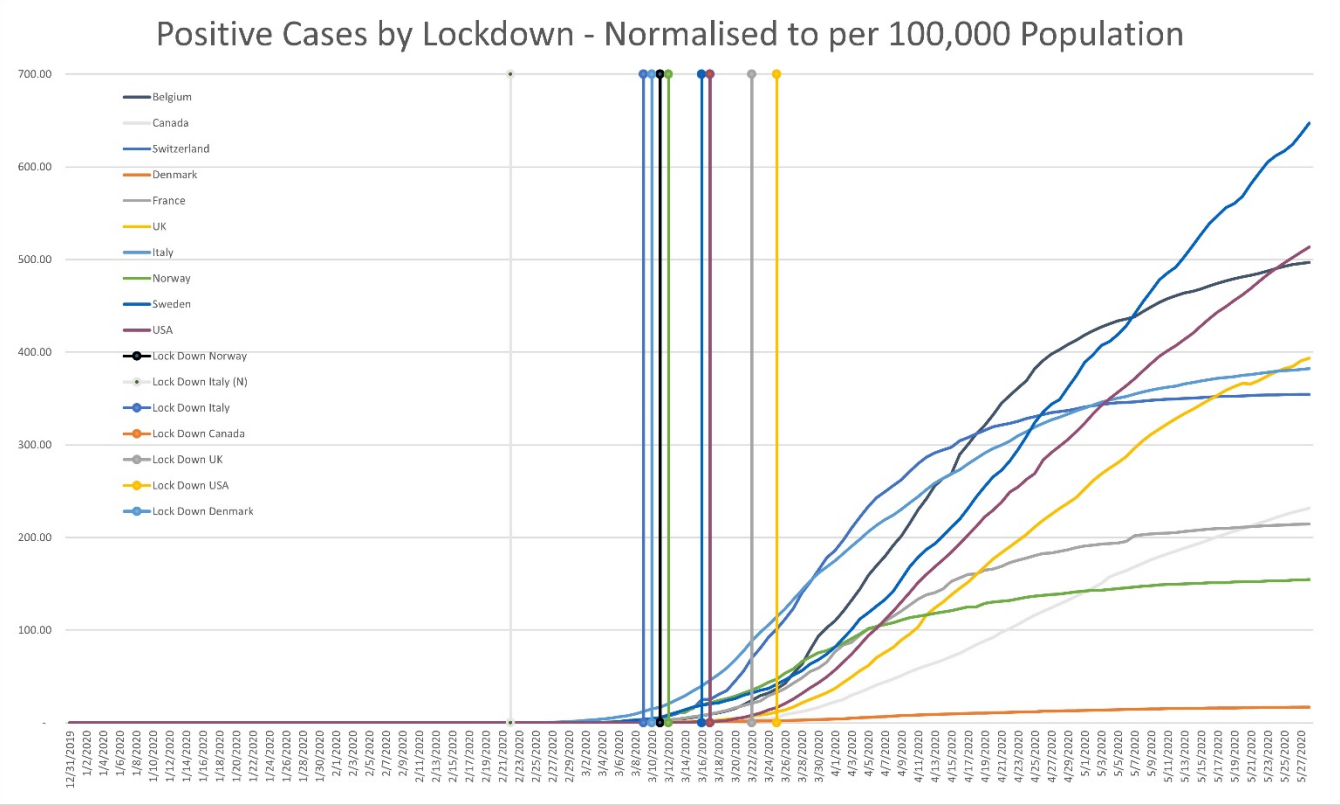
(CDC, 2020)

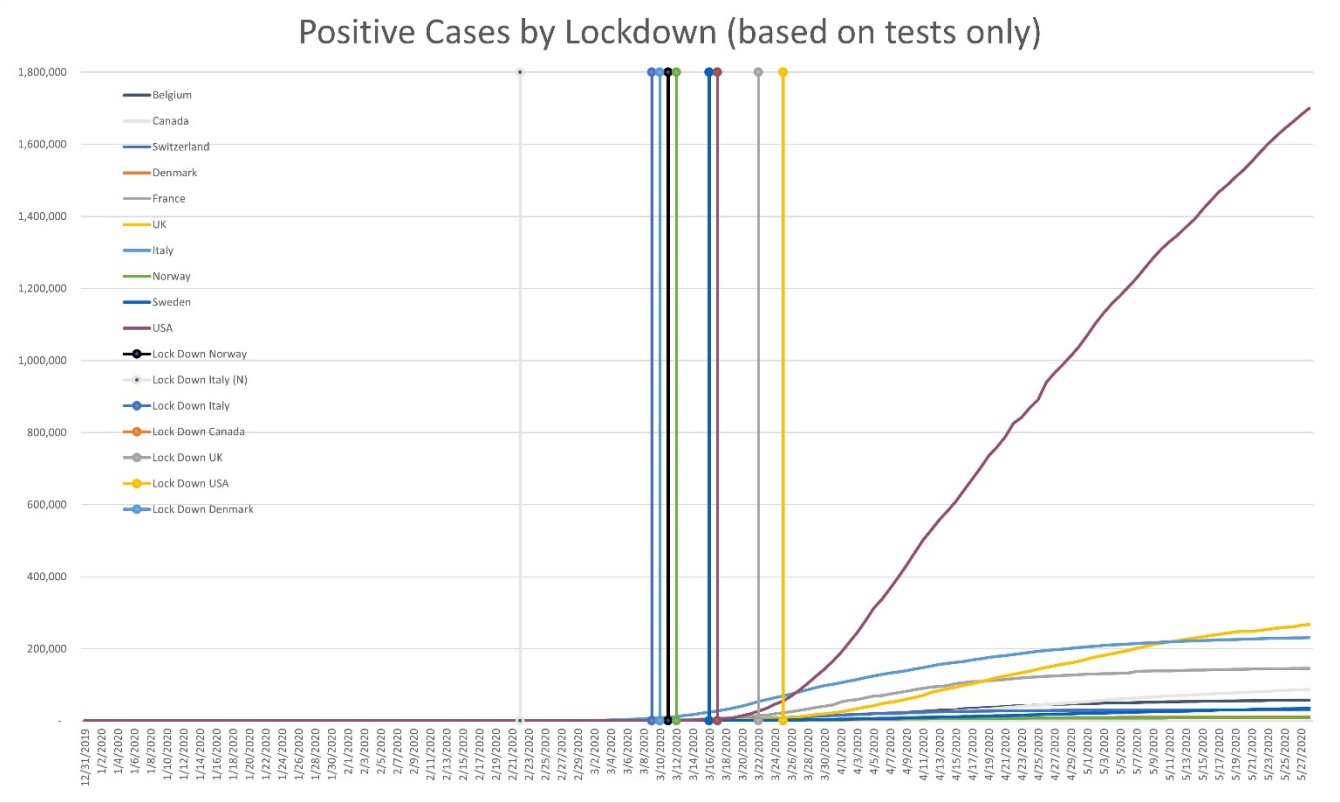
With most of the world now in full lockdown, how is this working to stop the reported virus spread?

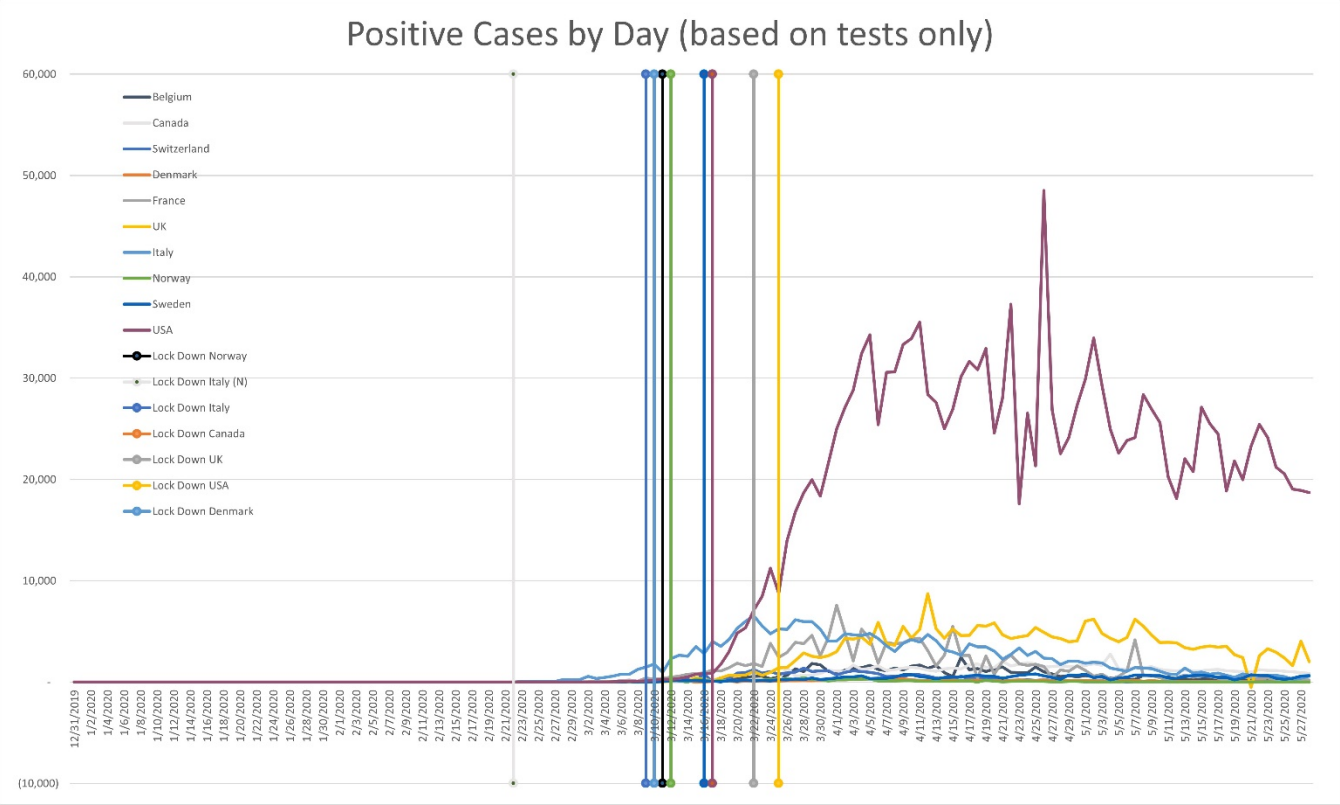
This chart shows what happened to the number of 'Positive Cases' before and after the lock down in each country.

As you look at the charts, ask yourself what else happened as we locked down countries?

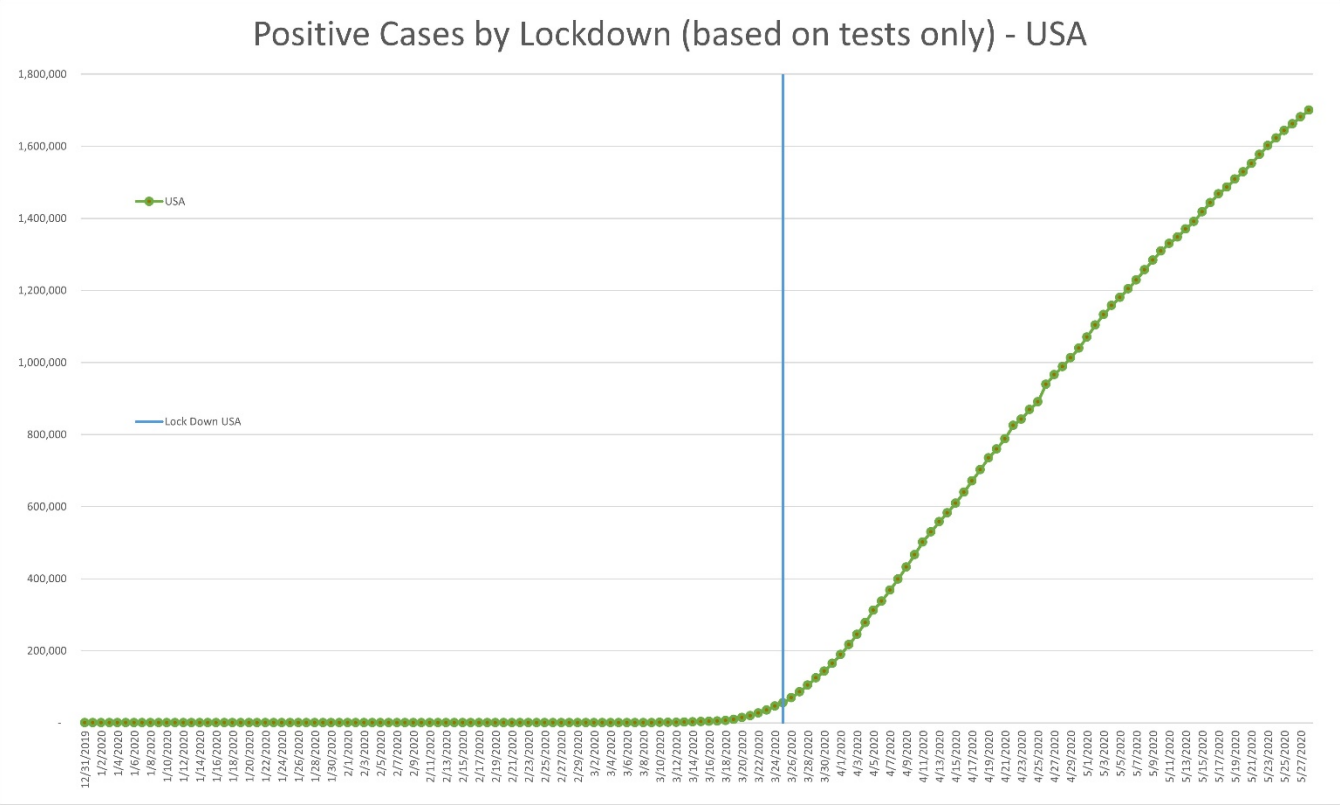
- **Question:** Did we increase the spread of the virus or increase the testing in every single case?
- **Answer: Test kits only spread misinformation without context.**

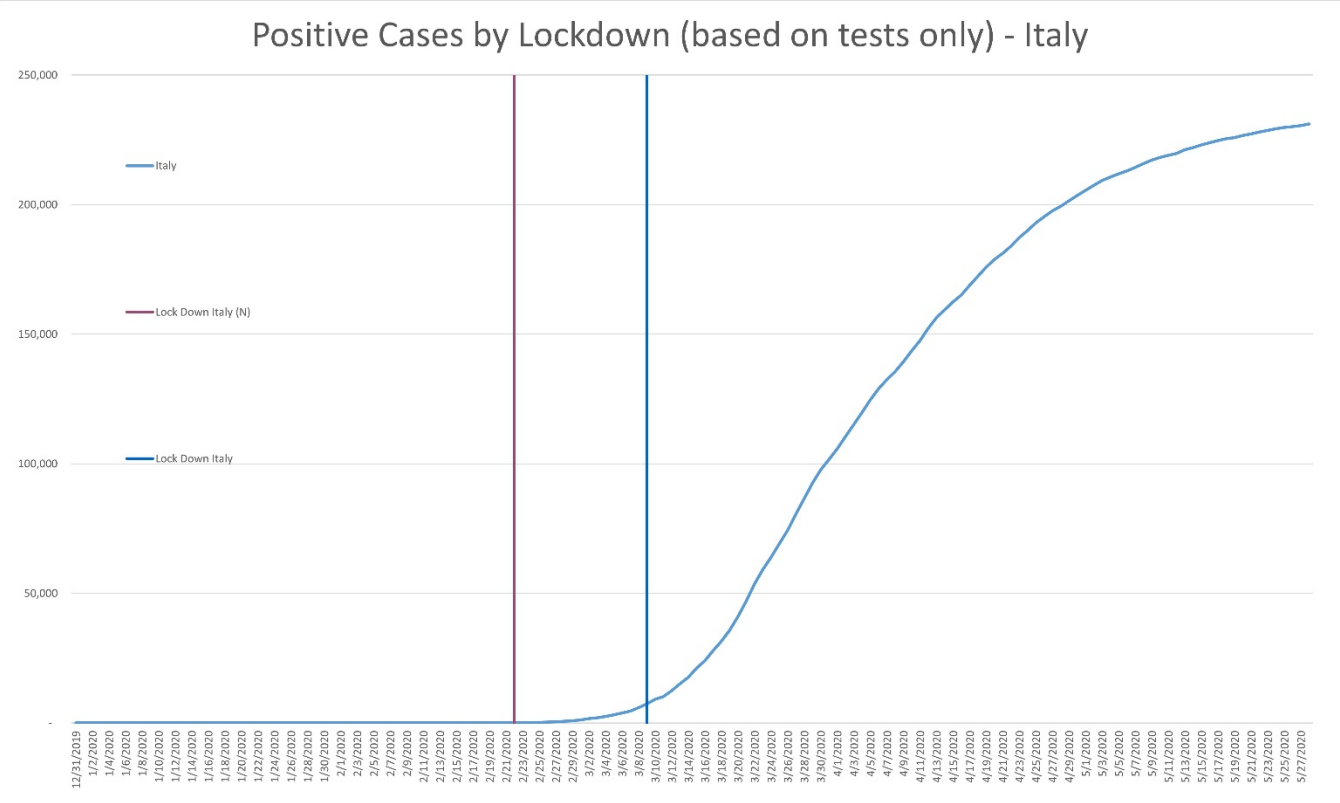

Positive Cases by Lockdown - Normalised to per 100,000 Population
700.00
600.00
500.00
400.00
300.00
200.00
100.00
-
Belgium
Canada
Switzerland
Denmark
France
UK
Italy
Norway
Sweden
USA
Lock Down Norway
Lock Down Italy (N)
Lock Down Italy
Lock Down Canada
Lock Down UK
Lock Down USA
Lock Down Denmark

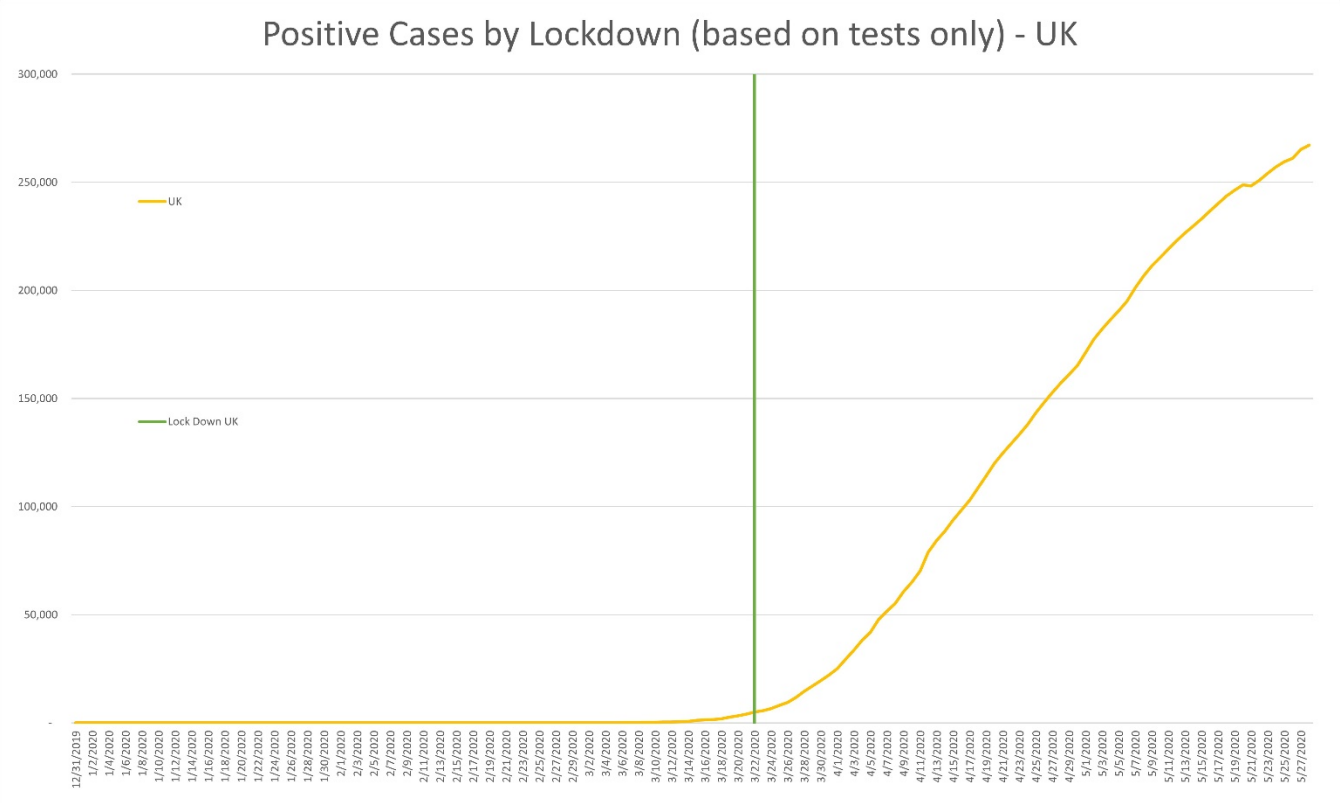

Positive Cases by Lockdown (based on tests only)
1,800,000
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
-
Belgium
Canada
Switzerland
Denmark
France
UK
Italy
Norway
Sweden
USA
Lock Down Norway
Lock Down Italy (N)
Lock Down Italy
Lock Down Canada
Lock Down UK
Lock Down USA
Lock Down Denmark

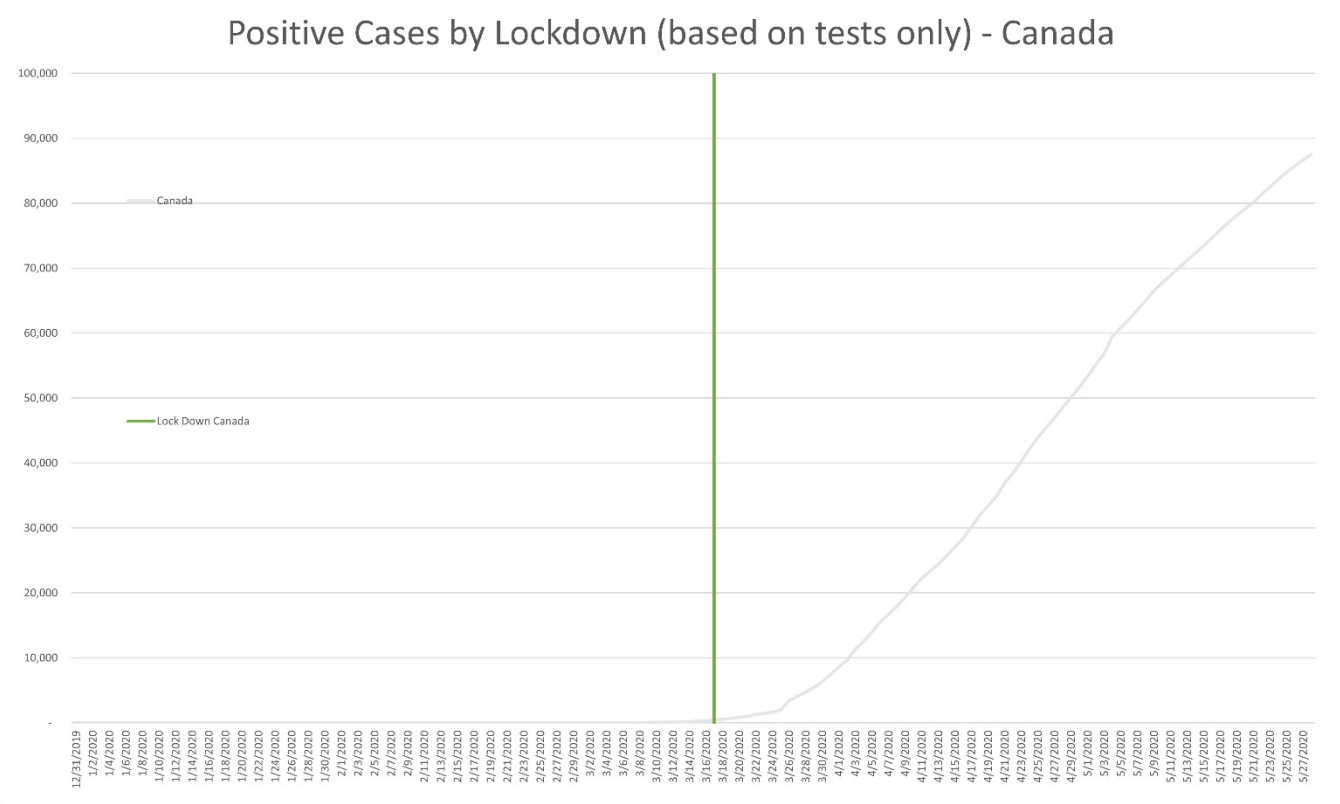


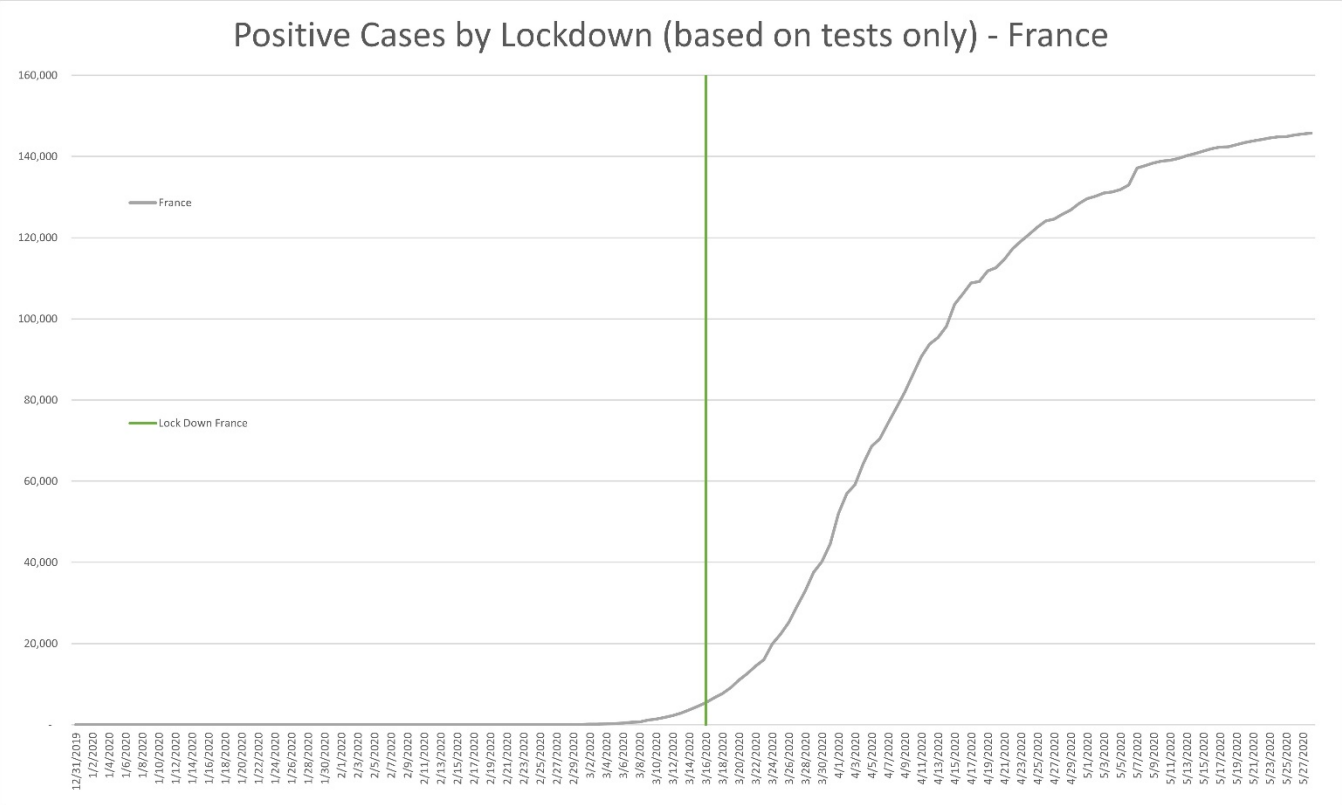
To further clarify this 'curve', look at each of these curves and compare them to the testing and positive cases. Is it likely that death would continue on this same exact curve, worldwide, for all three factors, regardless of population, environment, health care and more.

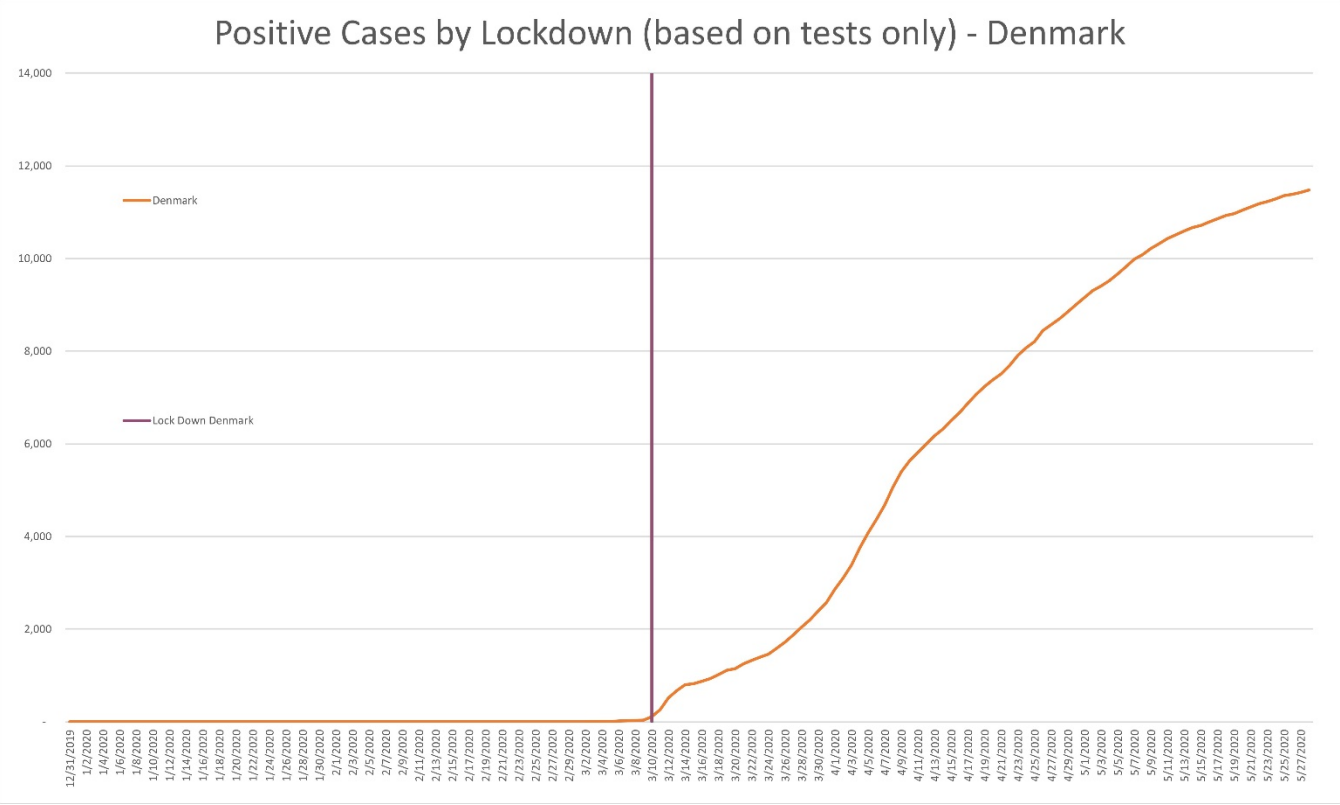

Positive Cases by Lockdown (based on tests only) - USA
1,800,000
1,600,000
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
-
USA
Lock Down USA

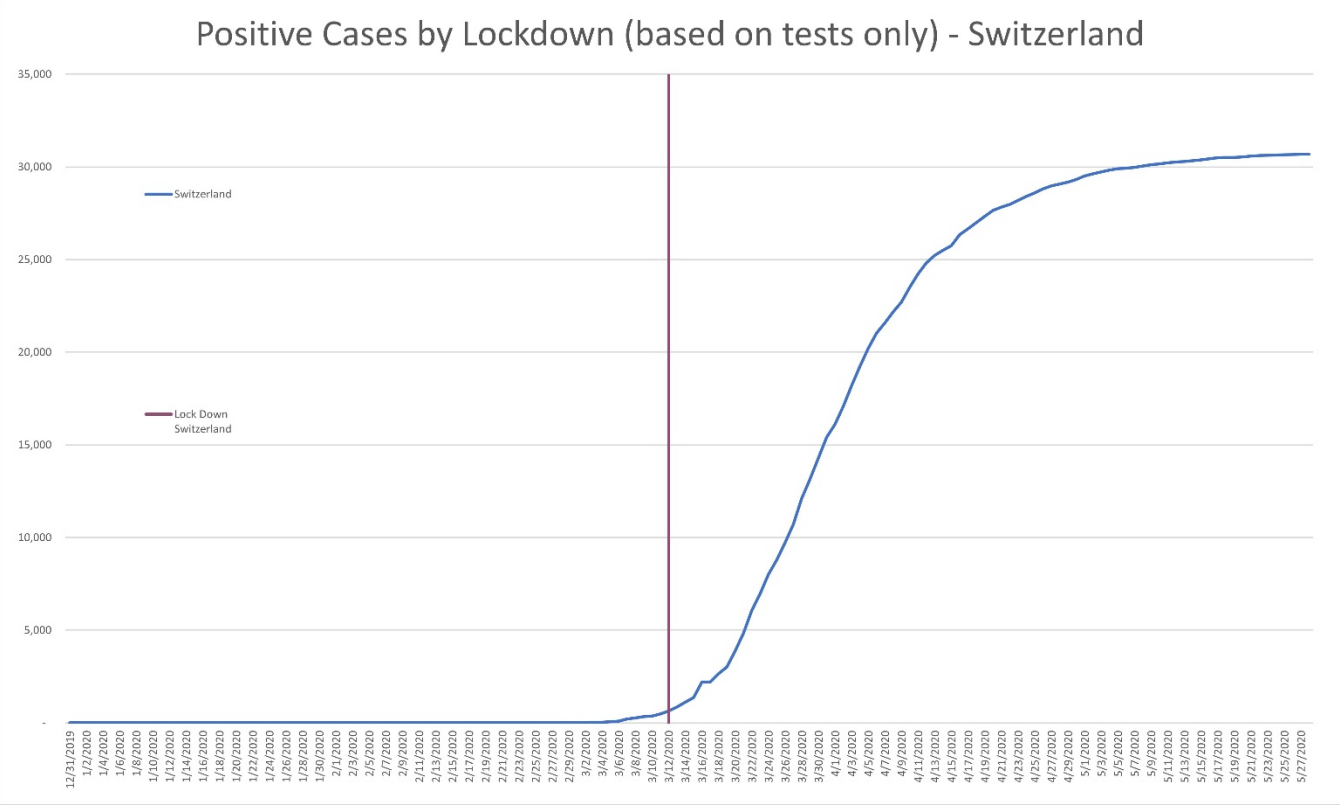

Positive Cases by Lockdown (based on tests only) - Italy
250,000
200,000
150,000
100,000
50,000
-
Italy
Lock Down Italy (N)
Lock Down Italy

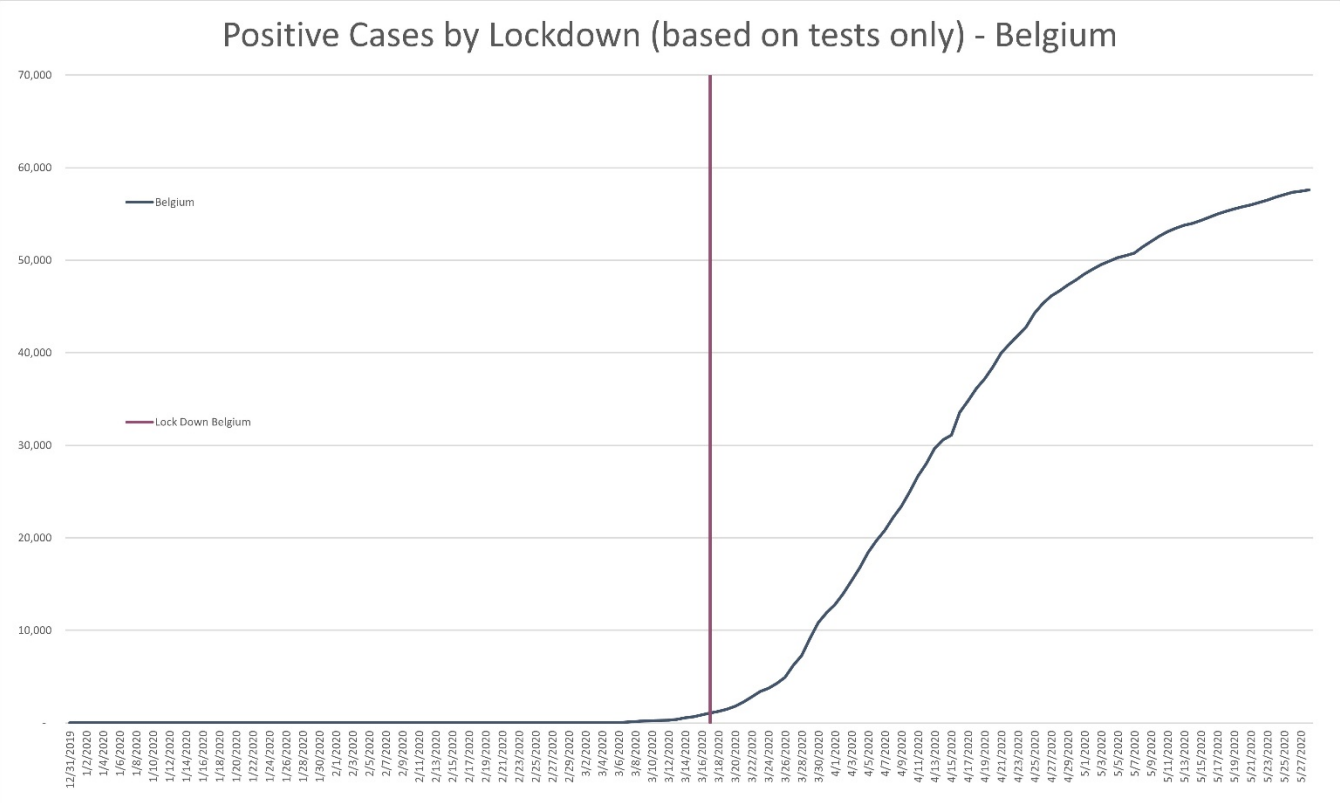

Positive Cases by Lockdown (based on tests only) - UK
300,000
250,000
200,000
150,000
100,000
50,000
-
UK
Lock Down UK

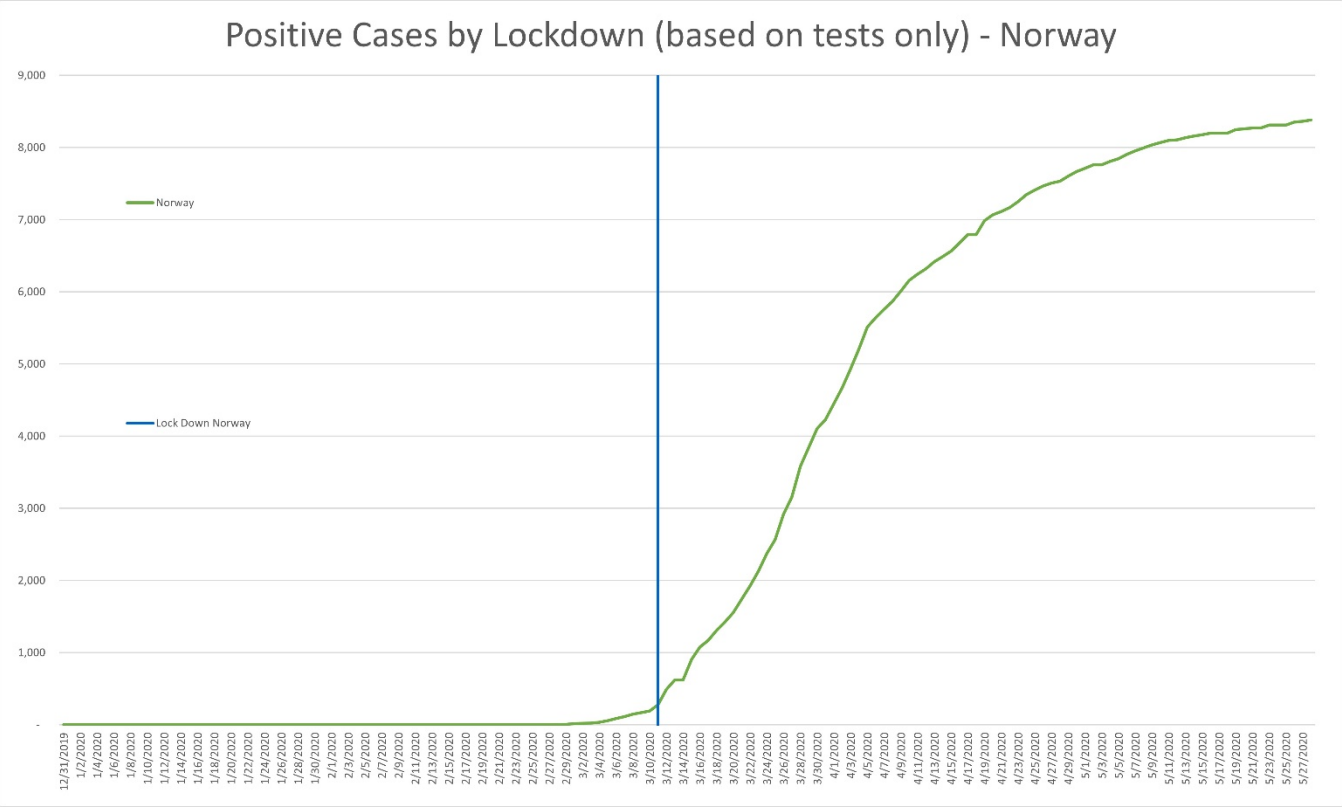

Positive Cases by Lockdown (based on tests only) - Canada
100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
Canada
Lock Down Canada


Positive Cases by Lockdown (based on tests only) - France
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
-
France
Lock Down France


Positive Cases by Lockdown (based on tests only) - Denmark
14,000
12,000
10,000
8,000
6,000
4,000
2,000
-
Denmark
Lock Down Denmark


Positive Cases by Lockdown (based on tests only) - Switzerland
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Switzerland
Lock Down Switzerland


Positive Cases by Lockdown (based on tests only) - Belgium
70,000
60,000
50,000
40,000
30,000
20,000
10,000
-
Belgium
Lock Down Belgium



Question: What is the only common factor in all these locations?

Answer: Test kits, all the way down the line.

Question: Other than testing, is there anything else that could be following the exact same curve in all instances?

Answer: All we are tracking is test kits.

Take a look at each country's lock down impact on the reported spread of the virus (Positive Cases). Note that Italy locked down in two phases, northern Italy and then all of Italy.

Note that the early testing took weeks to provide results to report. Hence, there is a lag from the lock down to the spike in some early adopters of testing.

All these countries saw an apparent spike immediately (based on test turn around) after the lock down that has grown exponentially since.

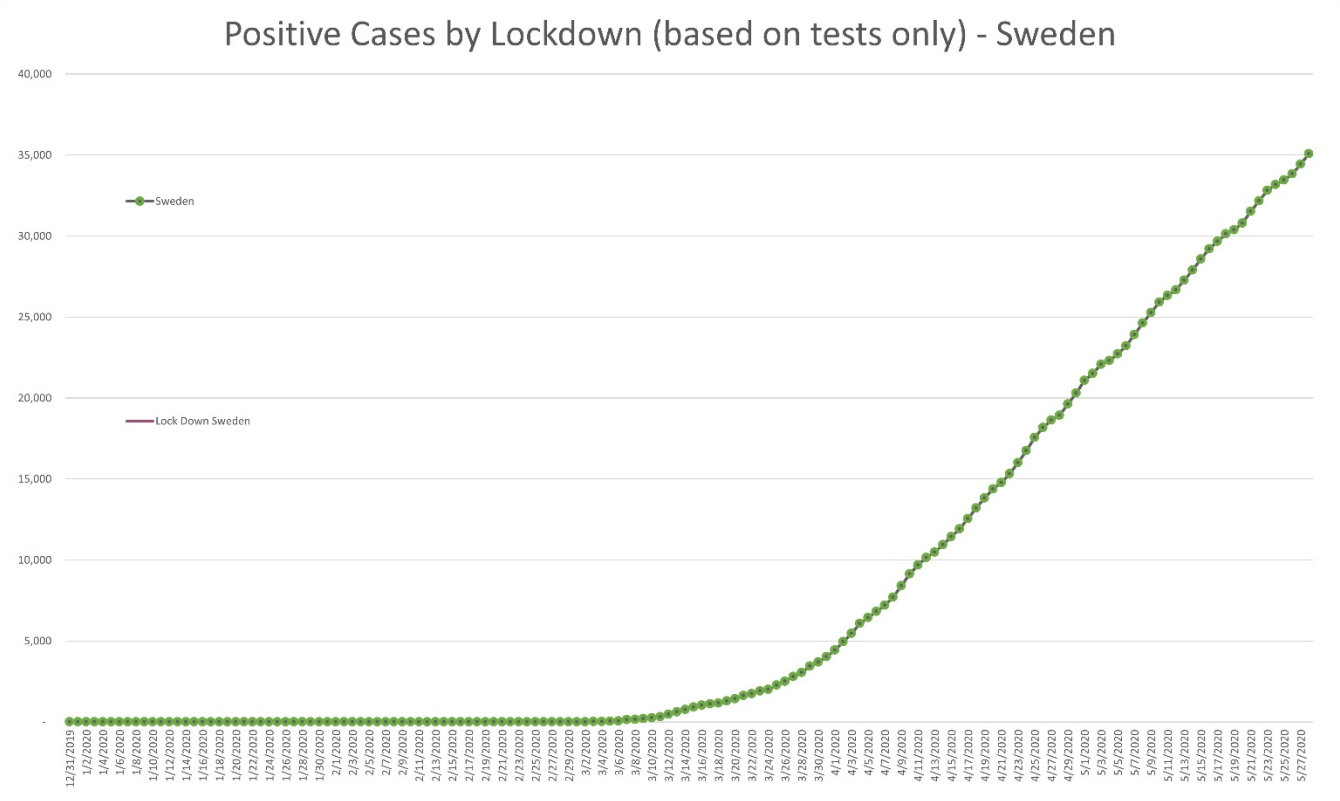
Question: Is the lock down helping or hurting?

That is the right question.

Question: Is it having any impact at all other than the tracking of how many tests we are performing?

Answer: Tracking test kits, without context is driving the panic.

What about Sweden and its lack of a lock down? They have continued to test.



Sweden has the same upswing more related to the curve the rest of the world is seeing than any measures taken. In fact, this curve is almost identical in every country no matter what the measures implemented.

Question: What is this curve really reporting worldwide?

Answer: If all we track is test kits, what else can it report?

Yet this is the standard upon which almost every civil liberty is being systematically removed from society today.

Businesses are going under by the minute. Half of small to medium businesses across the world are not expected to survive. For most countries, we are mere weeks into this…

What if it goes on for months?

COVID 19 deaths. The question of WITH vs OF.

Some are claiming we are slowing down the death rates. The reported deaths and reported cases show a very different position. But is it real?

Despite so many differing factors that would impact mortality due to a virus, we see almost identical curves in the numbers of deaths in every location in line with testing and positive tests.

Question: How can this be?

Answer: All we are tracking is test kits.

Authorities worldwide have confirmed that a death of a person who has tested positive for COVID 19 is, in most cases, being recorded as a death in the COVID 19 death reports.

The more people we test who die, or who die with a positive test, the more COVID 19 deaths are reported.

Does this align with daily deaths under normal circumstances? Can we correlate any other rate of death on a daily basis so closely with the rate of testing for COVID 19?

This is unusual and could explain this now very familiar curve. We are testing people who are admitted to hospital along with those who die with anything like a potential COVID 19 symptom.

Considering that the number of positive tests is climbing at the same rate as testing, maybe we now know the real picture behind the numbers.

Is this really an indication of how fast the virus has or will spread?

Is it really an indicator of how many will die because they caught COVID 19?

Answer: If all we are tracking is test kits, the indicator has no context.

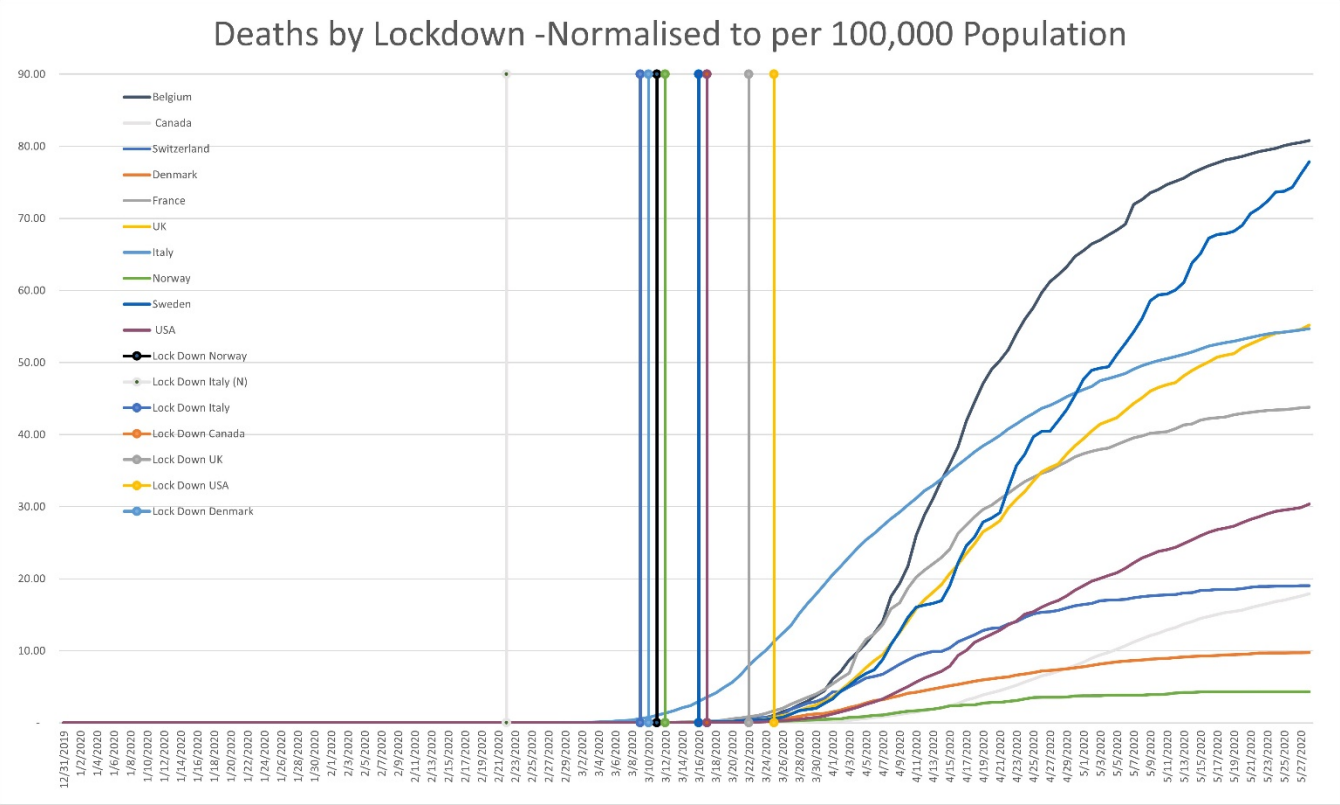
Based on the most likely widespread incidence of the virus since 2019, before we started testing, how many people died before that 'first' case in each country? How many people would have died of other causes if COVID 19 had never existed?

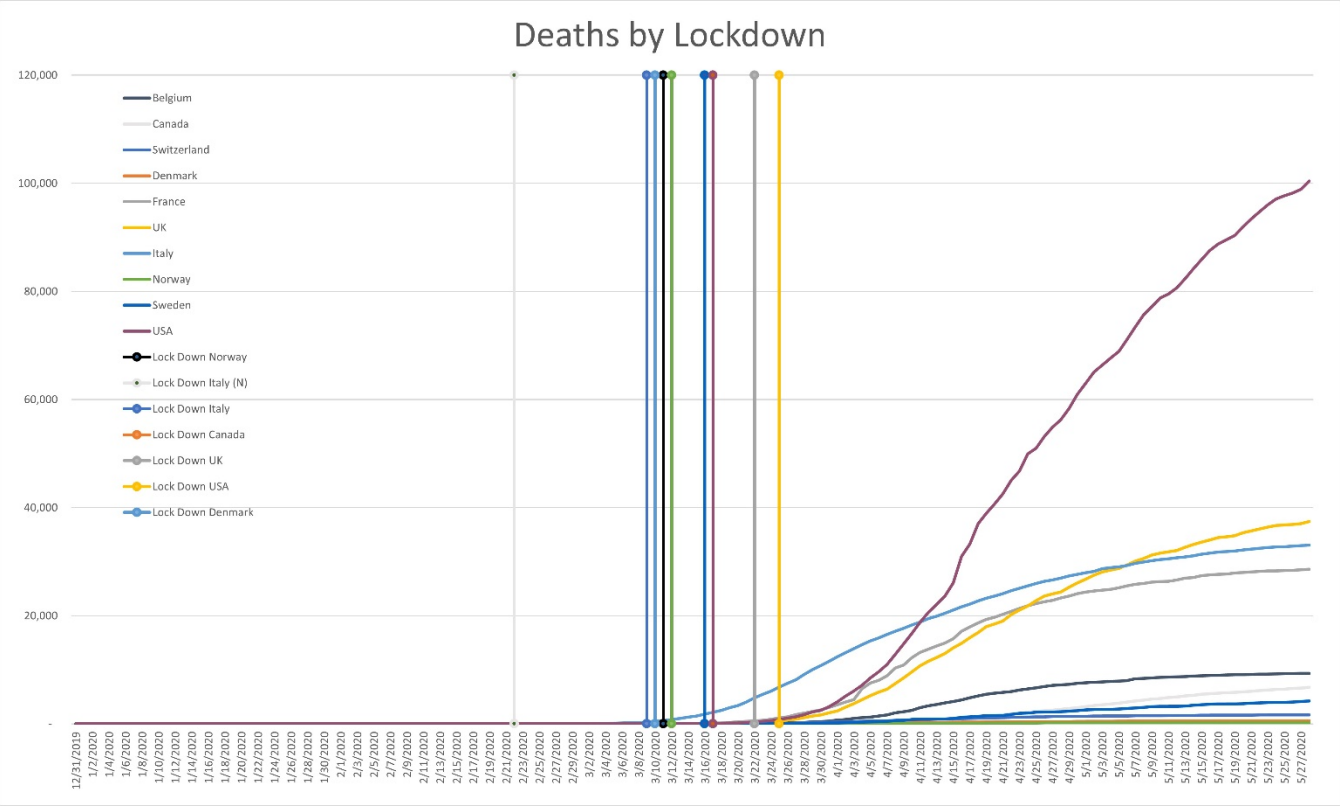
Overall deaths in the world did not spike sharply at the end of 2019. They do not continue to spike daily as COVID 19 appears to be reported.

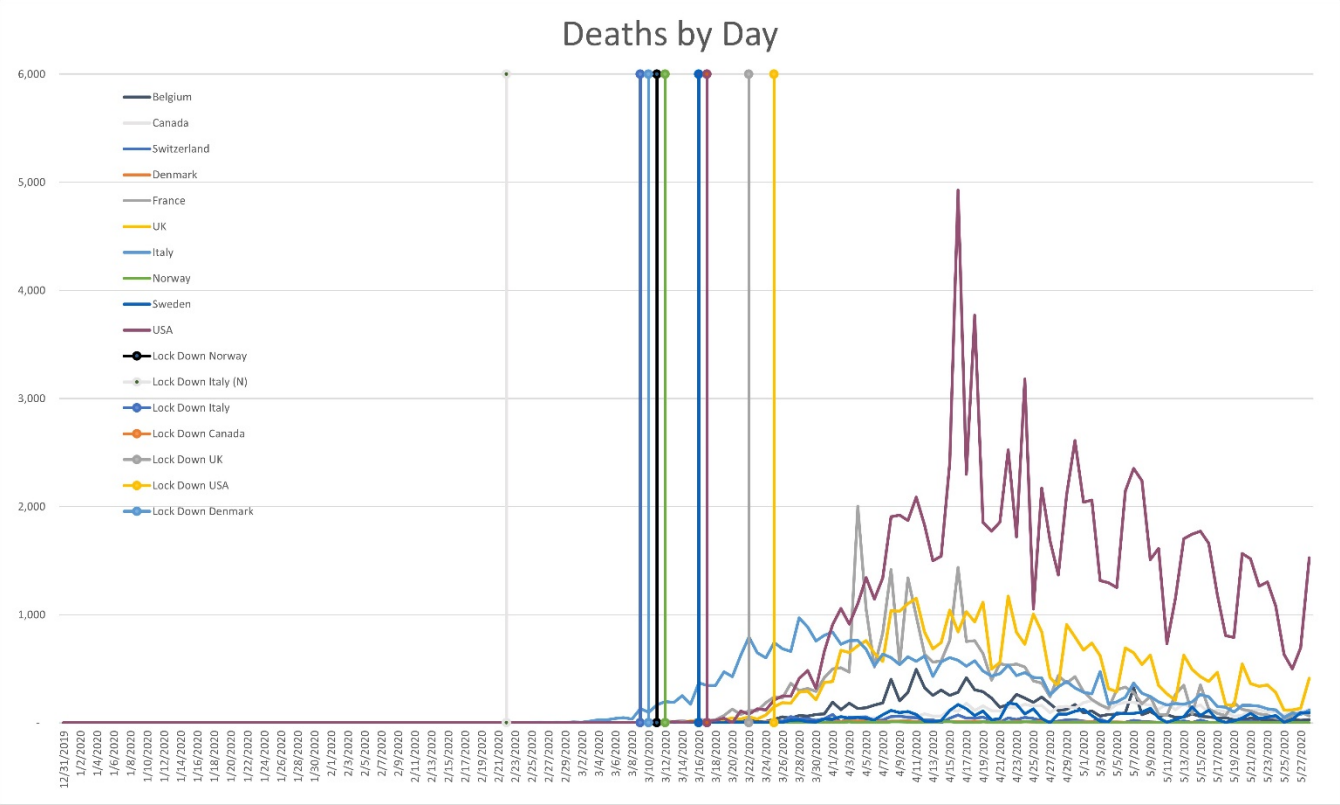
Are we really tracking a virus mortality, or are we just chasing test kits?

Answer: All we are tracking is test kits.

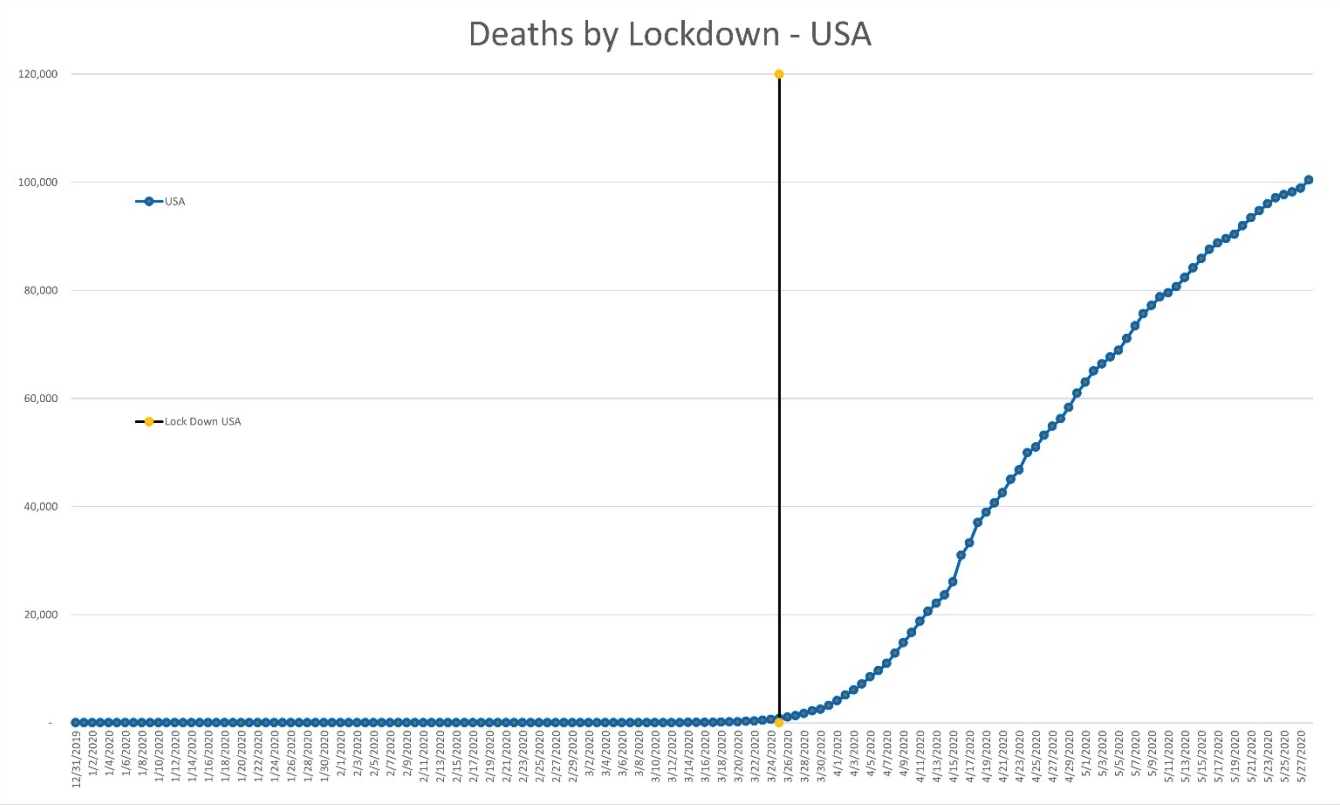
What about cases reported as COVID 19 deaths then? This chart shows what happened to the number of COVID 19 reported deaths before and after the lock down in each country. Note that Sweden did not lock down.

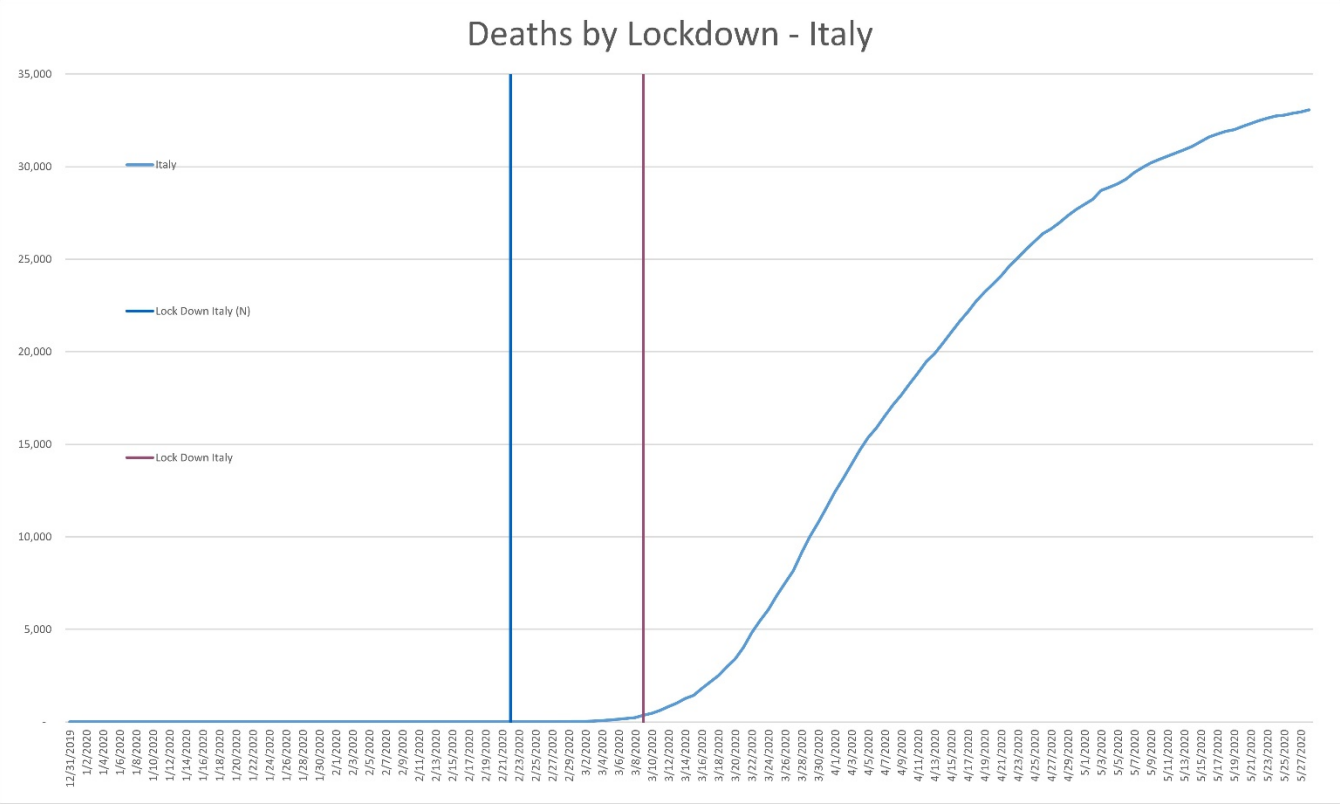

Deaths by Lockdown -Normalised to per 100,000 Population
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
-
Belgium
Canada
Switzerland
Denmark
France
UK
Italy
Norway
Sweden
USA
Lock Down Norway
Lock Down Italy (N)
Lock Down Italy
Lock Down Canada
Lock Down UK
Lock Down USA
Lock Down Denmark

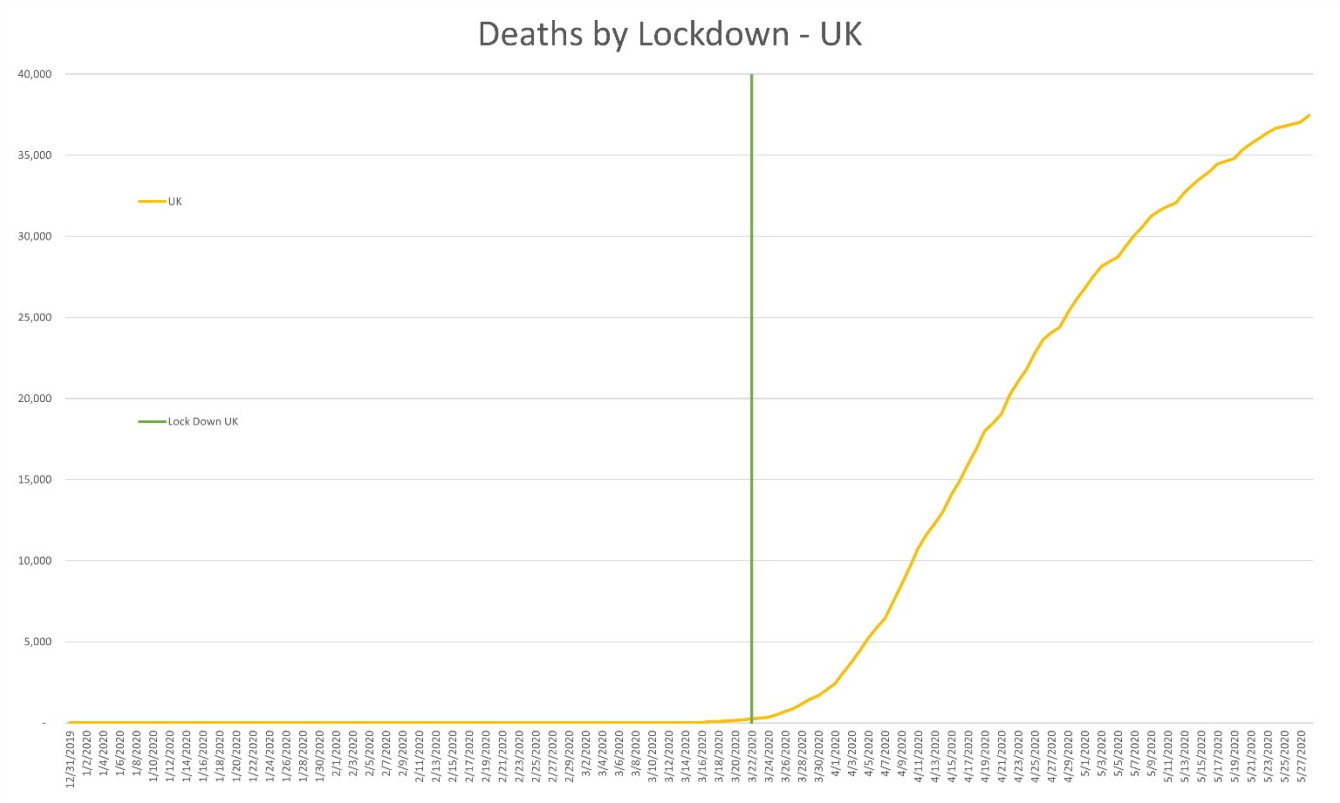

Deaths by Lockdown
120,000
100,000
80,000
60,000
40,000
20,000
-
Belgium
Canada
Switzerland
Denmark
France
UK
Italy
Norway
Sweden
USA
Lock Down Norway
Lock Down Italy (N)
Lock Down Italy
Lock Down Canada
Lock Down UK
Lock Down USA
Lock Down Denmark

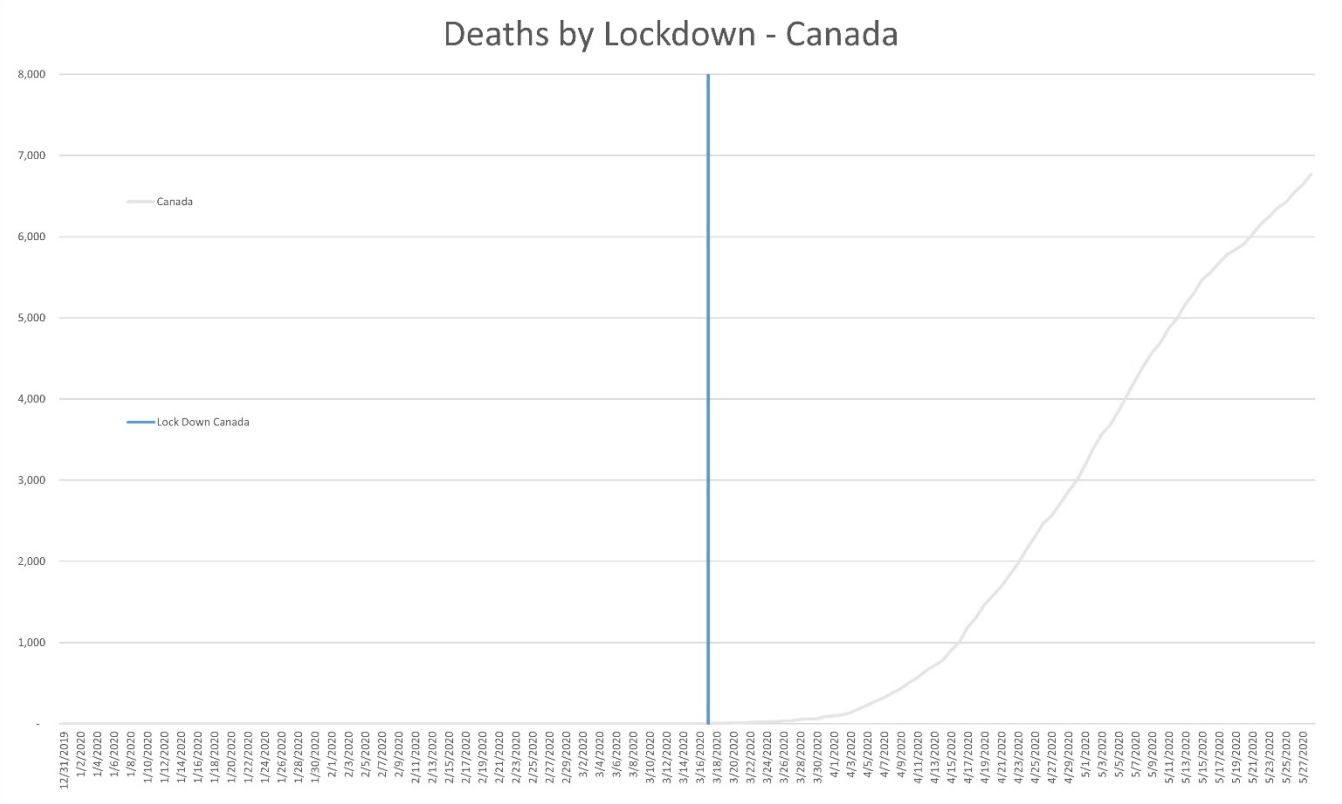


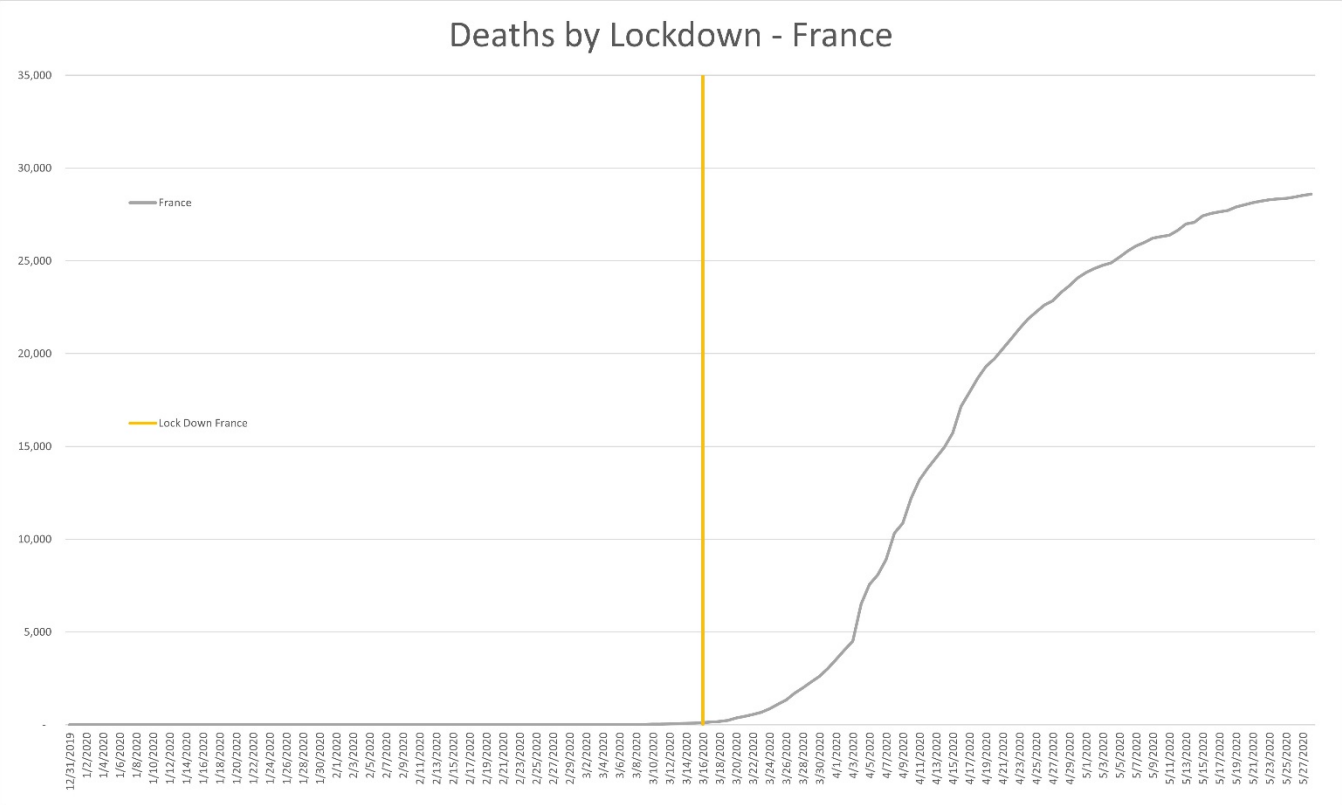
Is this curve starting to feel familiar? Looks like a case of test kits!!

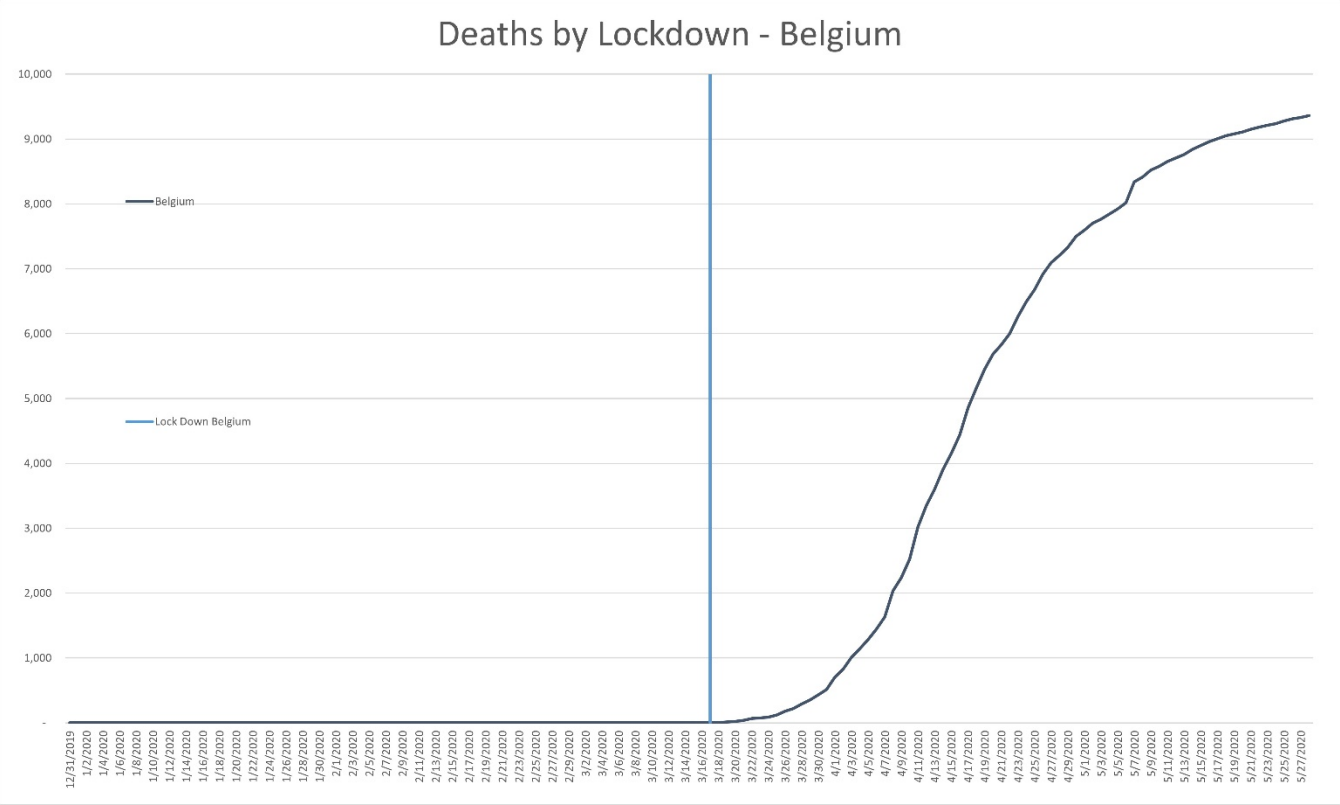

Deaths by Lockdown - USA
120,000
100,000
80,000
60,000
40,000
20,000
-
USA
Lock Down USA

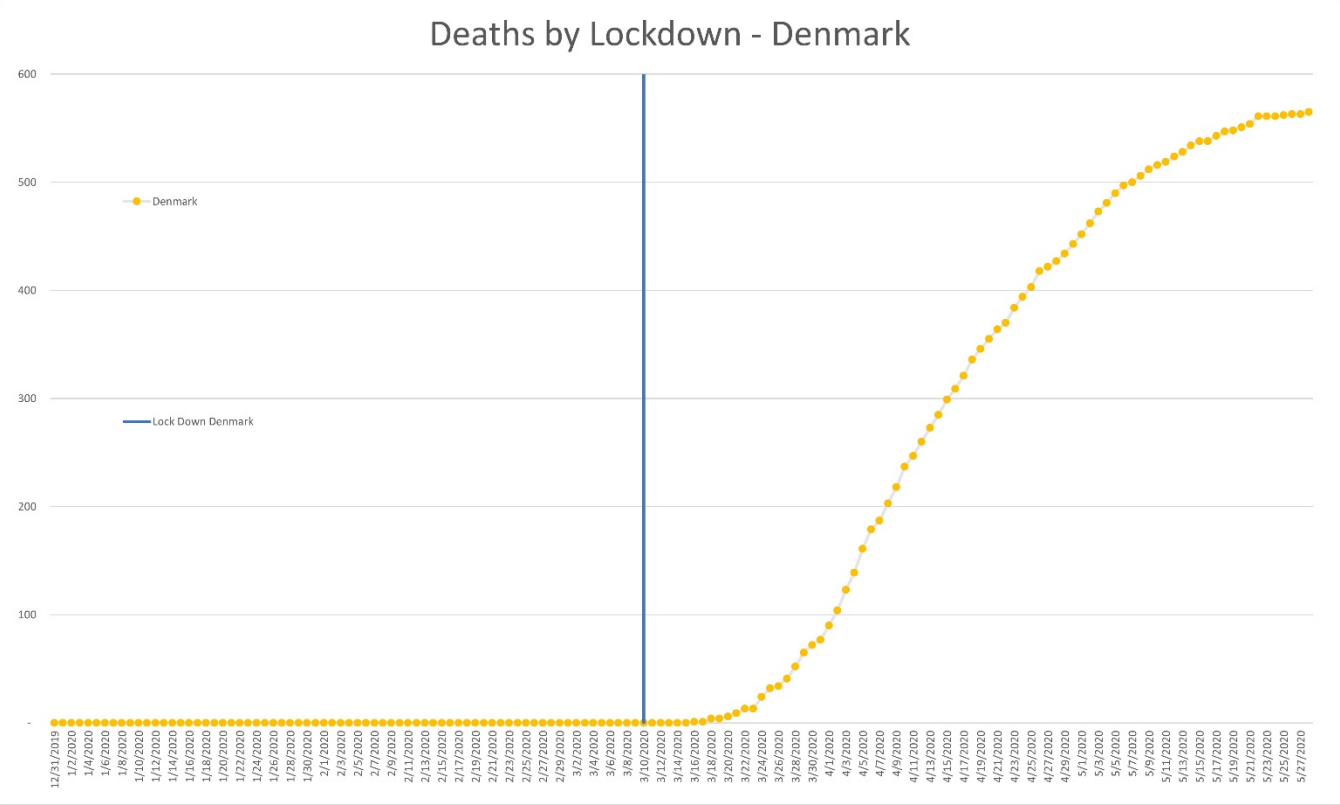

Deaths by Lockdown - Italy
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
Italy
Lock Down Italy (N)
Lock Down Italy

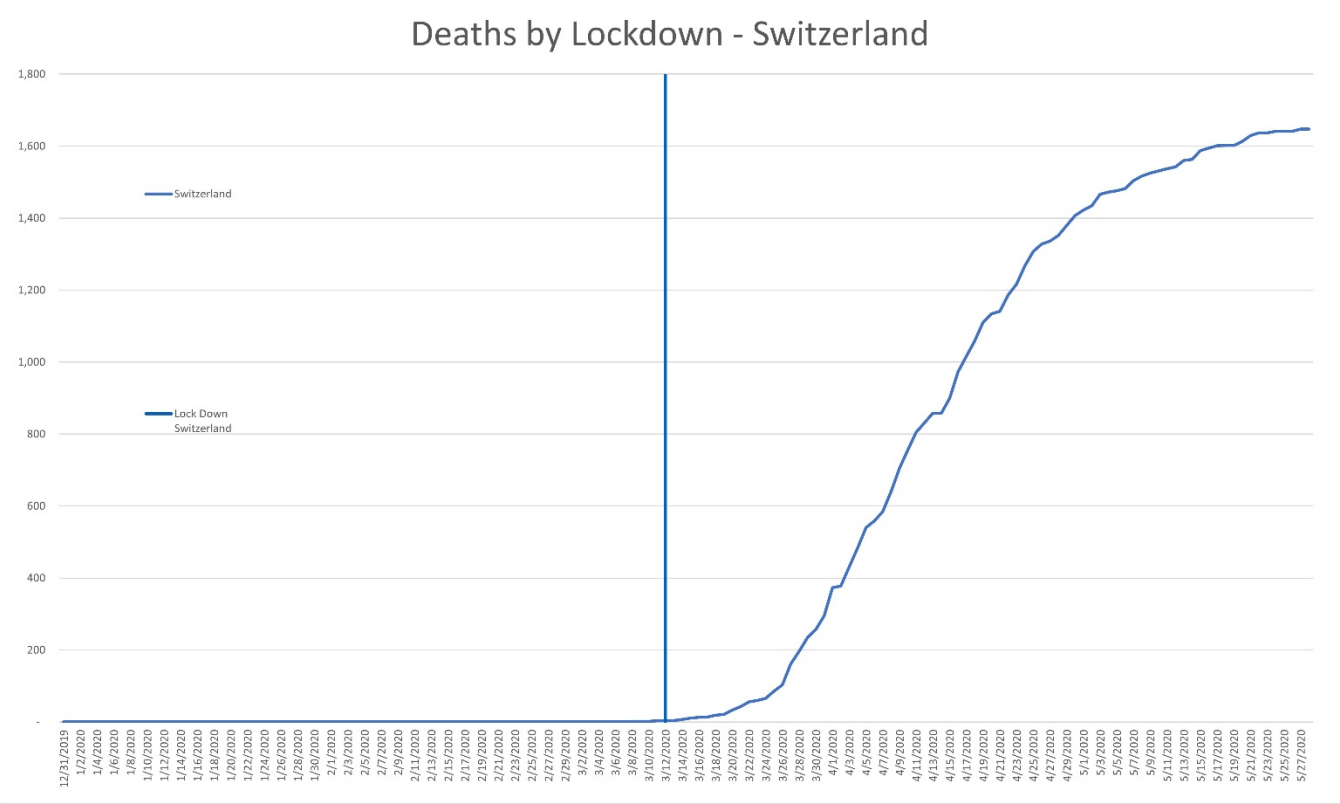

Deaths by Lockdown - UK
UK
Lock Down UK

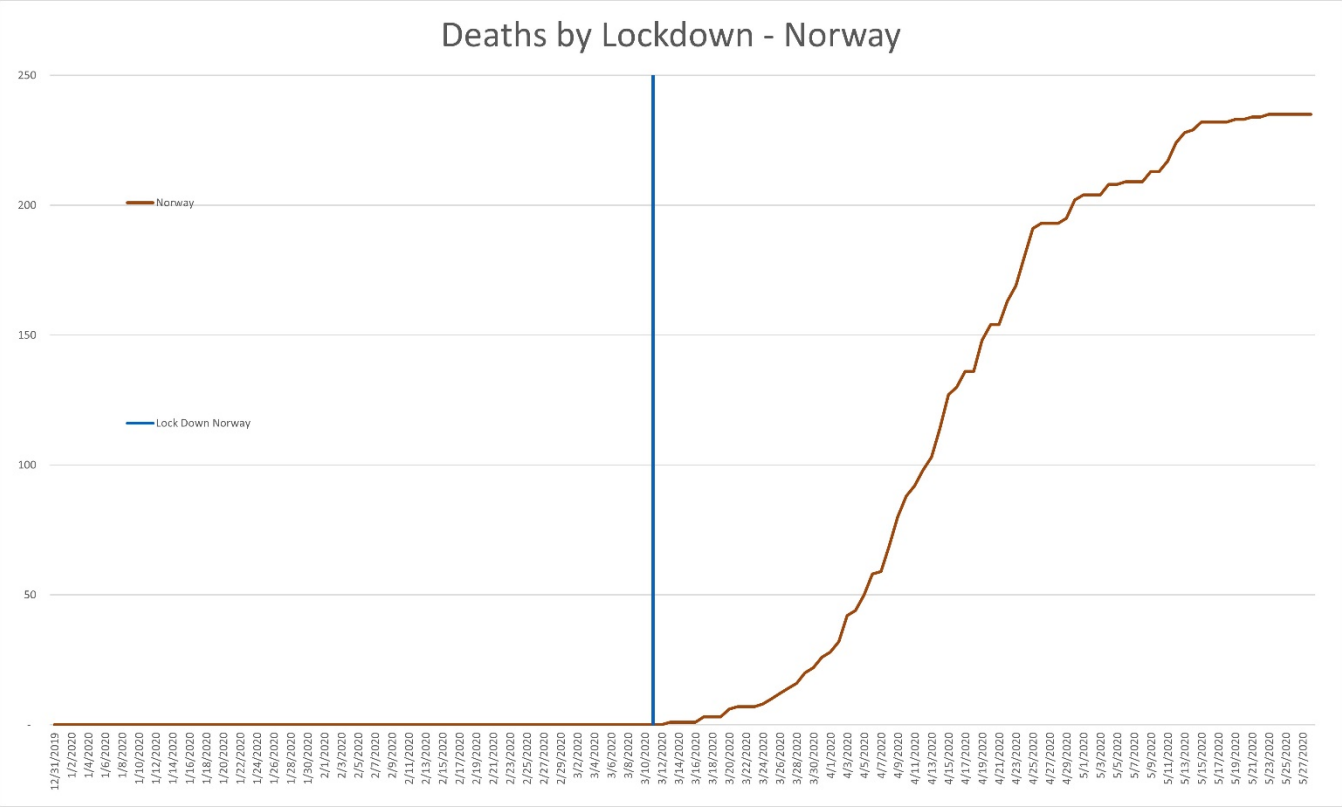

Deaths by Lockdown - Canada
Canada
Lock Down Canada


Deaths by Lockdown - France
35,000
30,000
25,000
20,000
15,000
10,000
5,000
-
France
Lock Down France

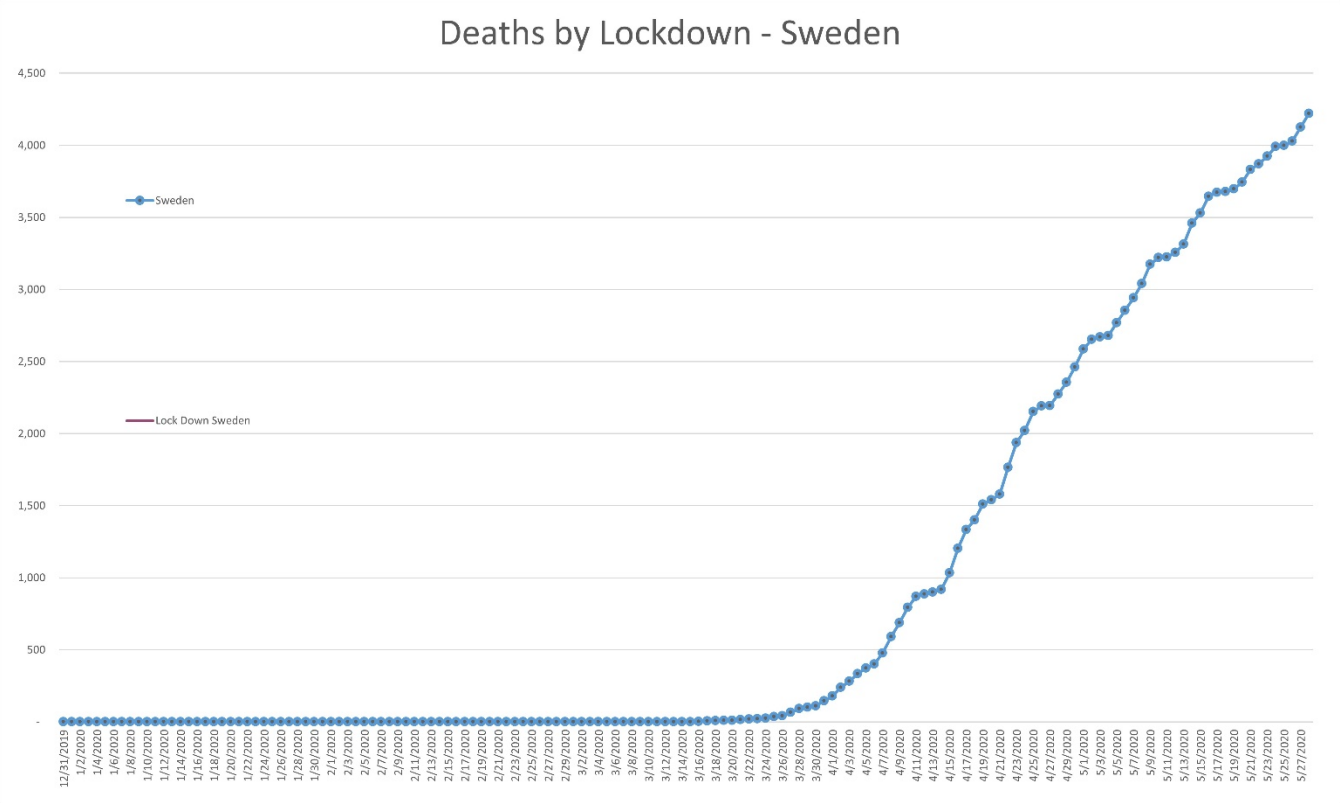

Deaths by Lockdown - Belgium
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
Belgium
Lock Down Belgium


Deaths by Lockdown - Denmark
Denmark
Lock Down Denmark
600
500
400
300
200
100
-


Deaths by Lockdown - Switzerland
Switzerland
Lock Down Switzerland
1,800
1,600
1,400
1,200
1,000
800
600
400
200
-


Deaths by Lockdown - Norway
250
200
150
100
50
-
Norway
Lock Down Norway
12/31/2019
1/2/2020
1/4/2020
1/6/2020
1/8/2020
1/10/2020
1/12/2020
1/14/2020
1/16/2020
1/18/2020
1/20/2020
1/22/2020
1/24/2020
1/26/2020
1/28/2020
1/30/2020
2/1/2020
2/3/2020
2/5/2020
2/7/2020
2/9/2020
2/11/2020
2/13/2020
2/15/2020
2/17/2020
2/19/2020
2/21/2020
2/23/2020
2/25/2020
2/27/2020
2/29/2020
3/2/2020
3/4/2020
3/6/2020
3/8/2020
3/10/2020
3/12/2020
3/14/2020
3/16/2020
3/18/2020
3/20/2020
3/22/2020
3/24/2020
3/26/2020
3/28/2020
3/30/2020
4/1/2020
4/3/2020
4/5/2020
4/7/2020
4/9/2020
4/11/2020
4/13/2020
4/15/2020
4/17/2020
4/19/2020
4/21/2020
4/23/2020
4/25/2020
4/27/2020
4/29/2020
5/1/2020
5/3/2020
5/5/2020
5/7/2020
5/9/2020
5/11/2020
5/13/2020
5/15/2020
5/17/2020
5/19/2020
5/21/2020
5/23/2020
5/25/2020
5/27/2020

Again, what about Sweden? The same story here.



Why are we not asking these questions when these very numbers are destroying lives daily worldwide? How many deaths are being reported that have resulted from the drastic steps taken already;

- *Accidental deaths in hospitals due to an overstressed system?*
- *Deaths due to priorities of dealing with a pandemic?*
- *Suicides due to job loss and confinement?*
- *Domestic abuse?*
- *People not receiving treatment they need due to fear of going out?*
- *People not receiving proper care? (cancelled surgeries, treatments etc.).*
- *and so much more...*

This is before we even get to the economic fallout. All the above will continue to rise when COVID 19 is a distant memory.

How many people remember Swine Flu? That is H1N1, the main cause of seasonal flu for many years. Now we call it seasonal flu.

Ask yourself, how can the rate of deaths match the exact same curve in every country? How can reported cases have spiked right after the lockdowns? How can deaths follow the exact same curve as the reported cases?

BECAUSE WE ARE TRACKING TEST KITS, NOT LIVES.

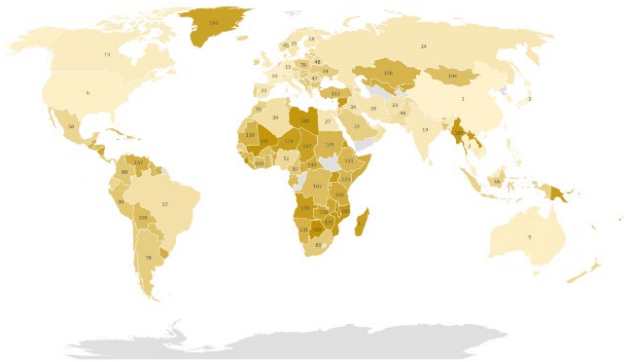
We have viable treatments for this particular Coronavirus, unlike most others like H1N1.

The vast majority of people who contract COVID 19 recover after mild to moderate symptoms. We can't wait for a vaccine. We can't stay inside forever.

We didn't beat SARS, MERS, H1N1 and H5N1 by shutting down society. We developed herd immunity, followed common sense protocols and eventually developed a vaccine. This time around, we also have treatment protocols to add to our arsenal in this fight.

It is time to stop the panic, bring back some semblance of normality. Everyone's physical, mental and economic health is under siege. It's not too late to save us all. Contact everyone you know from the highest levels of government to your closest friends and family. Share this message far and wide. Don't wait until it's too late. The clock is ticking for us all.

COVID 19 The Spread of A Virus



A SARS-COV-2 Story – Chapter 3

Published on April 5, 2020

As the media fiddles, we are watching Rome burn.

How did we get here?

One word. Panic. That was the trigger. The issue is what each country did next.

The panic appears to have started as a reaction to China's unusually public view into their reaction to the outbreak. Unlike any other time, news reports were 'leaking' in almost real time out of China. When does that ever happen, let alone as 4K drone footage, professionally produced? China apparently wanted the world to see it building massive hospitals in an apparent uncontrolled panic.

Anyone around the security services in the late 80's would be aware of the 'break glass in case of emergency' plan every country in NATO (and beyond) was using. If enough panic was induced, this plan could (and appears to have been) triggered.

The messaging from China appeared to demonstrate that COVID 19 was a highly infectious and deadly virus. This was helped by China appearing to misrepresent the numbers to underplay the outbreak, whilst letting the world see its apparent reaction. Thousands of temporary hospital beds, in 16 temporary hospitals built in days. However, very few reported deaths by comparison. China must be lying about the numbers, was the obvious reaction. What if the lie was the hospitals and beds, not the actual deaths?

In January 2020, the first reported cases outside of China started to appear around the world. However, no-one panicked as it spread initially. Remember, millions of infected people were moving in and out of China before the first case was reported outside of China. The virus is considered to be as or more infectious than flu. That we know, based on how it is being handled. Did it only start infecting

and killing people after we started testing though? Infectious AND Polite!? That would be novel for a coronavirus!!

What happens next is an apparent classification directive to count COVID 19 deaths 'as anyone who tests positive'. This is the baseline for COVID 19 deaths in all countries. Imagine if we did that with flu. The already astronomic rate of flu deaths would be terrifying and make COVID 19 look like a walk in the park.

Countries saw an initial spike in deaths, now associated **with** COVID 19 (but not necessarily **due to** COVID 19).

The focus of the world turned to Italy.

Why Italy though? Italy was the 22nd country to have a reported case, one month after China and two and a half months after the apparent start of the infection spread worldwide. Italy was the 8th country to have a reported death.

First Positive Case Reported		
Date	Country	Order
31-Dec-19	China	1
13-Jan-20	Thailand	2
15-Jan-20	Japan	3
20-Jan-20	South Korea	4
21-Jan-20	Taiwan	5
21-Jan-20	United States	6
24-Jan-20	Singapore	7
24-Jan-20	Vietnam	8
25-Jan-20	Australia	9
25-Jan-20	France	10
25-Jan-20	Malaysia	11
25-Jan-20	Nepal	12
26-Jan-20	Canada	13
27-Jan-20	United Arab Emirates	14
28-Jan-20	Germany	15
28-Jan-20	Cambodia	16
28-Jan-20	Sri Lanka	17
30-Jan-20	Finland	18
30-Jan-20	India	19
30-Jan-20	Philippines	20
31-Jan-20	United Kingdom	21
31-Jan-20	Italy	22

First Death Reported		
Date	Country	Order
11-Jan-20	China	1
02-Feb-20	Philippines	2
13-Feb-20	Japan	3
15-Feb-20	France	4
17-Feb-20	Taiwan	5
20-Feb-20	Iran	6
21-Feb-20	South Korea	7
23-Feb-20	Italy	8
01-Mar-20	Australia	9
01-Mar-20	Thailand	10
01-Mar-20	United States	11
02-Mar-20	San Marino	12
05-Mar-20	Spain	13
06-Mar-20	Switzerland	14
06-Mar-20	United Kingdom	15
06-Mar-20	Iraq	16
07-Mar-20	Netherlands	17
08-Mar-20	Argentina	18
09-Mar-20	Egypt	19
10-Mar-20	Canada	20
10-Mar-20	Germany	21
11-Mar-20	Lebanon	22

Northern Italy has a mortality rate for coronavirus type infections that is 600% higher than the US. It also has a high population of Chinese workers. This created a perfect storm for apparent COVID 19 related deaths. It also started using mass COVID 19 tests on the dead and dying.

Time to 'break the glass' in Italy.

That triggers protocols for biowarfare and radiological (nuclear) attack, the only plan in the government's arsenal. This is what is referred to as RBC (Radiological, Biological, Chemical) emergency response plan. Suddenly everyone is suited up from the receptionist and cleaner to the doctors and

nurses. Cue the trailer for the Andromeda Strain. Hospitals were not designed for this. Health facilities quickly started running out of masks and gloves which were now being used at an exponentially higher rate than normal. China stockpiled this equipment and material (as China NEEDED them). Panic escalated worldwide.

Test kits started arriving and lock downs went into effect. Like proverbial dominoes countries fell, one after another. Doctors were panicking about being infected so followed international (WHO and CDC) guidelines on INTUBATED ventilation instead of using masks or cannulas for oxygen. This is pretty much fatal for a pneumonia patient and ventilation is typically for someone with an inability to breathe mechanically, not for an issue with oxygen exchange in the lungs. Even in those without pneumonia, intubated ventilation can cause pneumonia and a loss of oxygen exchange, typically in 25%+ of cases. They even have a name for it - VAP (Ventilator Associated Pneumonia). Pneumonia + Age + Pre-Existing Conditions = Bodies start stacking up.

As the bodies are now considered almost hazardous waste, routine autopsies are deemed too risky. New ways have to be found to store the accumulating bodies. Normal processes to return the dead to undertakers and family is suspended adding to the strain on an already burgeoning health system. We are seeing this play out in New York daily now.

Why are patients being intubating then? Because affected patients require oxygen therapy for falling o2 saturation. However, the directives and protocols provided state that the virus is spread by aerosolization i.e. fine droplets. The cannula and mask (with holes in the front) aerosolizes the patient's breath... can't have that.

Why does the world suddenly need millions of ventilators when doctors continue to report that almost if not all patients who are intubated and placed on a ventilator ultimately die? What then is the point? Yet the cry for ventilators, masks and gloves is relentless. All of these are suddenly in short supply. All because of PANIC, hoarding and international health directives.

Is this deliberate or just incompetence? Who knows. Or maybe WHO does. But it is clear how the panic spread and how it has caused what is happening as a result.

Now we have a highly infectious disease everyone is concerned is spreading as easily as people breathe. This was circulating out of China and across the world for months before the first reported death outside of China. However, we can stop it (or slow it down to a crawl) by 'sort of' staying indoors!? Even if EVERYONE followed governments' directions to the letter, people would still be circulating, as would the virus. People in essential services are all leaving the house, as is virtually EVERYONE to collect food and medications at the very least.

Imagine the Andromeda Strain again. Through the level 5 containment process, the cleaner is sent out to get milk from ground zero and leaves the back door open to come and go. No biohazard protocols, just going shopping after all. How effective would that be?

This virus has been identified to have a R_0 (R naught) of between 2-4 (differing models have different numbers). This is the rate of spread i.e. R1 = 1 person infect one person. R2, one person infects two people etc. Based on a R_0 of 3 we would have had over 1 billion infections in the first 30 days. That would have been by mid December 2019. By now, we would be seeing infections in the range of 70% of the population, These are the models and numbers that were (and are) being used to justify the lock downs. Mortality rates of 2%-3% and above, all the way to over 10% in some countries have been cited. Why then have bodies not been piling up since Christmas worldwide?

Note that H1N1 has an R_0 of about 1.4-1.7. WHO projected an R_0 for COVID 19 as 3.4, upon which most models were based. More detailed studies in March moved that R_0 to closer to 5.7. Recently, models have been adjusted for the significant drop in mortality that is being seen, but the spread rates (R_0) are still felt to be accurate. For an explanation of R_0, see this video from 3Blue1Brown[38] [Video Link][39] . (3Blue Brown, 2020), (3Blue Brown, 2020)

If this is the case, the lock down does nothing for a virus that has already infected large numbers of the population and has spread so easily. However, if that many people have contracted COVID 19 and the

[38] https://www.3blue1brown.com/covid-thanks

[39] https://www.youtube-nocookie.com/embed/Kas0tIxDvrg

mortality rate is as bad as reported (almost 20% in Italy at one point), again, why are there not bodies piling up in the streets? This virus has a two-week incubation period and patient zero appeared in one of the most populous and internationally visited location as early as mid November 2019. Something does not add up.

Anyone saying the virus has already spread uncontrollably is silenced as it doesn't support the panic and reactions the governments have taken (or the media narrative). Now we are into a situation where governments have to justify what has been implemented. Governments implemented the 'break the glass' plan with as much thought as a person panic buying toilet paper. 'Italy did it, so we must!' seems to be the thought process. WHO was driving this?

Then some governments appear to have capitalized on the opportunities to power grab. Civil liberties and human rights dissolve as new laws and powers are enacted in record time, completely unchecked. Tracking, COVID 19 passports to leave the house and DNA testing once thought unconscionable, those many weeks ago, before the lockdown, are touted to become the 'new normal'. However, government has never been one to waste a crisis…

We are currently on a path with a plan that was designed in a way that it would guarantee tens of thousands would die. That plan would be justifiable in the carnage of what governments would be dealing with i.e. A nuclear, biological or large-scale chemical World War. That plan would normally have been executed over days. In this case, we are slowly following the script, so a lot of people don't recognize the steps. Even those who might are too focused on following protocols.

Mass surveillance, DNA testing and martial law may be coming to a street near you soon. All in a matter of weeks. How bad will it get in a few months?

All these actions are based on the premise that the virus is deadly and can be stopped (or slowed) by partially isolating the population. Does this make sense considering when it started and how fast and easily it spreads?

We can see from my previous articles that this is an assumption based on numbers and testing that is highly flawed but apparently directed from a single source.

What if we told people that the chance of getting COVID 19 was 20% or less (the actual numbers show that based on tested vs. tested positive in the US). What if the chance of death was orders of magnitude less than flu despite the implementation of steps that should be just as effective on flu? Seasonal flu (all ten strains this season) has taken many more lives in the same period as COVID 19 has been active. How many people would let the government ruin their lives, shut down businesses and take away every civil liberty based on this reality? However, broadcast glowing red maps and tell people that millions of people will die without full compliance and everyone stays indoors… well almost everyone.

What next? How will a vaccine help?

A flu by another other name. We have had a vaccine for H1N1 since October 2009, when it was more commonly known as Swine Flu. Care to guess what the primary flu killer (out of 10 strains) is this year? - H1N1[40] [CDC Link] (CDC, 2020). We have been dealing with strains of H1N1 for more than 100 years, since it was first made famous as Spanish Flu[41][CDC Link -Previous Pandemics] (CDC, 2020). If COVID 19 is truly more deadly and more contagious than seasonal flu, then how will the vaccine bring us below the numbers that triggered the global shutdown?

However, a treatment is available that has been tried and tested since 2003. China used it right away and opened their borders on the same day the last major country outside of China closed theirs. Coincidence?

There is some push back. People across the world are questioning the numbers. There is talk that it might not be so bad. Suddenly rumours surface that in other parts of China it has started to spread. Panic flares up again and people stop looking at what the real numbers are.

[40] https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm

[41] https://www.cdc.gov/flu/pandemic-resources/basics/past-pandemics.html

People were starting to ask, how did this spread across the world and not across China? That was a question that China and others did not need people asking. So, let's have another flare up in China, everyone goes back to the 'narrative', and re-focuses on all the apparent deaths from COVID 19 at home.

This all falls apart though when you take a good hard look at overall mortality. We have not had any worldwide spikes in overall deaths this year. In fact, total deaths are down year on year worldwide. Does that sound like a new pandemic killing many more millions this year? But the numbers of reported cases and COVID 19 classified deaths are climbing. Yes, they are, but at the exact same logarithmic scale as test kits are being distributed!!![42] [see COVID 19 – Is the lock down working?] (Dickson, Article, 2020)

In reality, experts are now speaking out and showing that this virus is no more deadly than seasonal flu. Current models expanding beyond the panic show it is in fact much LESS deadly than flu.

On top of that, we have a treatment that kills the virus in the body in 100% of cases (based on multiple studies). If caught early enough, it can save 100% of patients (barring other complications that would cause mortality regardless of COVID 19). But WHO and others are pushing back and delaying the use of it. Why? [Link to CDC trials][43] (CDC, 2020)

As a result, outside of China, the preference is to use much more risky blood plasma transfusions therapy. [Link to blood transfusion risks][44] (Utah University, 2020). Why is the proven 'off label' use of a cheap tried and tested medication that has been around for decades continually pushed to one side while people are dying with this virus?

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[42] https://www.linkedin.com/pulse/covid-19-lock-down-working-dave-dickson-/

[43] https://www.clinicaltrials.gov/ct2/show/NCT04315896

[44] https://webpath.med.utah.edu/TUTORIAL/BLDBANK/BBTXRXN.html

We need to stop counting bodies based on flawed statistics designed to induce panic. We need to start saving lives and get back to work.

The problem is that governments now need to do one of a few things to dig us literally out of this grave.

1. *Admit they overreacted. That won't go down well anywhere… and who goes first?*
2. *Confirm to everyone that the Hydroxychloroquine, Azithromycin and some other treatments are working.*
3. *Allow front line people to take precautions such as prophylactic use of medications above (a lot are already doing that 'off label').*
4. *Change how numbers are reported to accurately reflect deaths **from** COVID 19, not **with** COVID 19, say we are over the curve (flattened or otherwise).*
5. *Drop the biohazard protocols at the front line and go back to the protocols for MERS, SARS and H1N1.*

This reduces the stress and strain on the front line and society overall. The stress itself is killing in some cases. [Ontario increasing mental health resources to cope with COVID 19 fallout][45] (Government of Ontario, 2020). This is a story playing out in ever increasing numbers across the globe.

With these steps, people could go back to work, with some extra attention to cleanliness and overall health management. That might even generate some new cleaning and administration work to manage it.

In any of these scenarios, patients still need to be treated as needed. Leave the mild cases to run the course to build herd immunity and get the vaccine ready for round 2. For the 2009 H1N1 pandemic, they had a vaccine (we use today) by October 2009.

[45] https://news.ontario.ca/opo/en/2020/04/ontario-increasing-mental-health-support-during-covid-19.html

Then remember… this will be back. And next time we should not panic.

Numbers courtesy of [46] [47] [48] [49] [50] [51] [52]

(ECDC, 2020), (CDC, 2020), (Worldometers, 2020), (Government of Canada, 2020), (GoA, 2020), (Worldometers, 2020), (NextStrain, 2020)

[46] https://www.ecdc.europa.eu/en/publications-data/download-todays-data-geographic-distribution-covid-19-cases-worldwide
[47] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/testing-in-us.html
[48] https://www.worldometers.info/world-population/population-by-country
[49] https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html
[50] https://covid19stats.alberta.ca/
[51] https://www.worldometers.info/coronavirus/
[52] https://nextstrain.org/ncov/global

How the humble Gin & Tonic may save the world from COVID 19.

A SARS-COV-2 Story – Chapter 4.

Published on April 9, 2020

Note this is not medical advice. Never take any medication or assume you know the side effects or benefits of anything to treat COVID 19 or any other malady. Always take direction from your doctor. Now sit back, relax and have a Gin and Tonic. After all, what else do you have to do in lockdown?

There is a lot of negativity around the discussion about Hydroxychloroquine and Azithromycin. As a result, people are saying they wouldn't take this particular drug until there are 'official' studies completed. These could take years.

However, hydroxychloroquine is the safer version of chloroquine, a synthetic version of quinine, the active ingredient in tonic water[53]. (Lowe, 2020)

Tonic Water?

Tonic Water was invented to make it easier to take quinine to protect as a prophylactic against malaria. Its common use dates back to the 1800's. It was first commercially produced in 1858.

Yes, that bitter tasting fizzy drink which became a staple around the world to the point of being a legend! The British, (being what we are!) decided it needed a bit of a kick to wash it down. And thus was born the infamous Gin and Tonic.

[53] https://blogs.sciencemag.org/pipeline/archives/2020/03/20/chloroquine-past-and-present

"It is a curious fact, and one to which no-one knows quite how much importance to attach, that something like 85 percent of all known worlds in the Galaxy, be they primitive or highly advanced, have invented a drink called jynnan tonyx, or gee-N'N-T'N-ix, or jinond-o-nicks, or any one of a thousand variations on this phonetic theme.

The drinks themselves are not the same, and vary between the Sivolvian 'chinanto/mnigs' which is ordinary water served just above room temperature, and the Gagrakackan 'tzjin-anthony-ks' which kills cows at a hundred paces; and in fact the only one common factor between all of them, beyond the fact that their names sound the same, is that they were all invented and named before the worlds concerned made contact with any other worlds."
(Adams, The Restaurant at the End of the Universe, 1980)

Douglas Noel Adams (DNA), The Restaurant at the End of the Universe

We might have discovered just how much importance to attach to these prophetic words written in jest.

The history of tonic water and quinine is easy to find. It has been around almost forever. Please note that the current commercial versions of tonic water contain very little quinine. *Quinine is toxic if improperly taken, (as are many drugs). Do not try and self-medicate without the advice of your doctor.*

So, for Hydroxychloroquine we are now talking about an *'off label'* use of a medication that has been safely used on millions, if not billions, of people since the 1800's (or earlier in various forms). You know how many other medications are commonly used *'off label'* i.e. not for the use on the label? Almost all of them!

If you went to Africa (back when travel was allowed), your doctor probably gave you this drug to protect you from malaria. People take this without a thought for weeks or more. Lupus patients take this as a matter of course, without a thought, for years. Those with rheumatoid arthritis also take this

medication with great success. Note that long term use has some side effects. These drugs should never be taken without the advice and/or supervision of a doctor.

If you were given Hydroxychloroquine for COVID 19 for around 6 days, it would most likely be lifesaving. It has in almost all the thousands of people tested in small trials throughout the world. It was used to treat Avian Flu (1997), SARS (2003), MERS (2012/2015) and many other diseases that cause a cytokine storm (such as lupus) for decades. So, why is it now so bad and risky?

Some, patients will sadly still die after contracting COVID 19 despite taking this medication or indeed any other treatment. Those sad cases are a tiny proportion of those treated. However, in every reported case I have researched, the underlying complications and/or delayed treatment has been found to be the primary factor. This is all anecdotal evidence until you take the dozens of studies and add them together. As such, we already have had large scale randomized testing of this drug, provided under doctor's supervision, in combination with Azithromycin.

So, right now these are the few choices for patients dying with COVID 19 complications[54]. (CDC, 2020)

- *Dying on a ventilator.*
- *Taking an expensive and risky experimental drug on trial for Ebola (Remdesivir).*
- *Having a risky blood (plasma) transfusion from a previously infected patient.*
- *Taking an 'off label' medication that has already successfully treated thousands.*

Some positive results are being reported for Remdesivir and plasma transfusion, but neither of those have gone through rigorous double-blind studies in the treatment of COVID 19 either. So, why are these treatments acceptable and Hydroxychloroquine is not?

The CDC is not expected to publish results of Hydroxychloroquine trials before mid-2021. Would you really wait for double-blind studies to come back if your very life depended on it?

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[54] https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html

As of April 29th, 2020, the current CMAJ treatment guidelines remove almost all reasonable medication treatment protocols without any evidence to support the decision[55]. (Ye, 2020)

*"**Because the likelihood of death from COVID-19** in patients with nonsevere disease **is extremely low (in the range of 1/1000),** we are very confident that antiviral drugs will have little or no effect on mortality in such patients." (Ye, 2020)*

This article states that not using proven, cheap and safe treatments for COVID 19 is justifiable because it is no more dangerous than flu with a mortality rate of 0.1%. However, the CMAJ guidelines support lockdowns and known high risk protocols for COVID 19. These guidelines suggest corticosteroids for COVID 19. This makes no sense at all[56]; (Mehta, 2020)

*"As during previous pandemics (severe acute respiratory syndrome and Middle East respiratory syndrome), **corticosteroids are not routinely recommended and might exacerbate COVID-19-associated lung injury**." (Mehta, 2020)*

A vaccine, the only other long-term option presented, could be 12 to 18 months away. Also, we have a vaccine for H1N1 (also known as Spanish Flu, Swine Flu and since 2009, seasonal flu). H1N1 still kills tens of thousands or more every year. So, even with a vaccine, a treatment is also required to save lives.

[55] https://www.cmaj.ca/content/early/2020/04/29/cmaj.200648

[56] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30628-0/fulltext

For those who need hospitalization and end up on a ventilator, COVID 19 has proven fatal, if not treated early and appropriately, in almost every case.

There are two primary causes of death being reported in relation to COVID 19. The cytokine storm (similar to an autoimmune reaction such as in Lupus) and pneumonia. So, ask yourself, why does Hydroxychloroquine (a Lupus medication and anti-viral agent) with Azithromycin (a common antibiotic used for chest infections) work?

Can you really afford to wait? I couldn't and wouldn't. I haven't had a drink in almost four decades. But bottoms up! Pour me a G & T (derivative)!

For clinical trials see: [57] [58] [59] (NIH, 2020), (National Heart, Lung, and Blood Institute (NHLBI), 2020)

Hydroxychloroquine (the safer successor to Chloroquine and Quinine) [60] [61] [62] [63] [64] [65] [66]
(A.Devaux, 2020), (Yan, 2012), (Savarino D. A., 2006), (Ooi, 2006), (Kapoor, 2020), (Xinhua, 2020), (huaxia, 2020), (Drugbank, 2020)

[57] https://www.drugbank.ca/indications/DBCOND0126697#drug-trials

[58] https://www.nih.gov/news-events/news-releases/nih-clinical-trial-hydroxychloroquine-potential-therapy-covid-19-begins

[59] https://clinicaltrials.gov/ct2/show/NCT04332991

[60] https://www.sciencedirect.com/science/article/pii/S0924857920300881

[61] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3567830/

[62] https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(06)70361-9/fulltext

[63] https://virologyj.biomedcentral.com/articles/10.1186/1743-422X-3-39

[64] https://www.medrxiv.org/content/10.1101/2020.03.24.20042366v1.full.pdf

[65] https://crofsblogs.typepad.com/h5n1/2020/01/three-drugs-fairly-effective-on-novel-coronavirus-at-cellular-level.html

[66] http://www.xinhuanet.com/english/2020-01/30/c_138742650.htm

Remdesivir [67] [68] [69]

(NIAID, 2020), (Feldman, Covid-19, 2020), (Drugbank, 2020)

Vaccine [70] [71] [72] [73]

(Lihua, 2020), (Drugbank, 2020), (DrugBank, 2020), (University of Oxford , 2020)

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[67] https://clinicaltrials.gov/ct2/show/NCT04280705

[68] A 4% reduction in mortality for a $5,000 treatment. (Feldman, 2020)

"In a preliminary study, Rmdesivir from Gilead lowered mortality in hospitalized Covid-19 patients from 11.6 % to 8%." (Feldman, 2020)

https://www.bloomberg.com/opinion/articles/2020-05-06/america-has-no-plan-for-the-worst-case-scenario-on-covid-19

[69] https://www.drugbank.ca/drugs/DB14761

[70] http://www.chictr.org.cn/showprojen.aspx?proj=51154

[71] https://www.drugbank.ca/drugs/DB15655

[72] https://www.drugbank.ca/drugs/DB15656

[73] https://www.clinicaltrials.gov/ct2/show/NCT04324606

COVID 19 Risks - a Personal Message

A SARS-COV-2 Story – Chapter 5.

Published on April 9, 2020

This is deeply private and personal, but I've reached the point in trying to address this where the only way I might be able to make the point is to share the following. This isn't about me. Or you. It's about us all.

As some of you will know, I have been to hospital too many times due to pre-existing conditions. My wife, Karen, who would normally accompany me, would now not be allowed into the hospital, leaving me without a much-needed advocate. I can't talk and can barely catch a breath on bad days due to a lack of lung function. My o2 saturation levels crash. I exhibit classic signs that are attributed to COVID 19 today. These common symptoms used to be attributed to several possible maladies and treated accordingly. But now the world has only one disease - COVID 19. *CDC Guidance for Certifying COVID 19 Deaths March 4, 2020 [Link]*[74]. (CDC, 2020)

"COVID-19 should be reported on the death certificate for all decedents where the disease caused or is assumed to have caused or contributed to death."

Four months ago, I would receive pain medication and oxygen (as needed) through a cannula (nasal tube). I would have x-rays and antibiotics and be back with my family in a day or less. I know, because I have been successfully treated this way for the last decade, including this Christmas. Anyone else's family have a bad flu season this year? I can NEVER be put on intubated ventilation because that would quite literally end my life.

[74] https://www.cdc.gov/nchs/data/nvss/coronavirus/Alert-1-Guidance-for-Certifying-COVID-19-Deaths.pdf

Anything that impacts my lungs (a cold, flu, pneumonia and now COVID 19) could be a death sentence. It is a fear my family lives with constantly.

Other than a fear of coughing in public (simply me catching my breath when I walk!) and being reported to authorities, my life has not changed in the face of this novel virus.

Since the first reported case of COVID 19, the CDC has changed its direction on how I and others presenting with COVID 19 type symptoms are being treated, no matter the underlying cause. The following is now standard practice. Note: this is not due to any fault of anyone of the front line. Those in health care are simply following the protocols they believe are required in this crisis.

Today, I, in Canada, I would 'maybe' given a maximum of 5l cannula delivered o2. Current Canadian Anesthesiologists' Society (CAS) guidelines for COVID 19 [Link][75]. (Canadian Anesthesiologists' Society, 2020)

> *"Nasal cannula at 5l per minute or less maybe used to provide supplemental oxygen to the COVID-19 patient in respiratory distress."*
> *(Canadian Anesthesiologists' Society, 2020)*

This would not be enough for anyone on respiratory distress, as in every previous experience I have been on a minimum of 9l of o2 just to stabilize my o2 stats when not in distress.

The next step, as per the Canadian Guidelines, would be to be intubate me causing VAP (Ventilator Associated Pneumonia).

[75] https://www.cas.ca/en/practice-resources/news/cas-articles/2020/covid-19-recommendations-during-airway-manipulation#

"High flow nasal cannula (HFNC) or non-invasive positive pressure ventilation (NIV) should be avoided due to the possibility of increasing aerosolization." (Canadian Anesthesiologists' Society, 2020)

However, anyone following the CDC guidelines (most of the world from the US to Italy), would go directly to intubated ventilation.

I would then drown as my lungs filled up due to the pressure induced VAP. How do I know? Some years ago, I suffered a 75% bi-lateral intubation-initiated pneumonia that has left me with my current issues. I survived because the hospital took me off a ventilator and put me on oxygen as my lungs filled. Like almost every COVID 19 patient today, I could breathe. I needed oxygen, not assistance breathing. This I know from a few enlightened specialists and clinicians who have educated and worked with me to carefully manage my condition and give me quality of life.

Based on the new CDC guidelines, no one would even bother testing me for COVID 19. I would die on a ventilator. I would just be another one in the daily count. The same body count that is instilling so much fear and panic and is keeping people isolated in their homes.

You know what terrifies me? Not COVID 19, that is treatable with $20 of decades old medication used on H5N1(1997), SARS (2003) and MERS (2012/2015). I'll take my chances with that. Thousands already have and survived.

What is truly terrifying is the reaction to this that is slowly killing us all.

Social Distancing

Social distancing is the answer we are now told. Anything but social, this 'physical' distancing has a far more nefarious purpose than slowing or preventing the spread of a virus, already beyond control. Like quarantining the healthy and wearing ineffective masks, this is more about communication and control than anything else.

Social distancing is not supported by any science, but it has a purpose. The virus sits in the air for hours and on surfaces for weeks (or does it?). We have studies that show this but new guidelines from the CDC that say otherwise. If it is not airbourne and not transmitted from surfaces, there is only one logical conclusion. As it enters the body through the mucous membrane, we have had over 4 million people sneezing and coughing in each other faces in the past three months, most of whom have not noticed. So much for all the PPE for essential workers, doctors and other health workers who appear to have caught COVID 19 without noticing.

To stay away far enough to make a difference form the impact of a cough or sneeze, you would have to be at least 13 feet[76] (Guo, 2020) or more at all times (not just when convenient or in public when people can see). This would have to be a universal protocol for everyone, or the efforts would be wasted. This would include at home, not just in public. Without this universal protocol, are we stopping the spread from one person to another or just doing it for show?

If it is spread from surfaces (as it has been shown in other studies referenced here) the protocol would require every surface that was touched was sanitized immediately and full biohazard 'fit tested' full face respirators worn at all times.

Now, do doctors, nurses, police, paramedics, all keep social distance, or are they immune? How about hairdressers, nail salons, waiters.. The virus doesn't know the difference from a close companion, family member, essential worker or just another member of the public. So, how can the rules not apply equally? Do we have some sort of agreement with the virus that it will behave differently within these groups? If not, then why do we have so many differing and contradictory rules?

Have this been the protocol for the last millennia of deadly flu seasons or ongoing cold seasons? These are potentially deadly to myself and many millions like me around the world. Should we now expect this to be the new protocol forever for every deadly virus? If not, why not?

[76] https://wwwnc.cdc.gov/eid/article/26/7/20-0885_article

Are we willing to destroy society, never allow another hug, handshake or embrace for fear of the 'social distance' spies catching us in a time of need? Will we stand by when a passerby falls to the ground gasping for breath as they have a heart attack. Will we stand by and watch a child drown in a pool or lake? Will you stand by and let a child cry when they fall down? Will you watch children and grandchildren grow up alone, isolated and damaged beyond comprehension as a result of your social distancing insanity?

This is not the first deadly virus to circle the globe (we are tracking 10 flu strains this season alone) and it will not be the last. Will we continue this cycle of masks, lockdown and social distancing forever? The answer is no, because we won't last that long as a society if we continue this charade.

Social distancing if you believe in it, just like a mask, cannot be used as a badge of honour to be worn when convenient. It must be obeyed at all times. Otherwise it is a farce.

I would never ask anyone to destroy their own life let alone the world to protect me from my own condition. That is my responsibility. But watching people follow unscientific rules set out by the very talking heads who have got everything wrong to date, just to fit in, is heartbreaking.

Society will never survive social distancing. If it is truly required, then we will die off in isolation. If it is not needed (and there is no scientific proof to back that it has any benefit) then we are tearing society apart to bow to the masters and for no other reason.

Just for some context, here's the Math... 4 people social distancing at 2 meters require the same space, at all times, without any other items such as tables etc. as 169 people at a crowded outdoor concert. 72 people at normal spacing of say an airplane, train or movie theatre.

Now think back to when this started. From the beginning of November to the middle of March, most of the world did nothing while millions of people traveled around the world infecting each other. In the five months from it starting to the lockdown in the US, there were 1,050 reported deaths (with, not of COVID... but that is another story). In the next 7 weeks, over 80,000 deaths were reported in the US. All-cause mortality didn't change during that time, despite this deadly virus killing so many. If social distancing, lockdowns and masks are doing such a good job, we should have seen millions of excess

deaths before these steps were taken. Deaths should have dropped dramatically in the last two months of hell we have gone through. Yet, where are all the bodies? Why did deaths go up not down with the lockdown? All the answers are in plain sight. You just have to look. See this video for more details on Social Distancing https://youtu.be/lf6yBeXmzCo (Bailey, 2020)

[77] [78] [79] [80] (Johns Hopkins University, 2010), (Radonovich, 2018), (Ahmed, 2018), (Verbeek, 2019)

Masks (respirators).

To all those insisting everyone should be forced to wear a mask *"for everyone's safety".*

One question. Did you wear a mask during every flu season you have been through?

Flu is potentially deadly to me and many others like me. Flu kills 100's of thousands every year, including healthy people without co-morbidities. Is this not a serious concern?

Did we ever insist you wear masks all the time to protect us? Did we call you murderers for not conforming to our masters' voice?

The answer is no. We have evolved and are educated enough to know to cough into our hand, sleeve, hanky (or whatever the latest fad is... that isn't a mask).

These masks that are now 'mandatory' in many places, do nothing if you take a look at the way this disease spreads. You are likely to suffer from much worse with long term inappropriate use of an inappropriate (homemade or other) mask. There is a reason there were (and are) rigid, tested protocols for different types of masks (or respirators as they should be more accurately identified)

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[77] https://clinicaltrials.gov/ct2/show/NCT01249625

[78] https://academic.oup.com/ofid/article/5/suppl_1/S51/5206102

[79] https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-018-5446-1

[80] https://pubmed.ncbi.nlm.nih.gov/31259389/

before COVID 19 threw away all common sense. The N95 'mask' often discussed, is not actually a mask. It is more correctly identified as a respirator [81]. (Government of Canada, 2020)

- Masks make you touch your face more as you constantly adjust them.
- They absorb moisture (and all that comes with it).
- In a pool area, they will accumulate chlorine causing potentially fatal results if worn over a long period. - Yes, they will apparently be mandatory in indoor pools from the City, YMCA and even West Edmonton Mall.
- They interfere with CO2 expiration and oxygen inspiration.
- They should only be used (as an alternative to other long used mechanisms - see above) to prevent the spread by symptomatic individuals (and then only for short periods of time, and NEVER reused).
- They should be used in areas of poor air quality to filter out larger contaminants (the negative effects are offset in this case). This is why they are commonly worn in Asia. Not because masks are a fashion statement or to prevent viral inspiration. In Japan and other Asian countries, there are oxygen dispensing stations in the same way we have had drink dispensers for decades, all because of poor local air quality.
- Disposable or homemade masks should never be re-used as a virus barrier - they are not 'fit' for purpose.
- For most, a mask in this type of use is unhealthy. For those like myself, or those with many other respiratory maladies, a mask could prove fatal when used inappropriately.
- The N95 to N100 designation is a "respirator" not a 'mask'.

Chapter 6-10 - Canadian Biosafety Handbook, Second Edition [82]. (Government of Canada, 2020)

[81] https://www.canada.ca/en/public-health/services/canadian-biosafety-standards-guidelines/handbook-second-edition/chapter-6-10.html

[82] https://www.canada.ca/en/public-health/services/canadian-biosafety-standards-guidelines/handbook-second-edition/chapter-6-10.html

9.1.6 Masks and Respiratory Protection

"Masks are not intended to be used more than once."
[83]. (Government of Canada, 2020)

"Surgical masks and many types of dust masks offer little protection from airborne pathogens"

"Respirators are used when there is a risk of exposure to aerosolized toxins or infectious aerosols that can be transmitted through the inhalation route."

"Personnel education on airborne hazards and training on respirator selection, fit, inspection, and maintenance are some examples of elements of a workplace respiratory protection program, which is required for any workplace where respirators are used."

[83] https://www.canada.ca/en/public-health/services/canadian-biosafety-standards-guidelines/handbook-second-edition/chapter-6-10.html

9.1.6.1 Respirator Fit

"All respirators need to fit properly in order to function as intended."

"Using the wrong respirator or misusing one can be as dangerous as not wearing one at all."

"Most jurisdictions within Canada currently require qualitative or quantitative fit-testing to be conducted to demonstrate proper fit for the selected respirator(s) before an individual carries out any activities that require respiratory protection."

"In addition, standard CSA Z94.4, Selection, Use, and Care of Respirators, requires that an employer take reasonable precautions to verify that an individual is medically cleared to wear a respirator."

9.1.6.2 Air Purifying Respirators

"Disposable half-mask air purifying respirators, including the N95 and N100 type respirators, are designed for single use."

I have a doctor's exemption note for this very reason. Be careful when you judge those who wear (or do not wear) a mask. You do not know their circumstances.

Stop with the MASK Charade and do some research before you dance to the latest government marching orders.

This is not medical advice, but don't believe me, do some research and speak to someone qualified to provide the appropriate advice.

However, this is just my story. There are so many others like me. Please don't just believe or ignore me though. Turn of the TV and go and do your own research on drugs like Hydroxychloroquine and Azithromycin. Read the CDC guidelines and check their numbers. It is all there for anyone to find.

Please just take a moment to gather the facts. No-one should have to die due to of a lack of knowledge in the information age.

Before I go (hopefully not), we must now ask; What about the **avoidable deaths** that the lockdowns are **causing**. Do these lives not matter in the world where only COVID 19 appears to exist? Suicides, heart attacks, diabetes, depression, strokes, blood clots (caused by a 'new normal' sedentary life), delayed cancer screenings and so much more.

If we can report the daily deaths of COVID 19 we must be able to do the same with all causes of death. So please call on all the talking heads on TV and social media everyday to tell us the truth about who is truly dying and suffering unnecessarily.

The Canadian Medical Association Journal (CMAJ) guidelines state that COVID 19 has an overall mortality rate in tested positive cases as 0.1% (1 in 1000). CMAJ quote this low mortality rate as a reason not to use any proven safe, cheap and effective medications for the treatment of mild to moderate cases.

- For SARS-CoV-1 (SARS in 2003/2004) the actual mortality rate was 9.6%. We did not close a single country for that.
- For MERS-CoV (MERS in 2012/2015) the actual mortality rate was 34%. We did not close a single country for that.
- For COVID 19 (SARS-CoV-2), the actual mortality rate now appears to be close 0.1%, the same as seasonal flu.

We need to start asking questions about what the Lockdown is doing to society.

COVID 19 A Personal Story – Postscript

A SARS-COV-2 Story – Chapter 6.

Published on March 7, 2020

Now that care centers are opening and the 'new normal' appears to be that light at the end of the tunnel, this is the most critical piece of information you must have.

This article on ventilators was published last night (May 6th, 2020). I read it this morning and cried. https://off-guardian.org/2020/05/06/covid19-are-ventilators-killing-people/ (Knightly, 2020)

When I originally heard about the use of intubated ventilation in Italy, it was the trigger that pushed me to try and stop this.

My personal story (linked here: https://www.linkedin.com/pulse/covid-19-risks-personal-message-dave-dickson-/ (Dickson, A Personal Story - Article, 2020)) was the penultimate of five articles I have published, only because it was so hard to write. I have been screaming (as best I can with my compromised lungs) about this dangerous and terrifying response to COVID 19 for months. Yet no-one has been listening. Maybe doctors and experts will listen now.

I have given doctors a pass for months, because they were under stress. No more though. Any doctors who continue with a treatment protocol on patients who can breathe but require oxygen therapy need to be charged. (see my personal story linked above).

Doctors all know this protocol kills and saying *'I don't want to catch COVID 19'* is not an excuse. EVER!!! It has never been an excuse for any treatment, illness or disease. If it was, the human race would have died out long ago.

Do health care professionals let MRSA, Ebola, AIDS and TB (etc.) patients die alone while doctors cower and cry in the corner? Did the first responders who rushed into the clouds of dust and debris, that were the Twin Towers, stop for a second to check with the CDC? Would they have stopped anyway if

they were told the dust might be deadly? Smoke and fire kill. But fire fighters rush towards it daily as part of their vocation to save lives above all else.

In the hypothetical case above of health care professionals standing idly by while pateints die of infectious diseases, this would be a passive act. This would never be acceptable. In the case of COVID 19 and ventilators, doctors who are supporting and condoning an active role in the clear misuse of ventilators are essentially killing their patients. Why is this suddenly acceptable?

Those pleading ignorance or sitting quietly have no excuse either.

"The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis." Dante Alighieri *(Aligheri, 1265-1321)*

Should we now give all those infected with Ebola to AIDS a lethal injection so no-one else can be infected? I hope not. What has happened to "DO NO HARM"? Would doctors do this to each other? It is the Hippocratic oath, not the Hypocrisy Oath!

What's in store for the *'more deadly second wave'*? Do we just shoot anyone who comes into hospital with a cough in case someone else gets it? Are the Police and Sheriffs going to shoot people on the streets who don't wear a mandatory mask? I hope not as I have a doctor's exemption note.

However, this form of government sanctioned execution is what doctors have effectively done to those who got sick in the 'first wave'.

Note that these are the same experts and doctors;

- WHO locked us down because millions would die and revise their 'models' every day to fit the 'new normal' narrative.
- WHO pushed for ventilators to the point that vacuum and car manufacturers were making them without any experience or testing.
- WHO put COVID 19 on a death certificate even where there is no proof, just to pad the figures and keep us locked up. Why would they do this? In most countries, including the UK and US,

doctors get a blanket pass on liability if COVID 19 is on the death certificate. Equally, hospitals are paid more in many countries for COVID 19 patients and ventilator 'cases' but not for other 'cases' like heart attacks and diabetes. [link]

- WHO say social distancing works without any science to back it up, and with ample evidence showing it does nothing more than remove the ability to talk to more than one person at a time.
- WHO say shelter in place will slow or stop the virus, (but going shopping, essential workers in 'packs' of more than 15 etc. is fine).
- WHO say masks will help (then won't, then will) - They WON'T!

All of this when most, if not all, NY doctors and health care workers appear to have tested positive for antibodies. This means these health professionals, on the front line, caught COVID 19 and recovered, in most cases, without knowing they had it. Over 60% of the NY cases came from those 'sheltering at home' (not essential workers or doctors). Many others came from care homes that were locked down. How did we protect anyone by staying locked up?

We have to end the lockdown and get back to a real, not 'new normal' life. From death by ventilator and a failure to use a known cheap treatment (Hydroxychloroquine and Azithromycin) to the lockdown induced deaths from heart attacks, diabetes, stroke, suicide and more, we are slowly suffocating while being 'gas' lighted by the media daily.

Continuing this insanity is killing people. Those that are willing to go along with it because someone else told them… well we have heard that excuse before so many times in history.

*"**Human beings**, who are almost **unique** in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so." Douglas Noel Adams (DNA) (Adams, Last Chance to See, 1989)*

or

"Those who fail to learn from history are condemned to repeat it."

Sir Winston Churchill 1948 (Churchill, 1948)

This time it will not wash.

We need to get back to work. Get back to an actual normal not a 'new normal'.

We need to treat the sick and hold all of those responsible accountable.

We must **NEVER** let this happen again.

This may be the final chapter of the A SARS-COV-2 Story. In essence, it is Article 6 of 6 in a continuing story that is running out of hope.

As the media fiddles, we are watching Rome burn. Only China appears ready to rise from the ashes. So, don't be a Nero. Join the conversation beyond the four corners of your TV and help us climb out of this hole before it is too late. ***#COVID19***, ***#RomeIsBurning***, ***#ABetterPlan***, ***#jointheconversation***

1. ***The Best Laid Plans. COVID-19*** (Dickson, Articles, 2020)
2. ***COVID 19 – Is the lock down working?*** (Dickson, Articles, 2020)
3. ***COVID 19 - The Spread of A Virus*** (Dickson, Articles, 2020)
4. ***How the humble Gin & Tonic may save the world from COVID 19.*** (Dickson, Articles, 2020)
5. ***COVID 19 Risks - a Personal Message*** (Dickson, Articles, 2020)
6. ***COVID 19 - A Personal Message Postscript*** (Dickson, Articles, 2020)

For the more disturbing aspects of the tracing, tracking and COVID passport process you can see my earlier articles, currently being updated for the POST COVID 19 world.

https://www.researchgate.net/publication/341694309_Are_we_the_new_Digital_Soylent_Green (Dickson, Articles, 2020)

https://www.linkedin.com/pulse/we-new-digital-soylent-green-dave-dickson-/ (Dickson, Articles, 2020)

David Dickson is a Consulting C.E.O./C.I.O and owner at DKS DATA

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From: David Dickson
Sent: Saturday, September 5, 2020 9:34 AM
To: ' Redacted gmail.com' < Redacted gmail.com>
Subject: FW: COVID Concerns
Importance: High
Sensitivity: Confidential

Three of seven.

Please treat as confidential.

From: David Dickson
Sent: Thursday, August 20, 2020 12:45 PM
To: Catherine D Douglas <catherine.d.douglas@gov.ab.ca>
Cc: Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthadvocates.ca>
Subject: RE: COVID Concerns
Importance: High

Afternoon Catherine,

Sorry for the delay, this was in my spam folder for some reason. The last two days have been chaos due to the continuing saga and another lockdown at our mother, Redacted care home. This is being repeated apparently across Alberta due to continued asymptomatic testing being promoted daily by Dr. Hinshaw. On top of this, we have another denial of access to our mother contrary to Order 29-2020. See the attached for the latest correspondence on that.

The reason now being given is they don't have enough goggles! This is in a care center where not a **single resident** has tested positive despite **SIX** separate tests being performed on almost every resident since mid June. Many residents are now being isolated in their rooms 24/7 due to this asymptomatic testing of staff members. Even symptomatic testing is a waste right now as there are no unique symptoms to COVID but everything is automatically assumed to be COVID. There is no treatment being provided for COVID other than isolation until people are either too sick to treat, get better or die. As such, people who may have treatable disorders in these centers and elsewhere are being left to die without proper care.

There is so much more information I have. Please feel free to share everything you already have with anyone who can make a difference. Yesterday I spent almost 2 hours speaking directly with Dr. Dolores Cahill, (CV attached). She reached to me this week as a result of reading my research on ResearchGate (which you have). Dr. Cahill invented the technology that certifies the tests being used by AHS and many bodies around the world. She confirmed all I have brought forward and more. These tests are not fit for purpose and have never been certified or verified as accurate using approved protein sampling. Even AHS themselves have confirmed that asymptomatic testing cannot be used to infer an infection. However, we are rolling out and encouraging more expensive, risky and totally useless testing. This is resulting in more closures of businesses and more importantly care home. Next will be schools which are again targeted directly for testing before school even starts. None of this makes any sense at best. It is criminal at worst.

W are so happy and quite frankly relieved that you are moving forward with this. We cannot thank you and Janice enough for your assistance. I have so much research and speaking to so many world renowned experts on an almost daily basis. Please let me know what we can do to assist. Together I believe we can make a difference.

David

David T. Dickson
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Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

Microsoft Partner

From: Catherine D Douglas <catherine.d.douglas@gov.ab.ca>
Sent: August 19, 2020 9:10 AM
To: David Dickson <david.dickson@dksdata.com>
Cc: Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted
< Redacted albertahealthadvocates.ca>
Subject: COVID Concerns

Good Morning Mr. Dickson,

Janice Harrington is currently on vacation and has asked me to respond to you in her absence. Thank you for the recent correspondence attached here. Our office is currently making inquiries on your behalf to see which bodies may have commenced reviews/investigations into issues related to the COVID response. I have made some overtures and expect some feedback in the next few weeks.

It may be helpful for me to share parts or all of your story during my inquiries. Does our office nave your permission to do so?

Best Regards,
Catherine Douglas

Catherine Douglas BRE | Manager | Office of the Alberta Health Advocates
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Attachments

3-202006_CV_Professor_Dolores_Cahill.pdf

"Call this evening"
"RE: Centre lockdown"
"FW: CapitalCare CCD Update - August 18, 2020"

"Call this evening"

From: Karen Dickson <karen.dickson@dksdata.com>
Sent: Wednesday, August 19, 2020 6:58 PM
To: Redacted < Redacted capitalcare.net>; ' Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>; Redacted <Redacted gmail.com>
Subject: Call this evening

Redacted

Thank you for your call today.

As we stated in the call, Capital Care Dickinsfield and their staff will always be defended by our family. Having seen some of the horrendous and unjust statements made against care centres, we have come to the defence and championed the efforts of your staff and Dickinsfield on many social platforms and beyond. The sad truth of this tragedy is one harsh reality; the unsustainable and unsubstantiated protocols that have been placed on not just care centres but every walk of life, from meat packers, grocery stores, hospitals and more importantly than perhaps anything else, schools and care centres have already resulted in avoidable deadly consequences that have nothing to do with the virus.

Is it AHS's expectation that this will be "life" for the next two to three years? As we discussed, your staff, families and residents are unlikely to survive beyond Christmas as the lockdowns become permanent once school resumes and flu season arrives.

We look forward to your email tomorrow as discussed to provide clarity for this outbreak and the additional information you agreed to provide.

Karen and David
David T. Dickson
Consulting C.I.O.
Business/Enterprise Architect
Management/Legal Consultant
www.dksdata.com

"RE: Centre lockdown"

From: dksdata@gmail.com <dksdata@gmail.com>
Sent: Monday, August 17, 2020 8:56 PM
To: ' Redacted < Redacted capitalcare.net>; ' Redacted < Redacted capitalcare.net>
Cc: Redacted albertahealthservices.ca; Redacted albertahealthservices.ca; Redacted albertahealthservices.ca; Redacted albertahealthservices.ca; Redacted <Redacted gmail.com>; David Dickson <david.dickson@dksdata.com>; Karen Dickson <karen.dickson@dksdata.com>
Subject: RE: Centre lockdown
Importance: High
Sensitivity: Confidential

Redacted

We asked the following questions which need to be answered in the context of the whole email, attachments and history.

- WHO at AHS determined the "outbreak" and placed the centre on lockdown? Can we assume this is Dr. Redacted again, the same person who has already demonstrated some serious concerns over her handling of the last "outbreak"?
- Under exactly whose dictate were Designates refused admission?
- How long before Capital Care stand up for those in their care (residents and staff) and demands answers?
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Your response today provides NO additional information, NO answers to questions asked and NO alternate provisions for essential visitation and no ***"collaboration with residents and families"***.

Note that the previous and current basis for "outbreak" was based on positive asymptomatic testing alone. In the words of Alberta Health Services COVID-19 Scientific Advisory Group Rapid
Response Report:

- *"****Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable****."*
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testing is being completed in care centers, we have to question the actual cause of death in care homes, especially when almost all (~98%) in the province have been with known significant and mostly multiple mortality causing co-morbidities.

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Since that June testing, many residents have been subjected to highly invasive and totally useless asymptomatic testing as much a s SIX times already, with negative results on every single occasion.

- **How are these new staff positive tests suddenly appearing?**
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Surely contained within the first six rounds of tests, there wouldn't be anyone left who would consent to testing who hasn't already been tested multiple time. As seen above, these tests are useless in **AHS's OWN WORDS.**

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As you have failed to provide the contact information for who is in charge of this alleged asymptomatic "outbreak", we are including all the Edmonton zone MOH's. We expect a response from whomever is handling this for Dickinsfield. This is as per the requirement under 29-2020 for families and residents to be included in "outbreak" management.

David and Karen

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com**)**
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

From: Redacted capitalcare.net
Sent: 17 Aug 2020 20:06
To: dksdata@gmail.com
CC: david.dickson@dksdata.com, Redacted gmail.com, karen.dickson@dksdata.com
Subject: RE: Centre lockdown

Hello David,

The decision to pause visitation was made by me and the leadership team and is supported by PH, MOH and AHS. This difficult decision was made based on the need to use all staff resources to support resident care and to implement outbreak measures quickly on Friday and for the weekend. Staff must now wear face shields or goggles in resident neighborhoods and visitors would be required to do the same if visiting their loved one.

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We ask for your patience at this time. We will be reassessing our capacity to screen and support visitation and will continue communication with CCD families.

Kind Regards,

Redacted

acted Site Director|CapitalCareDickinsfield Campus
780.371.6525

From: dksdata@gmail.com <dksdata@gmail.com>
Sent: August 14, 2020 4:11 PM
To: ' Redacted < Redacted capitalcare.net>; ' Redacted < Redacted capitalcare.net>
Cc: 'Redacted <Redacted capitalcare.net>; David Dickson <david.dickson@dksdata.com>; Karen Dickson <karen.dickson@dksdata.com>; Redacted <Redacted gmail.com>
Subject: Centre lockdown
Importance: High
Sensitivity: Confidential

Hi Redacted et al,

Firstly, thank you, Redacted for your prompt reply to our last email. It was most helpful and answered our questions at that time.

Before you start reading this, please remember this is not an attack on Capital Care. It is a desperate plea for you all to pay attention and stop placating without question. Capital Care and all its staff has had an exemplary record prior to this insanity. However, you must remember you have a duty of care to these residents that cannot be abdicated to AHS and any of its proxies.

We want to put in writing how seriously concerned we are with these continuing “outbreaks”. We understand the impact it is having on you but even the shortest disruption in Designated, scheduled access has known and demonstrated risks to residents. This is the very reason Deena Hinshaw’s Order 29-2020 lays great emphasis on these visits, especially during an “outbreak”. In terms of risk analysis, the organization has to be cognizant of the fact that this risk is without doubt higher than the risk of the virus, based on AHS’s own information. EVERY ‘case’ to date has been the direct result of an asymptomatic staff member. This last “outbreak” includes multiple staff testing asymptomatic “positive” and apparently a few other staff members feeling sick from some unproven cause. During this insanity we all seem to have forgotten that people can and often do get sick from something other than this virus. In fact, the symptom list now in use for this virus covers such a wide range of common illnesses that we should all be very concerned that there is not more detailed investigation of each and every death currently checking the COVID box. The last “outbreak” was extended (and then reversed when challenged by us) for two instances of residents with gastric upset, coincidentally right at the point that the centre was due to reopen after over three weeks of lockdown. The same pattern of testing, “outbreak”, lockdown is being repeated in one centre after the next.

Above is an attachment which clearly outlines that these “positive” asymptomatic RT-PCR tests are NOT confirmation of an infection and thereby challenges the legality of ALL of the “outbreaks” to date. Note: this is not our interpretation.

These are the facts of AHS's OWN documentation. AHS cannot call an "outbreak" without a proven infection. In AHS's own words, an asymptomatic RT-PCR test cannot be inferred to suggest an infection. The continued assumption that anything and everything is the virus is preventing the appropriate early treatment of so many vulnerable people in our society. How many are dying as a result of an assumption rather than the virus? This behaviour is nothing less than gross medical negligence.

These lockdowns, as we have warned over and over, are cycling on a never-ending loop leaving residents with minimal care. Physio is limited, medical appointments almost impossible to make, dental treatment and therapies outside the centre denied, hair appointments unable to be scheduled, let alone the social impacts to these poor souls incarcerated interminably. THIS IS AN ABSOLUTE OUTRAGE AND A CRIME AGAINST THE MOST VULNERABLE IN OUR SOCIETY.

- WHO at AHS determined the "outbreak" and placed the centre on lockdown? Can we assume this is Dr. Redacted again, the same person who has already demonstrated some serious concerns over her handling of the last "outbreak"?
- Under exactly whose dictate were Designates refused admission?
- How long before Capital Care stand up for those in their care (residents and staff) and demands answers?
- As we move into flu season, ignoring everything that is written here and has been pointed out before will ensure centres will remain shut until there are few, if any residents, left to look after.

While we have the greatest faith in the frontline staff, management and Dickinsfield as a whole in terms of providing basic care, we are in absolutely NO DOUBT that residents will fade away from these restrictions. We are begging you, based on all the information we have provided to you, to take action to protect those who depend on you for their very survival. I leave you with this ominous thought. We guarantee you will soon have a slew of resident illness and deaths presumed 'WITH' not 'FROM' this virus. In fact, it is most likely, based on all the asymptomatic testing that happened first in Calgary and now in Edmonton, that MANY of these deaths are not only preventable but highly likely not even related to the virus. Under normal circumstances, residents of long term care would receive appropriate, early intervention and hospital treatment. This, along with known treatments for any possible virus, are being actively DENIED by this government. Deaths in care centres have and continue to be blamed on a virus with the only evidence being the known 'unfit for purpose' tests. If it was not for the virus, most of these centres in the last six months would be under police investigation for suspicious deaths. Sadly, if it was not for AHS's protocols and directions, most of these people would probably still be alive. Your centres are apparently being targeted, just like Good Samaritan Southgate was (and is), for round after round of testing to "prove" deaths from COVID to keep the facilities closed and care shut down.

You have a duty to protect those in your care, to question the process and protocols you are being forced to implement, to advocate and demonstrate to those demanding these measures that what is deemed as preventative and protective is, in actuality, punitive and perilous. PLEASE speak out before it is too late.

Karen and David for Redacted

Attachments

3-CapitalCareUpdate-August132020.pdf

CapitalCare Update - August 13, 2020

"FW: CapitalCare CCD Update - August 18, 2020"

From: Karen Dickson <karen.dickson@dksdata.com>
Sent: Wednesday, August 19, 2020 9:49 AM
To: Redacted capitalcare.net; ' Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; David Dickson <david.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>; Redacted albertahealthservices.ca
Subject: FW: CapitalCare CCD Update - August 18, 2020
Importance: High

RedactedRedacted

Firstly, we are still waiting for a response to the attached email, highly relevant now to this communication from last night.

The email below is not clear on what is meant by ***"We will provide an update on visitation next week."*** This was sent on a TUESDAY! Are you suggesting that again, you are continuing to deny, contrary to Order 29-2020, the scheduled designated family/support persons visits for the mental and physical wellbeing of the residents? **Please answer this specific question immediately so we can ensure a visit or next steps for the health and safety of** Redacted

Just to remind you of the offences you and anyone at AHS and Capital Care who you are working with have and still continue to commit under the Provincial Health Act by this position. Remember that you and any others part of this decision process cannot abdicate this responsibility. Neither can any of you plead ignorance of the law.

Under no circumstances do you or the Zone MOH or PH have any authority to "prohibit their *[Designated family/support persons]* presence". In addition, you have provided no alternate options and not consulted or even responded to our concerns (as per the attached). Regardless, Designated family/support persons visits CANNOT be restricted or denied. If we requested a virtual visit (our preference) then you would be expected to accommodate that. We do not wish for that, have not requested that and that would be OUR choice, not yours.

For clarity again from "health-cmoh-record-of-decision-cmoh-29-2020.pdf" (as referenced in multiple communications now).

Restricted Access

- *Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.*
    - *Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.*
- *An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.*
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        - *In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.*
    - *Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.*
    - *When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.*

Even when a resident HAS COVID, *" for continued access to the resident"* is required. *"In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

You don't have any COVID residents despite approximately 6 tests per resident since mid June. You don't actually have any evidence of a staff member being infected, just some positive unreliable RT-PCR tests. Note that I spent two hours on the phone to a Professor in UK this morning who designed and supervised the world program for verifying such tests (RT-PCR, Serology and more). No COVID test has ever been verified or certified, which supports the position below of AHS on these tests' accuracy and lack of confirmation of an infection.

- *"**Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable**."*
- *"Therefore a **RT-PCR positive result in a currently asymptomatic person is of unclear significance and RT-PCR positive status cannot be used to infer potentially infectious status**."*

David & Karen Dickson on behalf of Redacted

From: CapitalCare <info@capitalcare.net>
Sent: August 18, 2020 5:24 PM
To: Karen Dickson <karen.dickson@dksdata.com>
Subject: CapitalCare CCD Update - August 18, 2020 🔔

COVID-19

CapitalCare DICKINSFIELD

August 18, 2020

Dear Residents and Families:

We received confirmation August 15th that **one** student working at CapitalCare Dickinsfield has tested positive for COVID-19. Since August 11th, a total of **three** staff and **one** student have been found to be COVID-19 positive.

Dickinsfield remains on facility-wide outbreak status until otherwise directed by the Medical Officer of Health. For the safety of our residents, their families, and our staff, all visitation is temporarily paused. This helps reduce the risk of further spread or new illness at our centre.

What we know right now:

The student last worked August 14th, had no symptoms, and was discovered to be COVID-19-positive during centre asymptomatic swabbing. The student and all three staff members continue to isolate at home, and do not present an ongoing risk to our centre.

We recently completed testing asymptomatic residents and staff who consented to it and are pleased to report that all resident swabs results are negative.

Staff results continue to come in; at this time there are no additional cases in any staff member.

What are we doing?

Out of an abundance of caution, some residents have been placed on isolation. Dickinsfield staff have notified families of these residents. Dickinsfield staff from various departments and programs have been re-deployed to these neighbourhoods to provide extra time and attention and meal assistance**.**

All appropriate Infection Prevention and Control measures required have been implemented, and remain in place. This includes continuously wearing masks throughout the centre, as well as eye protection in care areas, and gowns continuously in designated areas. We are also doing extra cleaning of high- and low-touch surfaces. We remain confident in our Pandemic Response Plan to manage this situation. Visitation remains on hold as we adjust and focus our resources to the isolation and additional requirements for Personal Protective Equipment and cleaning.

We will provide an update on visitation next week.

Where to get more information:

If you have specific questions or concerns about your loved one, please call your care manager. Please know our managers are busy putting extra precautions in place and arranging care for residents in isolation; it may take more time than usual to get back to you. Your patience and understanding is appreciated.

Updates on the status of COVID-19 are posted on the News page of CapitalCare's website.

Please also visit Dickinsfield's page under the Centres tab and the Information for Families/COVID-19 page.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

If you have any general questions or comments please email us at info@capitalcare.net.

Sincerely,

Redacted Site Director
CapitalCare Dickinsfield

GET SOCIAL WITH US:

CapitalCare
6th Floor, 10909 Jasper Avenue
Edmonton, Alberta T5J 3M9
Ph: (780) 448-2421

Attachments

"FW: Centre lockdown"

David

David T. Dickson
C.E.O. DKS DATA *(www.dksdata.com)*
Consulting C.I.O.
Disabled Police Officer (retired - injury on duty)
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

Microsoft Partner

From: DKSDATA <DKSDATA@GMAIL.COM>
Sent: Monday, August 17, 2020 9:09 PM
To: David Dickson <david.dickson@dksdata.com>
Subject: Fwd: Centre lockdown
Sensitivity: Confidential

Get Outlook for Android

From: dksdata@gmail.com <dksdata@gmail.com>
Sent: Monday, August 17, 2020 8:55:51 PM
To: ' Redacted < Redacted capitalcare.net>; ' Redacted < Redacted capitalcare.net>
Cc: Redacted albertahealthservices.ca < Redacted albertahealthservices.ca>;
Redacted albertahealthservices.ca < Redacted albertahealthservices.ca>;
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<Redacted gmail.com>; David Dickson <david.dickson@dksdata.com>; Karen Dickson <karen.dickson@dksdata.com>
Subject: RE: Centre lockdown

Redacted

We asked the following questions which need to be answered in the context of the whole email, attachments and history.

- WHO at AHS determined the "outbreak" and placed the centre on lockdown? Can we assume this is Dr. Redacted again, the same person who has already demonstrated some serious concerns over her handling of the last "outbreak"?
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C.E.O. DKS DATA (www.dksdata.com)
Consulting C.I.O.
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Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

Microsoft Partner

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CC: david.dickson@dksdata.com, Redacted gmail.com, karen.dickson@dksdata.com
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Sent: August 14, 2020 4:11 PM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; David Dickson <david.dickson@dksdata.com>; Karen Dickson

<karen.dickson@dksdata.com>; Redacted <Redacted gmail.com>
Subject: Centre lockdown
Importance: High
Sensitivity: Confidential

Hi Redacted et al,

Firstly, thank you, Redacted for your prompt reply to our last email. It was most helpful and answered our questions at that time.

Before you start reading this, please remember this is not an attack on Capital Care. It is a desperate plea for you all to pay attention and stop placating without question. Capital Care and all its staff has had an exemplary record prior to this insanity. However, you must remember you have a duty of care to these residents that cannot be abdicated to AHS and any of its proxies.

We want to put in writing how seriously concerned we are with these continuing "outbreaks". We understand the impact it is having on you but even the shortest disruption in Designated, scheduled access has known and demonstrated risks to residents. This is the very reason Deena Hinshaw's Order 29-2020 lays great emphasis on these visits, especially during an "outbreak". In terms of risk analysis, the organization has to be cognizant of the fact that this risk is without doubt higher than the risk of the virus, based on AHS's own information. EVERY 'case' to date has been the direct result of an asymptomatic staff member. This last "outbreak" includes multiple staff testing asymptomatic "positive" and apparently a few other staff members feeling sick from some unproven cause. During this insanity we all seem to have forgotten that people can and often do get sick from something other than this virus. In fact, the symptom list now in use for this virus covers such a wide range of common illnesses that we should all be very concerned that there is not more detailed investigation of each and every death currently checking the COVID box. The last "outbreak" was extended (and then reversed when challenged by us) for two instances of residents with gastric upset, coincidentally right at the point that the centre was due to reopen after over three weeks of lockdown. The same pattern of testing, "outbreak", lockdown is being repeated in one centre after the next.

Above is an attachment which clearly outlines that these "positive" asymptomatic RT-PCR tests are NOT confirmation of an infection and thereby challenges the legality of ALL of the "outbreaks" to date. Note: this is not our interpretation. These are the facts of AHS's OWN documentation. AHS cannot call an "outbreak" without a proven infection. In AHS's own words, an asymptomatic RT-PCR test cannot be inferred to suggest an infection. The continued assumption that anything and everything is the virus is preventing the appropriate early treatment of so many vulnerable people in our society. How many are dying as a result of an assumption rather than the virus? This behaviour is nothing less than gross medical negligence.

These lockdowns, as we have warned over and over, are cycling on a never-ending loop leaving residents with minimal care. Physio is limited, medical appointments almost impossible to make, dental treatment and therapies outside the centre denied, hair appointments unable to be scheduled, let alone the social impacts to these poor souls incarcerated interminably. THIS IS AN ABSOLUTE OUTRAGE AND A CRIME AGAINST THE MOST VULNERABLE IN OUR SOCIETY.

- WHO at AHS determined the "outbreak" and placed the centre on lockdown? Can we assume this is Dr. Redacted again, the same person who has already demonstrated some serious concerns over her handling of the last "outbreak"?
- Under exactly whose dictate were Designates refused admission?
- How long before Capital Care stand up for those in their care (residents and staff) and demands answers?
- As we move into flu season, ignoring everything that is written here and has been pointed out before will ensure centres will remain shut until there are few, if any residents, left to look after.

While we have the greatest faith in the frontline staff, management and Dickinsfield as a whole in terms of providing basic care, we are in absolutely NO DOUBT that residents will fade away from these restrictions. We are begging you, based on all the information we have provided to you, to take action to protect those who depend on you for their very

survival. I leave you with this ominous thought. We guarantee you will soon have a slew of resident illness and deaths presumed 'WITH' not 'FROM' this virus. In fact, it is most likely, based on all the asymptomatic testing that happened first in Calgary and now in Edmonton, that MANY of these deaths are not only preventable but highly likely not even related to the virus. Under normal circumstances, residents of long term care would receive appropriate, early intervention and hospital treatment. This, along with known treatments for any possible virus, are being actively DENIED by this government. Deaths in care centres have and continue to be blamed on a virus with the only evidence being the known 'unfit for purpose' tests. If it was not for the virus, most of these centres in the last six months would be under police investigation for suspicious deaths. Sadly, if it was not for AHS's protocols and directions, most of these people would probably still be alive. Your centres are apparently being targeted, just like Good Samaritan Southgate was (and is), for round after round of testing to "prove" deaths from COVID to keep the facilities closed and care shut down.

You have a duty to protect those in your care, to question the process and protocols you are being forced to implement, to advocate and demonstrate to those demanding these measures that what is deemed as preventative and protective is, in actuality, punitive and perilous. PLEASE speak out before it is too late.

Karen and David for Redacted

Curriculum vitae
PROFESSOR DOLORES J. CAHILL
Full Professor, School of Medicine, Conway Institute, University College Dublin
Mobile: +353 (0) 86 172 55 72 email: dolorescahill@gmail.com

Overview: Companies Co-Founded and Academic Positions held:

- Full Professor, School of Medicine, University College Dublin (UCD) (2005-2020 present**)
- EU Policy & Strategy Seconded National Expert to European Commission, Brussels (2013-2014***)
- Co-founder & Shareholder Protagen AG, Dortmund, Germany (https://protagen.com/) (1997-2019*; **,***)
  - a spin-out company of the Max-Planck-Institute, Berlin and also a spin out of Ruhr University, Bochum
- Oncoimmune a world leader in diagnostics buys Protagen AG (March 2019) https://oncimmune.com/documents/1669/
- Co-founding shareholder & Advisory Board of Atturos Ltd (http://atturos.com/) (2016-2020). Prof. Pennington, Founder
- Group Leader of Protein Technology Group, Max-Planck-Institute Molecular Genetics, Berlin (1995-2003*)
- Associate Professor, Dept. of Clinical Pharmacology, Royal College of Surgeons in Ireland (2000-2005*)
- Senior Research Manager, Proteomics Core, Royal College of Surgeons in Ireland Dublin (2000-2002*)
- EU 'Human Capital and Mobility' Post-doctoral Fellow, Technical University, Munich (1994-1995)
- PhD in Immunology & Biotechnology from Dublin City University, Ireland (1989-1994)
- Natural Sciences II (Biological Sciences) Honours Bachelor's Degree specialising in Molecular Genetics and Biochemistry from Trinity College Dublin (1985-1989).

** - these positions were held simultaneously by agreement * (2000-2005), (2005-2019**) and* (2013-2014***).*

Biography:

- Over 20 years expertise in high-throughput protein & antibody array, automation, proteomics technology development & biomedical applications in biomarker discovery, diagnostics & personalised medicine.
- Since 2005 to present, Full Professor of Translational Science, School of Medicine, University College Dublin, Academic, Researcher, Lecturer, Module Coordinator in Pathology Teaching, School of Medicine & Conway Institute
- 15 years as Irish, EU & international expert & advisor including Seconded National Expert to European Commission
- Company Co-founder & Shareholder (1997-2019) of Protagen AG in Germany (https://protagen.com/). Protagen Protein Services (2012-2019) contract services to healthcare sector & pharmaceutical industry (https://protagenproteinservices.com/).
- Since 2016, co-founding shareholder and Advisory Board member of Prof. Stephen Pennington's UCD School of Medicine/Conway Institute spin-out company, Atturos Ltd. working to improve Prostate Cancer diagnosis (http://atturos.com/ and http://atturos.com/company/advisors/).
- Prof. Cahill has over 100 publications, with a total of over 5940 Citations, H (Hirsh)-index of 35, i10-index of 48.
- Project management: Has successfully obtained and project managed as Principal Investigator eight EU Programme funding grants from FP4, FP5, FP6, FP7 and Horizon 2020, Science Foundation Ireland, Enterprise Ireland, Health Research Board funding in companies and universities.
- Supervisor of over 20 completed PhD & Masters' degrees in total. Chair of ten UCD PhD committees.
- Holds several granted and licenced international patents (EU, USA, Japan, Australia) (1995-present).
- Has given over 100 Keynotes in USA, Europe, China, Japan, S. Korea, Australia, South America,

Selected Academic Leadership and Contributions: Member of Committees and Awards:

- Vice Chair, European Union Innovative Medicines Initiative Scientific Committee (2018-052020) and Member, European Union Innovative Medicines Initiative Scientific Committee (2016-052020) (https://www.imi.europa.eu/sites/default/files/uploads/documents/About-IMI/Governance/sc/IMI_SC_Bio_Dolores_Cahill.pdf).
- In 2016, nominated by Ireland (Irish Permanent Representative to EU & Enterprise Ireland) & elected by EU 28-Member State Committee to EU Innovative Medicines Initiative Scientific Committee (2016-052020).
- In 2018, elected Vice-Chair of IMI Scientific Committee by IMI SC Members (2018-052020)
- In 2013-2014, worked in European Commission, Brussels seconded full-time, as a Seconded National Expert (SNE) to the European Commission Research & Innovation (HORIZON2020) (DG RTD) Directorate, in a Strategy and Policy Development role for International R&D&I Cooperation between the EU & Asia (S. Korea, China, ASEAN) & for the Coordination of Health Research, Development and Innovation globally.
- In 2005, appointed by the Irish Prime Minister (Taoiseach) & Minister for Health as an Irish Government's Advisory Science Council (ASC) Member (www.sciencecouncil.ie) (2005-2013) & to develop Irish Strategy for Science, Technology & Innovation (2006-2013) with Universities, Industry & Health, Education, Enterprise & Finance Depts.
- Chaired the ASC Task Force 'Towards a Framework for Researcher Careers' & ASC Task Force member Report on 'Promoting Enterprise-Higher Education Relationships' (2009) and 'Sustainability of Research Centres' (2012).
- Member, Nobel Prize Nominating Committee for Chemistry, Norway (2016-2019).
- Honoured with a lifetime award from the Federation of European Biochemical Societies Award in Norway (2009) for her research & its significance. Other awardees: Prof. J. Craig Venter & Nobel Prize winner, Prof. Robert Huber.
- Awarded the prestigious BMBF BioFuture Prize by German Minister of Science (€1.5million) (2000).

Project management, Research and Peer-Reviewed Publications:

- Prof. Cahill has over 100 publications: Google Scholar Citations: https://scholar.google.com/
- Citations 5946: Hirsch h-index 35: i10-index 48.

Selected Academic Leadership and Contributions: Invited Speaker, Keynotes, Conferences organised:

- Prof. Cahill has given over 100 Keynotes in USA, Europe, China, Japan, S. Korea, Australia, South America:
  - 18th-19th May 2020: Chair, Global Bioprocessing, Bioanalytics & ATMP Manufacturing, Dublin.
  - 18th-19th June 2020: Keynote Speaker, BioTech Pharma Summit, CBB 2020, Portugal.
  - 24th-25th Sept 2020: Guest Speaker, Biotechnology Business Workshop, British Embassy & Biotech Atelier Sofia.
  - 8th-9th October 2020: Keynote Speaker, Global Engage, Liquid Biopsies Conference, London.
  - 13th-14th February 2019: Keynote Speaker Companion Diagnostics & Biomarkers Conference 2019
  - 13th-15th March 2019: Speaker, Intergovernmental meeting in Bulgaria
  - 10th -11th October 2019: Chair and Speaker, Immuno-oncology, London (http://www.giiconference.com/gel745785/)
  - 13th-14th September 2018: Speaker, 5th Precision Medicine & Biomarkers Leaders' Summit, Munich & Chair of Roundtable on Personalised Medicine & Adverse Events (http://www.giiconference.com/gel560004/catalog.pdf?1528437050).
- 9th March 2020: Prof. Cahill invited to speak on the panel 'A View from the Top: UCD Medicine Female Professors in Conversation' to mark International Women's Day 2020 (https://www.ucd.ie/medicine/whatson/title,485524,en.html)
- 17th-21st September 2017: HUPO2017: Human Proteome Organising (HUPO) Committee Member. The Annual HUPO World meeting was held in Dublin. UCD Prof. Stephen Pennington was Conference Chair. Prof. Cahill was HUPO 2017 Chief Financial Officer (http://hupo2017.ie/?team=prof-dr-dolores-cahill) & had over 1300 attendees with 90% from outside Ireland. Total budget € 1,300,000 & small profit made was returned to the sponsor, British Proteome Society. USA Vice-President (http://hupo2017.ie/news-2/) launched Global Cancer Moonshot at Conference Gala dinner.

Innovation: Commercialisation, Project Management, Patenting, Licensing & Business Development:

- Prof. Cahill negotiated, in 1997, exclusive licensing of her patents, technology & grant funding & in 2000, €1.5 million BMBF BioFuture Grant Prize (2000-2005) from German Minister for Science (3D Protein & Antibody Chips) into Protagen AG (https://protagen.com/).Protagen Protein Services spun out 2012(https://protagenproteinservices.com/).
- Protagen AG was sold on 19th March 2019 to Oncimmune (https://oncimmune.com/) a world leader in diagnostics and personalised medicine, which has sites in UK, USA, Germany and China.
- Protagen Protein Services company merged (11th April 2019) with BioAnalytix Inc. in Cambridge USA. (https://www.zf-hn.de/zfhn-portfolio-company-pps-enters-the-us-market/)

Innovation: Granted Patents USA, Europe, Worldwide: Selected Licensed Patents:

· PCT WO 09/070,590: Novel method for the identification of clones conferring a desired biological property from an expression library. Inventors: Dolores J. Cahill, Konrad Büssow, Wilfried Nietfield, Gerald Walter, Hans Lehrach. Exclusive - Protagen AG.
· PCT WO 09/070,547: A new method of selection of clones from an expression library involving rearraying. Inventors: Dolores J. Cahill, Konrad Büssow, Wilfried Nietfield, Gerald Walter, Hans Lehrach. Exclusively licensed to Protagen AG, Dortmund.
· PCT: E1131 PCT: Method for identifying and/or characterising a (poly)peptide. Inventors: Dolores J. Cahill, Eckhard Nordhoff, Joachim Klose, Holger Eickhoff, Frank Schmidt and Hans Lehrach. Exclusively licensed to Protagen AG, Dortmund, Germany.
· Europe PCT: A novel system for dual protein expression in Pichia pastoris and Escherichia coli. Inventors: Angelika Lueking, Caterina Holz, Hans Lehrach, Dolores J. Cahill. Licensed to MoBiTech, Germany.
· Europe PCT: A novel approach to generate cDNA expression libraries in yeast enriched for open reading frames (ORF). Europe PCT Inventors: C.Holz, A.Lueking, D.J. Cahill, H. Lehrach. Licensed to MoBiTech, Germany.

Policy & Strategy (2004-2020): Member, Irish Government Advisory Science Council (2004-2013); EU Seconded National Expert (2013-2014) & EU IMI Scientific Committee Member & Vice-Chair (2016-052020):

Member of the Irish Government Advisory Science Council (2004-2013):

- In 2005, appointed by Irish Prime Minister (Taoiseach) & Minister for Health as Member of the Irish Government's Advisory Science Council (ASC) (www.sciencecouncil.ie) (2005-2013) & to develop Irish Strategy for Science, Technology & Innovation (2006-2013) with Universities, Industry & Health, Education, Enterprise & Finance Depts.
- Chaired the ASC Task Force for Government Policy 'Towards a Framework for Researcher Careers' (http://www.sciencecouncil.ie/media/asc081009_researcher_careers.pdf) & Task Force member in ASC Policy Reports on 'Promoting Enterprise-Higher Education Relationships' (2009) and 'Sustainability of Research Centres' (2012), The Role of PhDs in the SMART Economy (2015) (http://www.sciencecouncil.ie/media/asc091215_role_of_phds.pdf).

European Union Policy and Strategy – EU Seconded National Expert to the European Commission, Brussels:

- Prof. Cahill was Seconded as a National Expert (SNE) in Policy to the European Commission Research & Innovation (HORIZON2020) (DG RTD) Directorate, Brussels (2013-2014) with a special emphasis on International Cooperation for Strategy & Policy coordination, EU with Asia, European Free Trade Area & enlargement countries, Russia & Pacific (C1 Unit). Prof. Cahill was was supported by School of Medicine, University College Dublin, Department of the Taoiseach (Prime Minister) Irish Government, Enterprise Ireland & the Irish Permanent Representative in Brussels. There were 27 other EU & global candidates interviewed for this role.
- This role involved 3 main aspects: - a Policy and Strategy Advice, Coordination and Development in Research and Innovation, including Horizon 2020, such as developing Innovation Centres globally to assist EU SMEs;
  - international cooperation for all strategic research & innovation areas with South Korea (including ICT, Health, Nanotechnology & Energy) & with backup responsibility for China & ASEAN, including organising South Korea-EU summit (November 2013) & a backup for innovation strategy talks EU-China, 31st March-1st April 2014, the first with President Xi, 'Deepening the EU-China Comprehensive Strategic Partnership for mutual benefit'.
  - responsibility for the Health Theme & Health coordination globally, working closely with DG-RTD Health.

EU Innovative Medicine Initiative Scientific Committee Member & Vice-Chair:

- Prof. Cahill was nominated by Ireland and elected by the EU Member State Committee as a Member of the EU Innovative Medicines Initiative (IMI) Scientific Committee (2016-052020). (https://www.imi.europa.eu/sites/default/files/uploads/documents/About-IMI/Governance/sc/IMI_SC_Bio_Dolores_Cahill.pdf).
- The IMI is a public-private partnership (PPP) between the European Union represented by the European Commission and the European Federation for Pharmaceutical Industries and Associations (EFPIA). The IMI Scientific Committee members (https://www.imi.europa.eu/about-imi/governance/scientific-committee) composed of 11 members & 2 ad hoc members suggested by the EU Member States, the EU States Representatives Group and countries associated to the EU's research programmes. The IMI SC members are recognised experts from a range of different fields and participate in their individual capacity and develop Call topics & coordinate projects in key areas & with European Commission's wider research programmes. The IMI Strategic Governing Groups comprise representatives of pharmaceutical companies, the European Commission & IMI Scientific Committee.
- On 17th October 2019, Prof. Cahill co-organised a visit of key researchers in UCD and across Ireland and the EU IMI office to discuss the next framework, EU Innovative Health Initiative: (https://cordis.europa.eu/event/id/147509-university-college-dublin-looks-forward-to-welcoming-the-innovative-medicines-initiative-to-i).

Recent IMI Scientific Committee recommendations and publications:

- 2019: EU innovative Medicines Initiative Scientific Committee recommendations/report: Public private partnership funding-what makes a topic ultimately suitable for this kind of funding model? (2019) (https://www.imi.europa.eu/sites/default/files/uploads/documents/About-IMI/Governance/sc/SCrecommendations_PPPfunding.pdf).
- 2018: EU innovative Medicines Initiative Scientific Committee recommendations/report: IMI-funded digital innovation and data integration in discovery of novel medicines (2018) (https://www.imi.europa.eu/sites/default/files/uploads/documents/About-IMI/Governance/sc/SC_VisionPaper_January2018.pdf)
- 2018: EU innovative Medicines Initiative Scientific Committee recommendations/report: Importance of sustainability of European Union IMI projects, evaluation criteria and assessments (2018): https://www.imi.europa.eu/sites/default/files/uploads/documents/About-IMI/Governance/sc/SC_Sustainability_June2018.pdf

EU Expert and Principal Investigator recipient EU funding (1997-2020)

- 1997-2020: EU: Prof. Cahill is an expert in the EU European Commission for nearly 20 years, for example, Reviewer European Research Council (ERC) PoC (2020); Vice Chair, EU Future & Emerging technologies (FETOPEN) call (2018-2020), Innovation Radar Expert in EU FETOPEN & MSCA RISE (2016-2019), EU Horizon 2020 expert TWINNING calls (2017-2019); European Research Council (2014-2017) and (2020-2022). Chair or Observer of European Commission Calls: H2020 Societal Challenges 1 (Health) (2018); the Innovative Medicines Initiative (IMI; 2014-2015); FP7 Health, FP7 Health- Innovation, FP7 Infrastructure, FP7 Energy & Smart Cities.
- Since 1997, Project Manager & Principal Investigator of EU FP4, FP5, FP6, FP7 and H2020 grants.

Selected International Advisory & Review Committees & Boards: Sweden, Germany, UK, Belgium & Ireland:

Sweden: (2003-2020)

- August 2020 (Postponed): Invited by KTH President as Member of Biotechnology Research Assessment Exercise Review Board of KTH, the Royal Institute of Technology, Stockholm to perform a Research Assessment Exercise of its complete research base, RAE2020. Prof. Cahill was Member of KTH RAE 2008 & 2012 Reviewing Boards.

Germany (2004-2020)

- June 2020: Invited by the Federal Ministry of Education and Research (BMBF) as Board member of its National Decade Against Cancer (www.dekade-gegen-krebs.de) to review, assess and identify up to four new excellent Comprehensive Cancer Centres (CCC) to expand National Centre for Tumour Diseases (NCT).
- 2016-2020: German Cancer Aid (Deutsche Krebs Hilfe) International Scientific Review Board Member assessing the research funding of Clinical Trials in German Cancer Centre Networks: (https://www.krebshilfe.de/informieren/ueber-uns/deutsche-krebshilfe/about-us-deutsche-krebshilfegerman-cancer-aid/).
- (2010-2017): Member of the German International Science Advisory Review Board of the German Translational Medicine in Cancer Strategic Programme funded by the German Department Health and the BMBF/DLF (http://www.dkfz.de/en/presse/pressemitteilungen/2011/dkfz-pm-11-24-German-Consortium-for-Translational-Cancer-Research-Gets-Started.php) with oversight of strategic planning & integration of proteomics, systems biology, genome screening & integration of personalised medicine technologies into German Hospital systems & electronic health record & is highly successful.

UK, Belgium, Switzerland & Ireland (2003-2019):

- Examples: BBSRC in the UK: Genes & Developmental Biology Committee (GDB) and their Strategic Reviews (2005, 2007 & 2011); Vinnova in Sweden (2009-2013), IWT in Belgium (2011), Science Advisory Boards Member: Human Protein Atlas, Sweden (2002-2017), ProNova Research Institute, Sweden (2007-2018); Complexinc, Switzerland (2010-2019), Atturos, Dublin (2016-2019).
- (since 2005): In Ireland, supporting initiatives to integrate research, biobanking, electronic health records in the health care sector, including a long-term supporter of Biobanking Ireland (http://www.biobankireland.com/) led by Prof. Eoin Gaffney and integration of the Biobanking & Biomarker Network (http://education.crdi.ie/page/g/s/91) & Clinical Research Development Ireland (https://www.crdi.ie/research/innovation/innovation-biographies/).

Selected Academic Leadership and Contributions: UCD Committees and Boards:

- Member, UCD Research Innovation and Impact Committee (RIIG), chaired by Prof. Orla Feely, UCD Vice-President for Research and Innovation and Impact (2014-2019).
- Chair, UCD European Activities Advisory Group (2015-2017- RIIG Sub-committee).
- Member, UCD Gender Equality Action Group chaired by Prof. Orla Feely, UCD Vice-President for RIII (2017-2020).
- Member, UCD ATHENA SWAN Steering Committee chaired by Prof. Orla Feely, UCD VP RIII (2014-2017).
- Chair, ATHENA SWAN Sub-Committee – Recruitment and Promotions for Athena SWAN application (2015-2017). UCD successfully awarded Athena SWAN Bronze Award in 2017.
- Chair, UCD Human Resources Strategy for Researchers Committee (UCD HRS4R) – a EU initiative for University wide HR Policy & Strategy. UCD is first University in Ireland to successfully obtained the HRS4R excellence award by the EU (http://www.ucd.ie/research/about/officeofthevpforresearchinnovationandimpact/hrstrategyforresearchers/)
- Member, School of Medicine Master Committees and PhD Transfer Committees and Chair, School of Medicine of Structured PhD Committees (2008-present); Aurora Mentor to first UCD Aurora Leadership Programme (2015-2017); Member, UCD Aurora Leadership Programme (2014-2018).
- Member, UCD HR Policies Equality and Diversity Review Advisory Group (2013); Member UCD Research Strategy Committee; Member, UCD SFI Advisory Committee, Board Member, Conway Institute Mass Spectrometry Core, Chair, UCD Researcher Careers Implementation Project (www.ucd.ie/hr/rcf).

Selected Academic Leadership and Contributions: UCD Lecturing and Teaching (2005-2020):

- PATH40020 Clinical Biomarkers: Prof. Dolores J. Cahill - Module Coordinator (Prof. S. Pennington)
- MDSA10210 Science Medicine & Society: Prof. Dolores J. Cahill - Module Coordinator
- PATH10010 Translational Research in Biomedical Health & Life Science: Prof. Bill Watson, Prof. Dolores J. Cahill
- PATH20000 Principles of Biochemistry, Immunology & Pharmacology: Dr. McGillicuddy, Prof. Cahill & Pennington
- BIOC40250 Biomedical Diagnostics & Devices/BIOC40110 Biomedical Diagnostics: Dr David Hughes
- CNWY40090 Intro to Omics & Advanced Imaging Technologies: Prof. Matthias Wilm & Prof. Dolores Cahill
- CNWY40160 Applied Proteomics: Prof. Matthias Wilm and Prof. Dolores J. Cahill

Innovation: Protagen AG (1997-2019) & Protagen Protein Services (2012 - 2019):

1997: Prof. Cahill co-founded Protagen AG as a spin-out from Max-Planck-Institute of Molecular Genetics with co-founder Prof. Helmut Meyer, spin out of the Ruhr-University, Bochum, a protein chip/array & protein analysis services company
1999: Prof. Cahill awarded the prestigious BMBF BioFuture Prize by German Minister of Science (€1.5million) including to establish Protagen AG as a co-founder & spin out from Max-Planck.
1999: Protagen GbR transforms into Protagen AG to expand with Proteomics Services.
2001: Protagen AG performs its first biosimilar analytics to define the quality target of authorized biological product.
2005: Protagen AG successfully releases testing concept for an autologous tumour vaccine to EMEA biotech working party.
2005: Panatecs GmbH secures Series A financing with ZHFN Heilbronn to establish GMP protein analytical services.
2006: Protagen AG awards its GMP certificate for performing protein analytical testing.
2008: Panatecs GmbH rescues a Big Pharma block buster market authorization by its innovative protein analytical approach.
2012: Protagen AG starts its first full biosimilar analytical CRO support.
2012: Protagen AG divests its protein analytical business unit as Protagen Protein Services GmbH (PPS) to ZFHN Heilbronn, one of the largest German funds - 100% privately financed by a family office.
2014: Protagen Protein Services GmbH (Dortmund) merges with Panatecs GmbH (Heilbronn) to increase capacity & capabilities.
2016: Protagen Protein Services (PPS) GmbH expands service portfolio to full service provider for protein analytical testing.
2018: Protagen Protein Services GmbH welcomes its 100th Employee & growth of service portfolio and capacities.
2019: Protagen Protein Services GmbH (PPS) and BioAnalytix Inc. in Cambridge, USA, merge to establish an integrated global contract research organization for providing best-in-class analytics in biopharmaceuticals.
2019: Protagen AG was sold in March 2019 to Oncimmune (https://oncimmune.com/) a world leader in diagnostics and personalised medicine, which has sites in UK, USA, Germany and China.

Project Management, Research, Scholarship and Innovation:

- Prof. Cahill has over 100 publications in Google Scholar Citations:
- Citations: 5946
- Hirsch h-index 35
- i10-index 48

Selected Peer Reviewed Publications:

· Medical Errors & Adverse Events: leading cause of death and disease burden. Cahill, Dolores (2018) Health Europa: 7:42-43. (http://edition.pagesuite-professional.co.uk/html5/reader/production/default.aspx?pubname=&edid=73e202a8-1e25-4d2e-afc3-1cd95c26e5ae)

·Anti-ribosomal-phosphoprotein autoantibodies penetrate to neuronal cells via neuronal growth associated protein (GAP43), affecting neuronal cells in-vitro. Kivity, Shaye; Shoenfeld, Yehuda; Arango, Maria Terresa; Cahill, Dolores J; O'Kane, Sara Louise; Zusev, Margalit; Slutsky, Inna; Harel-Meir, Michal; Chapman, Joab; Mathias, Torsten; Blank, Miri. (2017) Rheumatology RHE-15-1025.

· Ligand-directed targeting of lymphatic vessels uncovers mechanistic insights in melanoma metastasis D. R. Christiansona, A. S. Dobroffb, B. Pronetha,A. J. Zuritad, A. Salameha, et al., D. J. Cahill, J. E. Gershenwaldg, R. L. Sidmanj, Wadih Arap, R. Pasqualini (2015) Proceedings of the National Academy of Sciences PNAS USA 2015 Feb 6. pii: 201424994. PMID: 25659743 www.pnas.org/cgi/doi/10.1073/pnas.1424994112.

· Highly sensitive toxin microarray assay to improve Aflatoxin B1 detection in food. Beizaei A, O' Kane SL, Kamkar A, Misaghi A, Henehan G, Cahill DJ. (2015) Food Chemistry Vol 57: 210–215 DOI:10.1016/j.foodcont.2015.03.039.

·The Functional Bionano Interface–Mapping the Interactions at the Interface Between the Hard and Soft Protein Corona. O'Connell DJ, Baldelli Bombelli F, Cahill DJ and Dawson KA. (2014) Nanoscale: Sept 1: DOI: 10.1039/c5nr01970b

·Epitope presentation is an important determinant of the utility of antigens identified from protein arrays in the development of autoantibody diagnostic assays. Murphy MA, O'Connell DJ, O'Kane SL, O'Brien JK, O'Toole S, Martin C, Sheils O, O'Leary JJ, Cahill DJ. Journal Proteomics. (2013) 75(15):4668-75. PMID: 22415278.

· Vascular ligand-receptor mapping by direct combinatorial selection in cancer patients. Staquicini FI, Cardó-Vila M, Kolonin MG, Trepel M, Edwards JK, Nunes DN, Sergeeva A, Efstathiou E, Sun J, Almeida NF, Tu SM, Botz GH, Wallace MJ, O'Connell DJ, Krajewski S, Gershenwald JE, Molldrem JJ, Flamm AL, Koivunen E, Pentz RD, Dias-Neto E, Setubal JC, Cahill DJ, Troncoso P, Do KA, Logothetis CJ, Sidman RL, Pasqualini R, Arap W. Proc Natl Acad Sci U S A. (2012) 108(46):18637-42. PMID: 22049339.

·Assessment of the humoral immune response to cancer. Murphy MA, O'Leary JJ, Cahill DJ. Journal Proteomics. (2012) 3;75(15):4573-9. PMID: 22300580.

· Proteomic analysis & discovery using affinity proteomics and mass spectrometry. Olsson N, Wingren C, Mattsson M, James P, O'Connell D, Nilsson F, Cahill DJ, Borrebaeck CA. Mol Cell Proteomics. (2011) 10(10):M110.003962. PMID: 21673276.

· Optimized autoantibody profiling on protein arrays. O'Kane SL, O'Brien JK, Cahill DJ. Methods Mol Biol. (2011) 785:331-41. PMID: 21901610.

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CapitalCare DICKINSFIELD

August 14, 2020

Dear Residents and Families:

We received confirmation on August 11th that CapitalCare Dickinsfield is now on a COVID-19 outbreak due to **one** staff testing positive.

We received confirmation on August 13th of a **second** staff positive case, and August 14th of a **third** staff positive case of COVID-19 at CapitalCare Dickinsfield.

There are no confirmed cases in any resident at this time.

Dickinsfield remains on facility wide outbreak status until otherwise directed by the Medical Officer of Health.

What we know so far:

The first staff member who tested positive for COVID-19 last worked at Dickinsfield August 8th. The second staff member has not been at the centre since August 6th. The third staff member last worked August 13th, had no symptoms, and was discovered to be COVID-19 positive during centre asymptomatic swabbing. All three staff members are isolating at home and do not present an ongoing risk to the facility.

We are working with the local Edmonton Zone Medical Officer of Health to investigate the source of the infection and undertake contact tracing for anyone that might have had exposure to the affected staff members.

We expect the asymptomatic swabbing of all residents and staff with consent that was started August 11th, to be complete within the next 24 hours. We will contact you by telephone if your loved one tests positive.

Effective today, we are cancelling all visitation. We will notify you when visitation is ready to be resumed.

What are we doing?

CapitalCare has a comprehensive COVID-19 Pandemic Response Plan to ensure we respond immediately and effectively. This plan was enacted as soon as we got confirmation of the COVID-19 positive result.

Strict contact and droplet precautions are in place. Staff are wearing full Personal Protective Equipment (PPE) when they are caring for all residents in isolation, including wearing goggles or face shields in all neighbourhoods, taking extra precautions in donning and doffing their PPE when leaving and entering the resident's rooms and wearing masks ***and eye protection*** continuously when in other resident care areas. We also have enhanced cleaning in effect, and are continuously cleaning any high-touch or low touch surfaces.

Frequent updates on the status of Dickinsfield and all other CapitalCare centres will be published on CapitalCare's website at www.capitalcare.net, which will be updated daily Monday to Friday to reflect any changes in the current situation.

To keep you current, we will update the News page of the CapitalCare website going forward.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

Thank you for your support and patience during these challenging times.

Redacted Site Director

GET SOCIAL WITH US:

CapitalCare EDMONTON AREA

August 13, 2020

Dear CapitalCare Residents and Families:

We are pleased to report there are no confirmed cases of COVID-19 in any residents of CapitalCare at this time.

Earlier this week we notified residents and families of **CapitalCare Dickinsfield** and **CapitalCare Lynnwood** that one staff member at each centre tested positive for COVID-19. Both staff members are currently isolating at home.

Out of an abundance of caution, both centres are taking extra infection prevention and control measures, and testing asymptomatic residents and staff who have consented to it. Pre-arranged visits are continuing at these centres if and as the centres have the resources to accommodate them.

CapitalCare Strathcona remained on outbreak precautions this week after staff began experiencing nausea, vomiting, and diarrhea symptoms. Residents who were previously ill with the same symptoms tested negative for COVID-19 and have improved. The centre anticipates outbreak precautions may be lifted next week and is preparing to resume visitation at both Heritage and Harvest Houses.

Active cases of COVID-19 in our centres are posted on the COVID-19 News page of our website.

For current Alberta case counts and additional case information, please visit Alberta.ca/Covid19.

Visitation Update

Designated Support Persons

Thank you for your ongoing support as we continue to roll out our Safe Visitation policy. We have connected with 80% of Designated Support Persons (DSP) to set up their preferred schedule. CMOH Order 29-2020 allows for up to two DSPs per resident. Please speak with your care manager to schedule your visits. Just a reminder, the on-line form for is for outdoor and virtual visits only.

CapitalCare Strathcona is in the process of contacting DSPs to create a schedule for indoor visits at Heritage House and Harvest House. They are hopeful this schedule can begin Monday August 17; check the CapitalCare website for updates prior to your scheduled visit. DSPs for Laurier House will be contacted in the coming week.

Risk Tolerance Assessments

All of our centres have completed their risk tolerance assessments, which looked at physical space, available resources, and feedback from the resident/family/staff surveys. Overall, when it comes to indoor visits, 72.3% of people surveyed across our organization prefer those visitors to be **low risk**. We ask that DSPs postpone their visits if they assess themselves at anything above low risk.

Additionally, the survey indicates a tolerance for no more than 10 DSPs in the building at any one time. This means we will need to manage the visit requests to ensure we are within that range. Your support and understanding of these principles of risk tolerance are key to helping us create a satisfactory visiting environment for all.

Screening Process

The screening process for DSPs involves a daily risk assessment, review of visitor responsibilities, training on how to properly wear a mask and hand washing. The process at the screening station can take up to 20 minutes. Please visit the Info for Families/COVID Information page our website to prepare, and ensure you allow time to complete the screening before your scheduled time.

Outdoor and Virtual Visits

Outdoor and virtual visits continue at our centres, with up to four visitors and the resident for an outdoor visit. Outdoor and virtual visits must be booked using the online form.

A new automated booking system is in development and is expected to make coordinating the visits quicker and smoother for visitors as well as centre staff.

Frequency of Visits

Whether you visit indoors, outdoors or virtually, all of our centres are finding it challenging to schedule an equal number of visits for all families who would like to see their loved ones. Families and residents surveyed indicated a preference for visits once a week. We ask that you coordinate with your family members to ensure we can achieve one visit per week for each resident.

Visiting Hours

Visiting hours vary from centre to centre and are posted on the “Centres” pages of our website. Please check our website regularly; in the event of an outbreak, visitation may be paused.

Message of Support

We have been working hard to keep our residents and staff safe over the course of the pandemic and have appreciated receiving messages from our families. We wish to share these kind words from the family our most “senior” senior, on the occasion of her 108th birthday August 6:

Words cannot adequately express our gratitude to the outstanding team at Laurier House Lynnwood for all of your support in pulling off Mom's COVID-style celebration today.

I chatted with Mom earlier this week and unprompted she said "I'm so glad I chose here to live. They are always asking if I need anything and am I okay and what can they do for me. I feel I can ask them anything." If this is not a testament to the quality of your care and compassion I don't know what is.

We as a family are so grateful for CapitalCare's great communication, our opportunities to provide feedback and input and your exceptional work in keeping our loved ones and your staff safe.

Please pass on our thanks to all of the great members of your team.

– Loraine Anderton

Thanks to all of you for your support.

Kind regards,

The Executive Management Team

CapitalCare In the News

A CapitalCare resident and her family were featured on the CBC Edmonton News August 6. Vera Saunders, who celebrated her 108th birthday, is the oldest of 31 CapitalCare residents 100 years and older this year. Vera's family celebrated the milestone with a seven-car parade at Laurier House Lynnwood. Another distinction Vera holds is having lived through TWO pandemics: Vera was just six years old during the Spanish Flu of 1918. Read more…

Activities at the Centres

CapitalCare Strathcona's annual antique car show looked a little different this year, but residents enjoyed it just as much. Thank you to the Edmonton Antique Car Club and the good neighbours in Sherwood Park for this year's Classic Car Drive-By. Resident Jeannette Tate enjoyed sharing her memories of her first car, as well as seeing a few female drivers behind the wheel.

The beat goes on at CapitalCare McConnell Place West. Residents have been enjoying fun afternoons in the sun, dancing to live music on the patio!

Residents of CapitalCare Lynnwood have been enjoying afternoon socials: the ladies like their tea, while the men prefer beer and wings.

More photos of centre activities are on Facebook

Helping You Connect

CapitalCare FOUNDATION

FEAST RE-IMAGINED

At **CapitalCare Foundation**, we aim to build community in everything we do. Due to the ongoing COVID-19 pandemic, we are unable to hold what you have known as Feast on the Field at Commonwealth Stadium as we have in years past, but this hasn't stopped us from getting creative to bring you the re-imagined **Feast on YOUR Field!**

LEARN MORE

Did you know we've partnered with Skip The Depot , a bottle collection service that will let you donate your bottle refund directly to us! Click below to learn more.

SKIP THE DEPOT

The **Hearts for Healthcare** window decals are really making a difference. Send your messages in and give CapitalCare staff virtual gratitude through your inspiring messages!

SEND A HEART

Make a connection by sending a positive message to a resident living at CapitalCare Centres. Choose a postcard templates to send a special message.

SEND A POSTCARD

GET SOCIAL WITH US:

Key Messages from the Evidence Summary

1. Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable. A single positive RT-PCR without current symptoms could be classified as 1) Presymptomatic, 2) Asymptomatic (or paucisymptomatic), or 3) Positive after infection (regardless of symptoms) or rarely, a false positive result (which cannot transmit infection.) Transmission might occur from only the first two types of individuals (pre and asymptomatic infected persons).

- Interpretation of existing data (including that used in modeling studies) is clouded by a lack of clarity in 1) definition of "asymptomatic" (whether defined by Influenza Like Illness screening (absence of cough and fever) or a more comprehensive symptom list was used) and 2) lack of reporting of symptoms for 4 weeks prior to, and 2 weeks after the test.
- There is evolving data on viral kinetics in asymptomatic, pre-symptomatic, and paucisymptomatic SARS-CoV-2 infection. One series documented higher viral loads (by 60 fold) and a longer time to RT-PCR clearance in patients with severe illness, and a median of 24d to become RT-PCR

negative (with 32.1% still positive at 1 month post onset). Importantly, other studies have shown that SARS-CoV-2 RT-PCR can remain positive for 4 weeks in patients with milder outpatient managed COVID-19 as well.

- Therefore a RT-PCR positive result in a currently asymptomatic person is of unclear significance and RT-PCR positive status cannot be used to infer potentially infectious status.

From: David Dickson
Sent: Saturday, September 5, 2020 9:34 AM
To: Redacted gmail.com
Subject: FW: Care Homes
Importance: High
Sensitivity: Confidential

Four of seven.

Please treat as confidential.

From: David Dickson
Sent: August 28, 2020 3:47 PM
To: 'Janice Harrington' <Janice.Harrington@albertahealthadvocates.ca>
Cc: Redacted < Redacted albertahealthadvocates.ca>; Catherine D Douglas <catherine.d.douglas@gov.ab.ca>; 'health.minister@gov.ab.ca' <health.minister@gov.ab.ca>; 'deena.hinshaw@gov.ab.ca' <deena.hinshaw@gov.ab.ca>; 'jason.kenney@gov.ab.ca' <jason.kenney@gov.ab.ca>
Subject: RE: Care Homes
Importance: High
Sensitivity: Confidential

Afternoon Janice.

To be frank, I am not actually sure what your office does now. We have provided a list of what can only be described as crimes that go beyond the term 'administrative fairness'. The Ombudsman is not equipped to deal with this as you well know.

We have provided details of wrongdoing by Alberta Health Services, the CMOH (and her subordinates), Care Centers and more. There are many examples of these people breaching the PHA and the Orders of the CMOH. However, your answer is to complain to the very people who are taking actions that are quite frankly killing people and covering these deaths up under the mask of COVID 19.

Primary care doctors are banned from the care centers by AHS, the care center and those reporting directly to Deena Hinshaw and Tyler Shandro. But your answer is to call those very people to complain. We have. They ignored us as does everyone else. All the while people are suffering and dying. You can see with your own eyes from the material provided that statistics and testing is being falsified, deliberately misrepresented and misused to enforce measure that are destroying lives daily. All while Doctors and other health care workers are threatened and are terrified to come forward. Others continue to complicity act against their very oaths.

You mention filling in a questionnaire for the PHCOA (as was). Note that I designed their businesses processes and technical systems over 20 years ago so I know exactly what they do, or rather can't do. We have filled in their 'questionnaire' (heavily weighted as it is) so they can duly provide their report to the Health Minister. For what purpose I do not know.

All the politicians and groups you mention have been contacted. They continue to ignore us along with the many others crying out for help.

We have attached the last few emails regarding one of the Dickinsfield residents who is now just waiting to die. As you will see, she has just been discharged from hospital in a manner that can only be described as medical negligence. Once this family member passes, as with all the other deaths in care homes now, the resident will be bundled up and removed without the family being allowed to see them. The rooms are sanitized and all property removed. Our most precious members of society are being treated like toxic waste instead of the loved ones they are. This is nothing short of the destruction of evidence in an ongoing crime.

I had asked for a meeting or a call, but you don't appear to have any mandate that covers anything related to patients, the health system or indeed anything to do with Albertans.

You have everything now. Please keep it on file for one day these communications may become very important.

Lastly, I would like to know just what would be a concern that would fall under your mandate for an investigation as right now I can't think of anything. As always, I would welcome the opportunity to talk in person or on the phone.

David

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com)
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Privacy and Cybersecurity Expert.
Cell: Redacted
Fax: Redacted
Email: david.dickson@dksdata.com

my Linked in profile Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>
Sent: August 28, 2020 2:07 PM
To: David Dickson <david.dickson@dksdata.com>
Cc: Redacted < Redacted albertahealthadvocates.ca>; Catherine D Douglas <catherine.d.douglas@gov.ab.ca>
Subject: RE: Care Homes
Sensitivity: Confidential

Hello David,

Thanks for sharing this information. I appreciate your concerns and frustrations. Before I get to the causal issue, there are two issues of concerns raised in your email I would like to address off the top.

Lack of adequate care for residents is very concerning and I strongly encourage you and any other resident or family member to contact AHS Patient Relations to lodge a complaint as quickly as possible. You can find more information at: https://albertahealthservices.ca/about/patientfeedback.aspx
Phone: 1-855-550-2555
Fax: 1-877-871-4340 or mail:
c/o Patient Relations
10030 107 Street NW
Edmonton, AB T5J 3E4

I would also suggest you and any other resident or family member with concerns about care for patients related to COVID 19 contact the compliance line for Accommodation Standards and Protection for Person in Care. Toll free: 1-888-357-9339 (in Alberta) Hours: 8:15 am to 4:30 pm (open Monday to Friday, closed statutory holidays).

I am also greatly concerned with your story about family members expressing suicidal thoughts. Please suggest they speak to their doctor and/or utilize mental health support lines (e.g. Access 24/7). In Edmonton, the Distress Line can be reached at 780-482-4357. If you or they feel the situation is an emergency, don't hesitate to call 911. This situation is taking a toll on many and additional resources have been set up to help.
Regarding your disagreement with Chief Medical Officer's policies created in response to COVID 19, these are not areas which fall under the jurisdiction of the Health Advocate's office. Please reach out directly to her office. You can find information here: https://www.alberta.ca/office-of-the-chief-medical-officer-of-health.aspx#toc-5.

Additionally, please ensure you have shared your perspective with the Minister of Health:
Honourable Tyler Shandro, Minister of Health
Office of the Minister Health
423 Legislature Building
10800 - 97 Avenue
Edmonton, AB
T5K 2B6
Phone: 780 427-3665
Fax: 780 415-0961
E-mail: health.minister@gov.ab.ca

The legislation on the role of the Health Advocate is clear that if the concern falls under the jurisdiction of another body, our office is required to refer to that body. The Alberta Health Charter is an aspirational document and not a means of enforcement within the health system. Not every case referred to the Health Advocate undergoes a formal review. As per our legislation, if there are other agencies or organizations that have appropriate dispute resolution mechanisms, the Health Advocate shall refer the complainant to that person or body, in accordance with s.4(3) of the *Alberta Health Act*.

However, it is the role of the Health Advocate to ensure the experiences of Albertans are shared within the health care system so there is an understanding of the issues policy may create and I and my office have and will continue to share the stories and concerns. Your experience certainly highlights the challenges that are being faced by Albertans as a result of COVID-19 and the decisions being made to respond to the crisis.

If, after going through these processes, you feel there is an issue with administrative fairness, you may also wish to contact the Alberta Ombudsman:

In Edmonton
Phone: 780.427.2756
Fax: 780.427.2759
Edmonton Mailing Address
Alberta Ombudsman
9925 – 109 Street, Suite 700
Edmonton, Alberta T5K 2J8

Finally, we have also looked into what reviews to the COVID 19 response might be underway in which you may wish to participate. I have included here a fact sheet on work by the Health Quality Council of Alberta and I would encourage you to respond. You may also wish to spread the word to other families and residents so they can also participate.
My best wishes to you and your family,
Janice

Janice Harrington | Health Advocate / Mental Health Patient Advocate
106th Street Tower |9th Floor| 10055 – 106 Street NW | Edmonton, Alberta T5J 2Y2
General: 780-422-1812 | Fax : 780-422-0609
Email: janice.harrington@albertahealthadvocates.ca | www.albertahealthadvocates.ca

Classification: Protected A
From: David Dickson <david.dickson@dksdata.com>
Sent: Wednesday, August 26, 2020 10:20 AM
To: Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>
Subject: Care Homes
Importance: High
Sensitivity: Confidential

Morning Janice,

As you know from all the emails we have sent to you, we have been dealing with a very serious situation at one specific care home. Today we spoke to some other family members who we have been helping who have been refused access to their loved ones for weeks – the third of what is now a pattern of "outbreak" lockdowns. Two families went in yesterday and saw what can only be described as a horror story for their loved ones. The Care Centre and AHS is actively refusing to allow the primary care Doctor into the centre to see his patients. In the last few weeks, many residents have developed life threatening wounds, are visibly dehydrated, suffering physically and emotionally from outright lack of care. This is entirely because of asymptomatic staff testing. This asymptomatic testing has demonstrated over and over that these are false positives as there has been no source and no secondary infections. This is happening across the Province with a focus on Edmonton right now. The expansion to Pharmacy testing will make this considerably worse.

I have been talking to two families today. The first lady tried to commit suicide just over a week ago so she 'could be there waiting for my Dad when he dies'. She felt it was the only thing left she could do to help him, having exhausted all other avenues. This last comment was about a man who walked into the care home only six weeks ago and now is lifted in and out of bed into a wheelchair. The family have been told he will never walk again. He will certainly die soon. She is in the centre now, as I write, having demanded a welfare check as her Father is in a serious state of decline with pressure wounds. My wife has just checked her email and saw this which we received overnight, a different family but from the same facility. I have redacted some information as I have not received permission to share this yet, but it is too urgent for you not to be aware.

"My Mom is ill, she slept most of the afternoon away in her wheelchair while I was with her. In the last 12 days since I last saw her on Aug.13th, she has become very gaunt looking, dehydrated has definitely has lost weight.

> *Her nutrition is down and the HCA told me some days she was not eating well. She does not have much of an appetite. He pressure sore on her left foot that was stuck to her shoe on July 29, is infected and there is some redness to the top of her foot, despite being on Keflex for a week. The HCA said my Mom was crying at lunchtimes and if she would finish her meal they would promise to put her into bed for a nap.*

When I came home I called [Dr's Name Redacted] to tell him what is happening and he is quite concerned of her nutritional condition and her foot wounds not healing properly. I mentioned to him to get bloodwork done tomorrow AM. As she is very lethargic and not well. I asked if she had diarrhea from antibiotic and they told me no, but in the past, she has had from Keflex. This could put her electrolytes out and dehydrate as well.

The problem is [Dr's Name Redacted] has not been able to go in for over two weeks and my Mom is going downhill. He has pleaded with some top executive Dr. Redacted *to let him in to see 3 patients and to let him in to examine Mom. The response to him was you don't want another situation like Southgate Good Samaritan outbreak. I don't understand it is open for visiting now on that unit, why are you not able to go in to provide care? Doing care over the phone is not proper care in this situation.*

He said he will try to come in on Thursday and meet with me or this Saturday. I told him maybe I should be taking Mom into emergency. He cautioned me on taking Mom into a hospital at this time, but said it was up to me if I wanted to do so. Are they afraid that their negligence will be exposed?

The nursing staff over the last 12 days, have not disclosed Moms condition to me when I phoned to check on her."

Note that I have spoken unnamed Dr's, nurses and other heath care workers who are being threatened by AHS. Like my own GP and specialist, doctors are terrified to send anyone to hospital because of the protocols they have implemented. I urgently need a CT scan for my lungs but three Doctors who I have known for years have told me not to go to hospital.

I know you are doing everything in your power but I am begging you to act for these families. We are going to see many more deaths CAUSED by the people managing these asymptomatic 'outbreaks' which appear designed to kill. As a retired Police Officer, I am horrified at the lack of response and continued actions by these people. Time has run out.

Is it possible for you to call or meet urgently?

David

David T. Dickson
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Consulting C.I.O.
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Privacy and Cybersecurity Expert.
Cell: Redacted
Fax: Redacted
Email: david.dickson@dksdata.com

my LinkedIn profile Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

Attachments
"FW: Mom"
"FW: My Mom"
"FW: Response to outstanding questions - Redacted ***and the residents in Dickinsfield"***
"FW: My Mom"

“FW: Mom”
From: Redacted <Redacted hotmail.com>
Sent: Friday, August 28, 2020 11:50 AM
To: Karen Dickson <karen.dickson@dksdata.com>
Subject: Mom

Hi Karen,

This nightmare continues, Mom was discharged at 8:20pm from FSHC without letting me know!
The ER Dr. Doll told me I would be notified if Mom was moved from there.

My brother visited Mom because they could only accept one visitor as Mom was one precautions because of Dickinsfields outbreak status. He was told last night around 6:30 pm by the staff RN that Mom would be admitted to a bed there shortly.

The accepting unit doctor refused Moms admission at FSCH and sent her back to Dickinsfield with 6 weeks Rx for Amoxi-Clauvalin oral antibiotics.

Again, I was not consulted on this decision or even called, she was just discharged. They have information that I am Moms Medical Directive and POA.

I am waiting on a call back from FSCH, as the unit manager Besy in ER is going to pull Moms file to let me know why this was done.

Redacted

"FW: My Mom"

From: Redacted <Redacted hotmail.com>
Sent: Wednesday, August 26, 2020 10:41 PM
To: Karen Dickson <karen.dickson@dksdata.com>
Subject: Re: My Mom

Hi Karen,

My finished her supper meal and fell asleep during the meal. I was standing off to the side watching, then the HCA came to help her eat, so she could finish her meal.

They got her paperwork ready to go and called for an ambulance. The nurse also called Dr. Redacted and he was ok with her going to emergency. The paramedics arrived and assessed Mom in her room. Then talked me down from taking her and to be assessed by a community paramedic onsite treatment. The paramedic left and the community paramedic onsite service came in to assess Mom wounds and her hydration. He consulted Dr. Redacted by phone and he said he could not guarantee he would be in tomorrow to see Mom.

The onsite community paramedic knew that Moms wound was larger a month ago because I showed him a photo on my camera. It also smelled bad after one week of antibiotics and I asked if she could have IV antibiotics. He said he could not make that call.to treat her. So he asked for a decision from me to send her to hospital by ambulance, I agreed and said yes.

When they arrived they got Mom onto the stretcher and made a call as to where she could be seen. No hospital ERs available in the city- Mom was taken to Fort Saskatchewan Hospital. I did not go with them I have no way to get there and back. They told me to take a taxi to Edmonton!

She will be seen by a doctor there and they will decide if she gets IV antibiotics. I am also worried there is something going on with her heart failure. I hope I made the best decision for my Mom, she is now there alone.

Redacted

From: Karen Dickson <karen.dickson@dksdata.com>
Sent: August 26, 2020 9:45 AM
To: Redacted <Redacted hotmail.com>
Subject: RE: My Mom

Redacted

I've just left you a message. Please call me. She has to go to emergency. Her situation is dire.

I know you document everything. Take photo's if you can. I am in agony reading this.

This email must go to Janice Harrington **immediately**.

My God, they are literally killing people.

Karen

From: Redacted <Redacted hotmail.com>
Sent: Wednesday, August 26, 2020 12:12 AM
To: Karen Dickson <karen.dickson@dksdata.com>
Subject: My Mom

Karen,

My Mom is ill, she slept most of the afternoon away in her wheelchair while I was with her. In the last 12 days since I last saw her on Aug.13th, she has become very gaunt looking, dehydrated has definitely has lost weight.

Her nutrition is down and the HCA told me some days she was not eating well. She does not have much of an appetite. He pressure sore on her left foot that was stuck to her shoe on July 29, is infected and there is some redness to the top of her foot, despite being on Keflex for a week. The HCA said my Mom was crying at lunchtimes and if she would finish her meal they would promise to put her into bed for a nap.

When I came home I called Dr. Redacted to tell him what is happening and he is quite concerned of her nutritional condition and her foot wounds not healing properly. I mentioned to him to get bloodwork done tomorrow AM. As she is very lethargic and not well. I asked if she had diarrhea from antibiotic and they told me no, but in the past, she has had from Keflex. This could put her electrolytes out and dehydrate as well.

The problem is Dr. Redacted has not been able to go in for over two weeks and my Mom is going downhill. He has pleaded with some top executive Dr. Redacted to let him in to see 3 patients and to let him in to examine Mom. The response to him was you don't want another situation like Southgate Good Samaritan outbreak. I don't understand it is open for visiting now on that unit, why are you not able to go in to provide care? Doing care over the phone is not proper care in this situation.

He said he will try to come in on Thursday and meet with me or this Saturday. I told him maybe I should be taking Mom into emergency. He cautioned me on taking Mom into a hospital at this time, but said it was up to me if I wanted to do so. Are they afraid that their negligence will be exposed?

The nursing staff over the last 12 days, have not disclosed Moms condition to me when I phoned to check on her.

I am very sad, sick about this tonight. My Mom asked me to please help her tonight and bring her with me. Really how long should she have to wait for CARE at this point.

"FW: Response to outstanding questions - Redacted and the residents in Dickinsfield"

From: Redacted < Redacted capitalcare.net>
Sent: Thursday, August 27, 2020 5:32 PM
To: Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Dear Karen,

As Redacted has indicated Dickinsfield, as with all public Alberta Continuing Care sites, is mandated to follow all Alberta Health Chief Medical Officer of Health orders and direction from Public Health as mandated in a Public Health emergency.

If you have questions or concerns regarding these orders, please reach out to Alberta Health or the Office of the Chief Medical Officer of Health via phone (Toll free: 310-0000 or 780-427-2711) or email https://www.alberta.ca/contact.cfm.

We recognize that the residents living in Continuing Care sites are heavily affected by the pandemic, and are doing our upmost to support them every day.

Regards,
Redacted

From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Thursday, August 27, 2020 8:35 AM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Redacted

I am glad you have put in writing that you are "simply following orders". There is a significant point in history where this happened before. All those who did just that were subsequently held to account. In addition, despite being the Chief Operations Officer with a wealth of experience directly at Dickinsfield, and your participation in Zoom calls, your absence from this conversation is notable, Redacted

We have spent months trying to explain how incredibly dangerous, to the point of life threatening, the measures you have implemented, are to residents, families and staff. From the misuse of PPE, lack of basic care to residents and extended isolation, you are already experiencing and WILL see continue to witness the downward spiral of these protocols, with no scientific support, on a level never seen before.

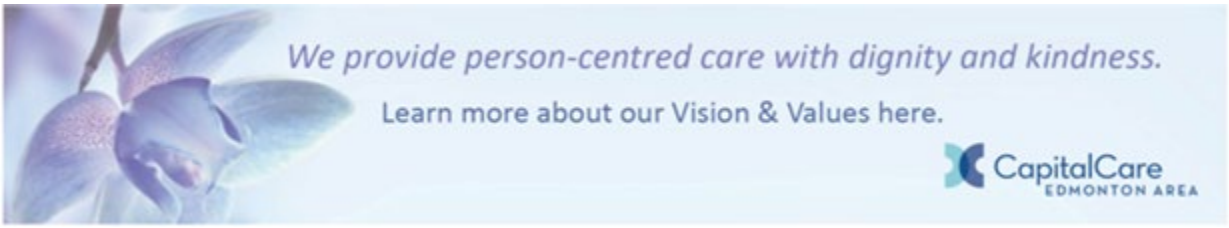
You have not answered any of the questions we have raised. You are deferring to authority even where the questions are directly your responsibility. As we have said before, Redacted if you cannot or are unwilling to answer these critical concerns, then escalate the complaint above you. At least that way, you can arguably absolve yourself from immediate culpability in this situation.

Karen & David Dickson

From: Redacted < Redacted capitalcare.net>
Sent: Wednesday, August 26, 2020 11:57 AM
To: Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Hello,
I have received your email. We acknowledge that we are facing many challenges as we navigate through this COVID-19 pandemic and that residents, families and staff are affected by the changes and measures we must put in place. As we make all efforts to balance resident quality of life with safety, we must follow the CMOH orders which are legislated and the Infection, Prevention and Control measures as directed during an outbreak.

Redacted Site Director|CapitalCare Dickinsfield Campus
780.371.6525



From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Tuesday, August 25, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Redacted and Redacted

We are still waiting for the name of the MOH responsible for managing this current “outbreak” and on responses from our previous emails. Note that you had indicated the outbreak was being handled, not by a Doctor but by an AHS ‘Program Manager’. How is this appropriate considering the new and insane protocols that have now been implemented? Should you be unable to provide answers to the specific questions, we would like them to be answered by a senior member of Capital Care’s leadership team and AHS. The health and welfare of residents, staff and families is the focus of these questions and answers are imperative.

I visited Mum (Redacted yesterday 24th August, and she is notably despondent at what is now the third lockdown and limitation of her care needs. These lockdowns are beginning to tell on her emotionally and physically. When I saw her last week, she barely waved at me from the window, her head in her hands. It is agonizing and heartbreaking to endure. She is unable to receive her full physio program, has been denied what were weekly massages for what is now six months, (essential for mobility and pain relief since her stroke), is unable to have her hair cut and has been isolated again from her whole family for another 10 day period. Yet again, this has been from staff members taking tests and getting asymptomatic positive results which AHS, along with the rest of the scientific and health community KNOWS are so unreliable and unfit for purpose that they CANNOT be used to infer ANY infection. Note, no residents, despite six or more highly invasive rounds of testing, have come back positive. Yet many are detained and isolated in their rooms for days at a time in conditions worse than those provided to prisoners who are at least afforded an hour’s exercise a day (even when in lockdown). There will be NO END to these cycling lockdowns, imprisoning and segregating the most vulnerable. I remain at a loss as to how this qualifies as appropriate and considered risk management. I would argue vehemently that the negative impacts are far outweighing any risk from the virus.

I arrived yesterday at lunchtime and was devastated to see every resident (Mum included) at a ‘socially distanced’ table. The isolation and sadness was visible. It was awful. When these residents would be deemed cohorts, I have to ask what reason dictates they be distanced from the only source of companionship they have left? This is downright cruelty. In fact, I will boldly state this is manifestly Munchausen’s by Proxy. While in the centre, a member of staff I spoke to, like most, was wearing both a face shield and mask. She said the residents are increasingly upset and have been asking her when they are going to be taking off the masks… she noted that that was BEFORE shields/goggles have been added. It was clear from the discussion that the PPE is becoming increasingly difficult for the residents to live with. She also said the face shields are very hard to wear as the glare from them is blinding. This is a safety risk for both the staff and the residents. As David mentioned, when shields were suggested for drivers picking up residents, PPE worn like this is highly inappropriate and dangerous. I should also add, I saw one staff member in the centre with her googles in her hand. When I asked her why, if this is so serious and now required PPE, she was not wearing said equipment, her reply was that she was “taking a break” from them. The endless contradictions, inconsistencies and unmanageable protocols which are hopelessly being implemented are serving no useful purpose whatsoever. At some point, there will be an accident by their over/misuse.

When I left, Mum wanted to follow me down to the foyer. I noted to the staff member that I assumed this was not an option due to the other floors not even allowing access to people deemed low risk. I assumed that Mum would be confined to the third floor as the lower floors were more severely impacted by the lockdown, either in part or as a whole. I was told “No.. your Mum goes all over the place, wherever she wants, just not offsite.” So residents are free to roam the centre in areas where apparently asymptomatic staff have frequented and which are locked down to DSP’s but there is no risk to them? Again, I can’t begin to fathom the rationale which I believe is sadly lacking at best and non-existent at worst.

The endless paradoxes serve only to cast doubt on the entire handling of COVID19 and all its insane and contradictory measures not supported by ANY science. As it relates to care centres, almost everything that has been done has put residents in danger of more serious injury, illness and death way beyond anything this ILI could have posed.

I still can't believe what we are documenting as the new "best practice". These measures guarantee chaos, a negative result and are devastating.

From the email yesterday, it looks like you have now opened all of Floor 2 but Main is still closed. I would like to know why. The email on Friday noted that only Floor 3 and part of Floor 2 would be opening. What changed over the week-end between these two emails?

What both saddens and angers me the most is that you will likely take none of the human tragedy of this email on board. Instead, you will hone in on staff comments for "correction". You will dismiss what is of ultimate importance, the health and welfare of your residents and staff. We are living in a time of dictatorship from the top, where true care for those most vulnerable has been abandoned in favour of a ruthless regime, the sole focus of which is a perfectly treatable virus. No one in a senior position can ignore this and simply say they are following orders without question. I do know though that at some point, the growing weight of evidence as it relates to the care home response will bear witness to an unmitigated tragedy and those responsible or complicit will be held to account.

I would appreciate a reply at your earliest convenience.

Karen

David & Karen Dickson

"FW: My Mom"

From: Redacted <Redacted hotmail.com>
Sent: Thursday, August 27, 2020 12:40 PM
To: Karen Dickson <karen.dickson@dksdata.com>
Subject: Re: My Mom
Sensitivity: Confidential

Hi Karen,

Yes, Karen and David Dickson, you have my permission to contact Alberta Health Patient's Advocate on my behalf. An investigation into the level of care that Dickinsfield is providing at this time needs to take place.

Thank you for your help and support for me and my Mom.

Redacted

From: Karen Dickson <karen.dickson@dksdata.com>
Sent: August 27, 2020 7:29 AM
To: Redacted <Redacted hotmail.com>
Subject: RE: My Mom

Oh Redacted You must be in pieces. But you made the right decision.

I am available mid afternoon if you want me to drive you to the hospital to see your Mum. She needed to be seen in a fully equipped hospital with proper care.

You absolutely made the right decision. But you must get in to the hospital in Fort Saskatchewan to see her. I can wait for you there. However long that takes.

Can we communicate this to the Alberta Patient Advocate? She is actively investigating cases now and needs this information.

Thanks, and keep me posted if there is anything I can do to help.

Karen

From: Redacted <Redacted hotmail.com>
Sent: Wednesday, August 26, 2020 10:41 PM
To: Karen Dickson <karen.dickson@dksdata.com>
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They got her paperwork ready to go and called for an ambulance. The nurse also called Dr. Redacted and he was ok with her going to emergency. The paramedics arrived and assessed Mom in her room. Then talked me down from taking her and to be assessed by a community paramedic onsite treatment. The paramedic left and the community paramedic onsite service came in to assess Mom wounds and her hydration. He consulted Dr. Redacted by phone and he said he could not guarantee he would be in tomorrow to see Mom.

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From: David Dickson
Sent: Saturday, September 5, 2020 9:34 AM
To: Redacted gmail.com
Subject: FW: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High
Sensitivity: Confidential

Five of seven.

Please treat as confidential.

From: David Dickson
Sent: September 2, 2020 8:43 AM
To: Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>
Subject: FW: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

FYI.

David

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com**)**
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

Microsoft Partner

From: Karen Dickson <karen.dickson@dksdata.com>
Sent: September 2, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Redacted and Redacted

We have just checked the last communications from Capital Care (attached) and have more concerns. On the point of eyewear for PPE purposes. As per Redacted email August 24th, 2020, "All DSPs must wear a mask and safety glasses or goggles at all times while in the centre. Please bring your own safety glasses or goggles, which can be purchased in most hardware stores." we were instructed to go out and buy safety glasses/goggles. We bought multiple pairs of both as the instruction was not clear. No sooner had we done this, the instruction changed to DSP's only being allowed to wear the standard issue centre provided goggles. This was an unnecessary expense we incurred which, like so many of the measures put in place, changes without any supportable science, reasonable notification or

consultation. It is also a concern that the 'goggles' provided by Capital Care are 're-used' by multiple people. **Sharing of such PPE is a serious health concern**. Further, we would like to request the documentation Capital Care Dickinsfield is relying on for the mandated use of goggles by DSP's and staff. Please provide more than the usual 'AHS says so'. If they 'say so' please provide the written communications.

Attached are the last communications from Capital Care for reference. We are now into week four of the latest "outbreak" lockdown where residents are again relegated to their rooms. This is eerily reminiscent of the last lockdown; then, at the eleventh hour of a three week lockdown for staff testing asymptomatic positive, the centre was just about to re-open when someone reported a couple of residents displaying gastric issues. At that time, we contacted the Edmonton Zone health official directly who was responsible for the extension of the lockdown. It was immediately reversed after the health official admitted that she had not checked the file and was wrong in extending the lockdown. Based on this current "outbreak" timing, had we not achieved the opening up on the holiday weekend of August 3rd, this would have ensured that the lockdown would never had ended making this the 8th week of closure. Some residents will, in actuality, be suffering from this as they didn't manage to avail themselves of that brief window of freedom in that week. If we are now in a position where endless lockdowns leave residents in unending isolation in what can only be described as an obscene carousel of injustice, then there is no hope.

According to the last online update (September 1st), Outdoor Visitation was to resume August 31st, 2020, despite the outbreak ending two days earlier. This communication also states, misleadingly, that "We are pleased to report that across our organization, all staff and students who tested positive for COVID-19 have recovered." To our knowledge, all staff, like before, tested asymptomatic using an unreliable test that AHS states cannot be used to infer an infection. No further testing (which would be just as unreliable) has been done. Under what criteria have you made this unsupported statement that appears more designed to further ongoing fear and confusion than provide accurate information? How does someone's health status improve from asymptomatic?

According to the timing of the student last being on site (and the August 27th email from Redacted (attached)), the "outbreak" was over August 29th. There is no explanation online or in the communications for any date change. Do we presume that outdoor and offsite visits are now permitted and the outbreak is actually over? If so, the staff are not aware of this, communication at all levels being a consistent failure for all concerned, residents, staff and families. If not, please explain the circumstances which have determined yet another extension of lockdown and why this has not been officially communicated. Turnaround for testing is supposed to be 24hrs as a target, with 72hrs as a maximum under an accelerated program for long term care. We are way beyond that now.

We have repeatedly asked for the name of the Edmonton Zone Officer responsible for this latest lockdown. This has been met by comments ranging from silence to "I don't know. But I'll get back to you tomorrow" from you, Redacted Sadly, tomorrow never comes. We are more than prepared, researched and able to address those who are mandating these measures which are far more dangerous than a virus to residents and staff. You have residents and staff in this facility struggling to survive in these oppressive and appalling conditions. We have no idea how you sleep at night. As we have noted in writing many times, there will be accountability for this in the future.

We are hearing from staff overwhelmed by their working conditions. Of residents crying after seeing their family members after weeks of separation. The endless and onerous changes, all in the name of "safety" are anything but. Essential medical care is being delayed and denied. Every manner of appointment in and out of the centre is being denied. And that is before we even begin to address the social impacts, critical to the wellbeing of these vulnerable souls.

We are now hearing from family members whose loved ones no longer want to live like this. They are begging to end their life rather than continue to suffer in this never ending horror show.

For the record, this is a tragedy on a human scale like never seen before…

Please note again that you continue to insist you must follow AHS guidelines but also MUST follow Order 29-2020 (now incorporated into the PHA). As we have pointed out, the requirement to follow the PHA is a legal requirement that you and AHS continue to fail to adhere to.

We await your full response to the above and prior unanswered emails.

Karen and David on behalf of Redacted
David T. Dickson
Consulting C.I.O.
Business/Enterprise Architect
Management/Legal Consultant
www.dksdata.com

From: Redacted < Redacted capitalcare.net>
Sent: Wednesday, August 26, 2020 11:57 AM
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Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

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Redacted Site Director|CapitalCare Dickinsfield Campus
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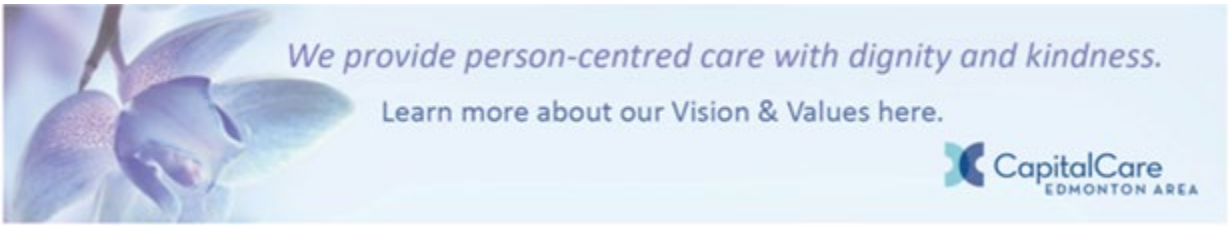

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there is no risk to them? Again, I can't begin to fathom the rationale which I believe is sadly lacking at best and non-existent at worst.

The endless paradoxes serve only to cast doubt on the entire handling of COVID19 and all its insane and contradictory measures not supported by ANY science. As it relates to care centres, almost everything that has been done has put residents in danger of more serious injury, illness and death way beyond anything this ILI could have posed.

I still can't believe what we are documenting as the new "best practice". These measures guarantee chaos, a negative result and are devastating.

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What both saddens and angers me the most is that you will likely take none of the human tragedy of this email on board. Instead, you will hone in on staff comments for "correction". You will dismiss what is of ultimate importance, the health and welfare of your residents and staff. We are living in a time of dictatorship from the top, where true care for those most vulnerable has been abandoned in favour of a ruthless regime, the sole focus of which is a perfectly treatable virus. No one in a senior position can ignore this and simply say they are following orders without question. I do know though that at some point, the growing weight of evidence as it relates to the care home response will bear witness to an unmitigated tragedy and those responsible or complicit will be held to account.

I would appreciate a reply at your earliest convenience.

Karen

David & Karen Dickson

Attachments

CapitalCare Update - August 28, 2020

CapitalCare DICKINSFIELD

August 27, 2020

Dear Residents and Families:

We are pleased to inform you the isolation period for residents living on neighbourhoods Main A ended yesterday, and Main B and Main D ends tomorrow. We expect our facility-wide outbreak to be declared over Saturday, August 29.

Pre-arranged visits by Designated Support Persons (DSPs) can resume as follows:

- Main A – today
- Main B & D - Saturday

Pre-arranged visits by DSPs for all other neighbourhoods resumed earlier this week. To arrange for this type of visit, please call the centre directly at 780.371.6500.

Note to DSPs: **While we are on outbreak,** you must wear a mask and safety glasses or goggles at all times while in the centre. You must also remain on the property. If you would like to go outside, please use the front grounds; the back patio is for residents only.

Reminder to DSPs: You must be screened before you enter the building. The process at the screening station can take up to 20 minutes. You can complete the education online; we suggest doing it from a desktop computer or tablet. Check out the resources under the Quick Links section of the Info for Families-COVID-19 Information page of our website to prepare.

Outdoor Visitation

Scheduled outdoor visits resume August 31, 2020. Please continue to use the online form to arrange these visits. A reminder that these visits are available Monday to Saturday (no outdoor visits on Sundays and holidays).

Virtual Visits

At this time, we are focused on restarting in-person visits, which involve significant staff resources. We will try our best to accommodate virtual visits in exceptional

circumstances and as our resources allow. Please contact your care manager or the centre directly to request this type of visit.

Thank you for your understanding as we resume safe visitation. If you have additional questions, please email info@capitalcare.net.

I would like to share a moment of levity we experienced this week. Justin Cooper lives on the second floor. He received a surprise visitor this week when his neighbourhood came off isolation. The “dinosaur” is Justin’s dad. Yes, even dinosaurs get screened.

I’m delighted to welcome you all back.

Redacted Site Director

GET SOCIAL WITH US:

CapitalCare EDMONTON AREA

August 28, 2020

Dear CapitalCare Residents and Families:

This email comes once a week from CapitalCare Corporate Services and is intended to provide general information applicable to all centres. In addition, you may receive email communications with specific information that applies to your centre only. This has been the case recently for four CapitalCare centres that have been dealing with small numbers of staff testing positive to COVID-19.

We are pleased to report that across our organization, all staff and students who tested positive for COVID-19 have recovered. Importantly, testing of asymptomatic residents and staff who consented to it determined that there was no spread of COVID-19 to residents of any of our centres. We credit this to quickly identifying cases, putting infection prevention measures into place, and following public health guidance.

During these periods of outbreak, we were pleased to continue with visitation where possible. This was made possible due to our screening processes in place for Designated Support Persons (DSPs), as well as enhanced infection prevention measures. At Dickinsfield for example, DSPs wore safety goggles in addition to masks, and could not leave the property while visiting.

Our largest centres and some of our smaller centers have all had experience dealing with cases of staff testing positive for COVID-19. In all cases there has been no transmission to residents. Each outbreak increases our confidence in our ability to manage this pandemic. We ask for your continued support as we prepare staff with school-aged children for the return to school next week.

You can help us by limiting your phone calls to the centres and visiting our website.

Status updates are posted on the COVID-19 News page.

Visitation resources are posted on the COVID-19 Info for Families page.

Centre specific information such as visiting hours are on the centres pages. Please note, in the event of an outbreak, visitation may be paused. Please check our website before coming to the centre for a scheduled visit.

If you have non-urgent questions, please email Corporate Services at info@capitalcare.net and we will forward your question to the centre.

We are committed to communicating with you throughout this pandemic. Your partnership in this process is appreciated.

Reminder: Parking Fees take effect September 1

CapitalCare will be reinstating parking fees for staff and the public at our centres, effective September 1 for the public. As traffic at our sites increases, the reinstatement of parking fees helps ensure appropriate parking spaces are available for staff and visitors. Parking fees will resume at the rates in place prior to the suspension of fees in April.

Activities at the Centres

Centres on outbreak had their hands full this week trying to keep visitation ongoing where possible. But the fun and games of recreational activities carried on at CapitalCare Grandview, where residents braved the wind yesterday for an exciting game of water balloon target toss. Meanwhile, residents at CapitalCare Kipnes Centre for Veterans were treated to live entertainment in various outdoor courtyards.

More photos of centre activities are on Facebook

Helping You Connect

CapitalCare FOUNDATION

DONATE WITH SKIPTHEDEPOT

Did you know we've partnered with Skip The Depot , a bottle collection service that will let you donate your bottle refund directly to us! Click below to learn more.

SKIP THE DEPOT

The **Hearts for Healthcare** window decals are really making a difference. Send your messages in and give CapitalCare staff virtual gratitude through your inspiring messages!

SEND A HEART

Make a connection by sending a positive message to a resident living at CapitalCare Centres. Choose a postcard templates to send a special message.

SEND A POSTCARD

GET SOCIAL WITH US:

From: Karen Dickson
Sent: Saturday, September 5, 2020 9:34 AM
To: Redacted gmail.com
Subject: FW: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High
Sensitivity: Confidential

Six of seven.

Please treat as confidential.

From: Karen Dickson
Sent: September 4, 2020 7:24 PM
To: Redacted < Redacted capitalcare.net>
Cc: Redacted < Redacted capitalcare.net>; Redacted <Redacted gmail.com>; David Dickson <david.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Hi Redacted

Thank you for your response. Sadly and predictably, it provides little in the way of transparency save to pass the responsibility for these disastrous measures on to AHS.

Dickinsfield is still deemed to be on "outbreak". This in now WEEK 4 of incredibly onerous and unmanageable restrictions for all concerned. All communications clearly state the outbreak was over on the 29th August. You have not notified anyone of any further positive tests (redundant as AHS knows they are). Yet the centre remains closed. Short of an illegal imprisonment, please provide details of why the centre is still NOT open. There is no possible way that tests would still be outstanding after this length of time. In fact, it was clear from the communication of the 27th, there were no further tests outstanding. This has to be immediately addressed.

1. Why was Dickinsfield the only centre selected for the mandated use of goggles? Again, where is the actual documentation from Public Health regarding this?
2. We have taken our concerns to AHS and further. The impacts we have discussed extensively are being seriously reviewed.
3. We will contact Redacted next week on her return. It would have been helpful to have her contact details months ago in this ongoing and most serious situation.

Order 32-2020 comes into effect on the 17th Sept. We are fully versed in the detail as it relates to all in long term care. We hope that the same will apply to all leadership in Capital Care to the benefit of residents, staff and families.

Karen and David Dickson on behalf of Redacted

From: Redacted < Redacted capitalcare.net>
Sent: Friday, September 04, 2020 2:05 PM
To: 'Karen Dickson' <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>; Redacted < Redacted albertahealthservices.ca>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Hi Karen,

1. PPE– We were directed by Public Health to use googles in this outbreak , we were unsure if we would have adequate quantity for staff, hence the family request.
   More supplies did become available and we were able to supply to those who were unable to purchase goggles. We do disinfect and clean all items that are not single use.
2. Outbreak management – Direction is provided by Public Health/CDC as per CMOH orders and direction to staff is provided similarly is provided direction about when they are considered recovered. Have you contacted Alberta Health about your concerns?
3. Zone contact –Please contact Redacted , Quality Coordinator , Concerns Management AHS to discuss concerns. Redacted will be returning to work next week.

Kind regards,
Redacted

From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Wednesday, September 02, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Redacted and Redacted

We have just checked the last communications from Capital Care (attached) and have more concerns. On the point of eyewear for PPE purposes. As per Redacted email August 24th, 2020, "All DSPs must wear a mask and safety glasses or goggles at all times while in the centre. Please bring your own safety glasses or goggles, which can be purchased in most hardware stores." we were instructed to go out and buy safety glasses/goggles. We bought multiple pairs of both as the instruction was not clear. No sooner had we done this, the instruction changed to DSP's only being allowed to wear the standard issue centre provided goggles. This was an unnecessary expense we incurred which, like so many of the measures put in place, changes without any supportable science, reasonable notification or consultation. It is also a concern that the 'goggles' provided by Capital Care are 're-used' by multiple people. **Sharing of such PPE is a serious health concern**. Further, we would like to request the documentation Capital Care Dickinsfield is relying on for the mandated use of goggles by DSP's and staff. Please provide more than the usual 'AHS says so'. If they 'say so' please provide the written communications.

Attached are the last communications from Capital Care for reference. We are now into week four of the latest "outbreak" lockdown where residents are again relegated to their rooms. This is eerily reminiscent of the last lockdown; then, at the eleventh hour of a three week lockdown for staff testing asymptomatic positive, the centre was just about to re-open when someone reported a couple of residents displaying gastric issues. At that time, we contacted the Edmonton Zone health official directly who was responsible for the extension of the lockdown. It was immediately reversed after the health official admitted that she had not checked the file and was wrong in extending the lockdown. Based on this current "outbreak" timing, had we not achieved the opening up on the holiday weekend of August 3rd, this would have ensured that the lockdown would never had ended making this the 8th week of closure. Some residents will, in actuality, be suffering from this as they didn't manage to avail themselves of that brief window of freedom in that week. If we are now in a position where endless lockdowns leave residents in unending isolation in what can only be described as an obscene carousel of injustice, then there is no hope.

According to the last online update (September 1st), Outdoor Visitation was to resume August 31st, 2020, despite the outbreak ending two days earlier. This communication also states, misleadingly, that "We are pleased to report that across our organization, all staff and students who tested positive for COVID-19 have recovered." To our knowledge, all staff, like before, tested asymptomatic using an unreliable test that AHS states cannot be used to infer an infection. No further testing (which would be just as unreliable) has been done. Under what criteria have you made this unsupported statement that appears more designed to further ongoing fear and confusion than provide accurate information? How does someone's health status improve from asymptomatic?

According to the timing of the student last being on site (and the August 27th email from Redacted (attached)), the "outbreak" was over August 29th. There is no explanation online or in the communications for any date change. Do we presume that outdoor and offsite visits are now permitted and the outbreak is actually over? If so, the staff are not aware of this, communication at all levels being a consistent failure for all concerned, residents, staff and families. If not, please explain the circumstances which have determined yet another extension of lockdown and why this has not been officially communicated. Turnaround for testing is supposed to be 24hrs as a target, with 72hrs as a maximum under an accelerated program for long term care. We are way beyond that now.

We have repeatedly asked for the name of the Edmonton Zone Officer responsible for this latest lockdown. This has been met by comments ranging from silence to "I don't know. But I'll get back to you tomorrow" from you, Redacted Sadly, tomorrow never comes. We are more than prepared, researched and able to address those who are mandating these measures which are far more dangerous than a virus to residents and staff. You have residents and staff in this facility struggling to survive in these oppressive and appalling conditions. We have no idea how you sleep at night. As we have noted in writing many times, there will be accountability for this in the future.

We are hearing from staff overwhelmed by their working conditions. Of residents crying after seeing their family members after weeks of separation. The endless and onerous changes, all in the name of "safety" are anything but. Essential medical care is being delayed and denied. Every manner of appointment in and out of the centre is being denied. And that is before we even begin to address the social impacts, critical to the wellbeing of these vulnerable souls.

We are now hearing from family members whose loved ones no longer want to live like this. They are begging to end their life rather than continue to suffer in this never ending horror show.

For the record, this is a tragedy on a human scale like never seen before…

Please note again that you continue to insist you must follow AHS guidelines but also MUST follow Order 29-2020 (now incorporated into the PHA). As we have pointed out, the requirement to follow the PHA is a legal requirement that you and AHS continue to fail to adhere to.

We await your full response to the above and prior unanswered emails.

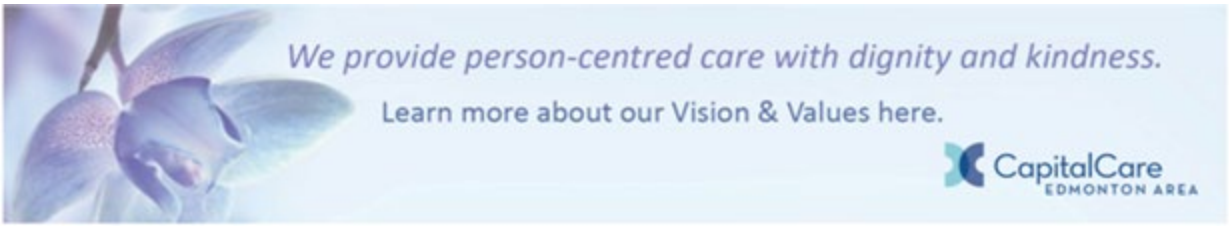
Karen and David on behalf of Redacted
David T. Dickson
Consulting C.I.O.
Business/Enterprise Architect
Management/Legal Consultant
www.dksdata.com

notify the sender and delete this e-mail message. Note: DKS DATA is not a Law firm and does not provide Legal Advice but can provide business advice on legal topics. If you require Legal Advice we can recommend one of our partnering Law Firm.

From: Redacted < Redacted capitalcare.net>
Sent: Wednesday, August 26, 2020 11:57 AM
To: Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Hello,
I have received your email. We acknowledge that we are facing many challenges as we navigate through this COVID-19 pandemic and that residents, families and staff are affected by the changes and measures we must put in place. As we make all efforts to balance resident quality of life with safety, we must follow the CMOH orders which are legislated and the Infection, Prevention and Control measures as directed during an outbreak.

Redacted Site Director|CapitalCare Dickinsfield Campus
780.371.6525



From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Tuesday, August 25, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
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I would appreciate a reply at your earliest convenience.

Karen

David & Karen Dickson

Attachments

CapitalCare Update -September 4, 2020

CapitalCare EDMONTON AREA

September 4, 2020

Dear CapitalCare Residents and Families:

We are pleased to report that currently there are no confirmed cases of COVID-19 at any of our centres.

Centre updates

CapitalCare Norwood is no longer under investigation with enhanced surveillance. Visitation continues and admissions are occurring.

Visitation for designated support persons (DSPs) has resumed at **CapitalCare Dickinsfield**. As a DSP, you must remain in the room of your resident while visiting.

At **CapitalCare Strathcona,** pre-arranged indoor and outdoor visitation at all three houses (Heritage, Harvest, and Laurier) has resumed.

The YMCA day care at the **Kipnes Centre for Veterans (KCV)** has opened again. Updates have been made to the program space to ensure that the day care functions completely independent of the KCV centre. The day care has a separate entrance from the rest of the building and inter-generational activities are on hold at this time.

Visitation Update: Quick tips to make the most of your visits

1. Before coming in for a visit, check the “Centres” page on the CapitalCare website. This page provides the most up-to-date information about visitation at your centre.

2. To make visits safer for everyone, avoid creating congestion at the front entrance or screening station.

- Keep a distance of at least 6 feet (about 2 arms’ length) from other people waiting to enter the building or be screened, and
- If possible, wait in your car and do not enter the building until you can comfortably practice physical distancing at the front entrance or screening station.

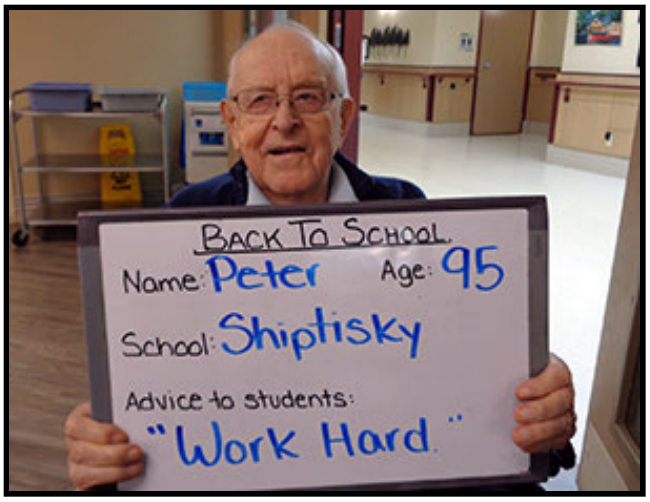
3. COVID-19 has changed many things in our lives including how we connect with those we love. Even though visits look and feel a little different we can still receive great joy and feel connected. Just saying ‘Hi’ and seeing someone can sometimes be enough but don’t hesitate to be creative with your visits.
Here are a few ideas:

- bring something with you to talk about
- have an activity to do
- have questions prepared to talk about
- bring some pictures that are blown up
- share your local travel or summer staycation news
- bring a whiteboard and play games such as x’s and o’s or hangman
- listening to music
- If on a Zoom or a Skype call, feel free to cook ‘together’ and visit while you are cooking your favorite recipe or share a tour of your own home.

CapitalCare COVID-19 status updates are posted on the COVID-19 News page.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

Activities at the Centres



School is back in session and as residents at CapitalCare Strathcona reminisced about their school days, they decided to share some advice to students returning to school this week.

CapitalCare Lynnwood brought Heritage Days to the centre celebrating everyone's heritages from around the world! Recreation made delicious food, shared great stories and listened to music from all around the world.

More photos of centre activities are on Facebook

Alberta Health Services

Greater Edmonton Health Advisory Council Engagement Event

Join us for a virtual conversation and facilitated Panel Q&A about AHS' response to Seniors Health during COVID-19 in the Greater Edmonton Area.

Thursday, September 10 @ 6:00 p.m. to 7:30 p.m.

To register, https://sept10-greater-edmonton-hac-event.eventbrite.ca

To learn more about AHS' Health Advisory Councils visit:
www.ahs.ca/advisorycouncils

Helping You Connect

CapitalCare FOUNDATION

Did you know we've partnered with Skip The Depot , a bottle collection service that will let you donate your bottle refund directly to us! Click below to learn more.

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Importance: High

Seven of seven.

Please treat as confidential.

From: Karen Dickson
Sent: September 5, 2020 8:51 AM
To: Catherine D Douglas <catherine.d.douglas@gov.ab.ca>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthadvocates.ca>
Cc: Redacted <Redacted hotmail.com>; Redacted Elliott <Redacted outlook.com>; Redacted < Redacted icloud.com>
Subject: FW: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Good Morning Janice, Redacted and Catherine.

Firstly, we want to say a heartfelt thank you from everyone here (David, Karen, Redacted Redacted Redacted and our loved ones). Below and attached are the latest communications in this tragedy that have Dickinsfield Care center still in lockdown despite the last positive 'case' being onsite over three weeks ago. Although Capital Care have not officially disclosed any reason for this, Contrary to the Provincial Health Act, Order 29-2020 (and soon Order 32-2020), we are reliably informed of the actual reason. AHS, at the direction of Deena Hinshaw and the Zone Medical Officers, are apparently too busy testing teachers and children to provide the resources to respond to Capital Care and provide the all clear! Remember this is the same asymptomatic testing that AHS has publicly declared is useless as a positive test cannot be used to infer an infection. This is nothing less than criminal and constitutes unlawful imprisonment by Capital Care, AHS and the Chief/Zone Medical officers.

We are now into a holiday weekend so even if AHS deems to give the all clear to a center that has never had a confirmed infection related to it (and never had anything other than negative tests in the residents after more than 7 separate testing rounds), they will have been locked down for almost 4 ½ weeks. During this time, some residents, such as Redacted Elliot's father and Vera's Husband over 60 years have been in isolation unable to leave their room for that time because 'he had contact with one of the asymptomatic staff members'. Mr. Elliot is a man with dementia who has suffered greatly during this outrageous behaviour by AHS et al. Redacted was unable to join us on the call but we have included her and Redacted in this email. They are part of the group of highly concerned family members we have mentioned in our other communications.

One thing to remember about all these lockdown precautions. Let's just assume all the statistics are correct that have been used to justify everything that has happened in the last 6 months. We know from AHS testing of blood samples that the virus was in Alberta **no later than November 2019**. From then until mid March 2020, **no preventative actions were taken**. The virus was freely circulating at the same or greater rate of infection (rates of infection slow over time). Do you known anyone who was sick with COVID like symptoms during that period from October to Mid March? Note that excess mortality i.e. all cause mortality from any reason was actually DOWN the world over during this time. Then, from mid November to the Lockdown, there were 8 reported deaths **with** COVID in Canada. In the next 5 months immediately after we locked down the province, there were over 9,000 reported deaths **with** COVID. This does not include all the deaths from suicide, undiagnosed cancer, delayed surgeries (resulting in the untimely death of Jerry Dunham in Medicine Hat, and many others like him). These avoidable deaths are now causing a spike in all cause mortality the world over. It is clear that the actions of AHS and the CMOH office have directly caused the deaths of many Albertans deliberately or through neglect and this is being exacerbated by the widespread increase of improper testing for an improper purpose. Speaking of Jerry Dunham, I am in direct contact with his family and they too have been

ignored by everyone. They are willing to provide all the information they have that also demonstrates the gross negligence and criminality of these lockdowns.

Effectively, even if you take the information AHS and other 'powers that be' as accurate and not overblown, it is clear that LOCKDOWNS and the protocols associated with them KILL. We have never done anything like this in history before and yet we continue to expand this insanity daily to the point that now masks are essential indoors, even for children, unless seated or eating. Does the virus know this?

Please, we implore you, get us in front of the people who can put a stop to this before more people die unnecessarily. If nothing else, Dickinsfield Care Center MUST BE OPENED IMMEDIATELY.

Many thanks,

David, Karen, Redacted Redacted Redacted , Redacted Redacted and Redacted

From: Karen Dickson
Sent: September 4, 2020 7:24 PM
To: Redacted < Redacted capitalcare.net>
Cc: Redacted < Redacted capitalcare.net>; Redacted <Redacted gmail.com>; David Dickson <david.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Hi Redacted

Thank you for your response. Sadly and predictably, it provides little in the way of transparency save to pass the responsibility for these disastrous measures on to AHS.

Dickinsfield is still deemed to be on "outbreak". This in now WEEK 4 of incredibly onerous and unmanageable restrictions for all concerned. All communications clearly state the outbreak was over on the 29th August. You have not notified anyone of any further positive tests (redundant as AHS knows they are). Yet the centre remains closed. Short of an illegal imprisonment, please provide details of why the centre is still NOT open. There is no possible way that tests would still be outstanding after this length of time. In fact, it was clear from the communication of the 27th, there were no further tests outstanding. This has to be immediately addressed.

1. Why was Dickinsfield the only centre selected for the mandated use of goggles? Again, where is the actual documentation from Public Health regarding this?
2. We have taken our concerns to AHS and further. The impacts we have discussed extensively are being seriously reviewed.
3. We will contact Redacted next week on her return. It would have been helpful to have her contact details months ago in this ongoing and most serious situation.

Order 32-2020 comes into effect on the 17th Sept. We are fully versed in the detail as it relates to all in long term care. We hope that the same will apply to all leadership in Capital Care to the benefit of residents, staff and families.

Karen and David Dickson on behalf of Redacted

From: Redacted < Redacted capitalcare.net>
Sent: Friday, September 04, 2020 2:05 PM
To: 'Karen Dickson' <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson

<david.dickson@dksdata.com>; Redacted < Redacted albertahealthservices.ca>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Hi Karen,

1. PPE– We were directed by Public Health to use googles in this outbreak , we were unsure if we would have adequate quantity for staff, hence the family request.
   More supplies did become available and we were able to supply to those who were unable to purchase goggles. We do disinfect and clean all items that are not single use.
2. Outbreak management – Direction is provided by Public Health/CDC as per CMOH orders and direction to staff is provided similarly is provided direction about when they are considered recovered. Have you contacted Alberta Health about your concerns?
3. Zone contact –Please contact Redacted , Quality Coordinator , Concerns Management AHS to discuss concerns. Redacted will be returning to work next week.

Kind regards,
Redacted

From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Wednesday, September 02, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

Redacted and Redacted

We have just checked the last communications from Capital Care (attached) and have more concerns. On the point of eyewear for PPE purposes. As per Redacted email August 24th, 2020, "All DSPs must wear a mask and safety glasses or goggles at all times while in the centre. Please bring your own safety glasses or goggles, which can be purchased in most hardware stores." we were instructed to go out and buy safety glasses/goggles. We bought multiple pairs of both as the instruction was not clear. No sooner had we done this, the instruction changed to DSP's only being allowed to wear the standard issue centre provided goggles. This was an unnecessary expense we incurred which, like so many of the measures put in place, changes without any supportable science, reasonable notification or consultation. It is also a concern that the 'goggles' provided by Capital Care are 're-used' by multiple people. **Sharing of such PPE is a serious health concern**. Further, we would like to request the documentation Capital Care Dickinsfield is relying on for the mandated use of goggles by DSP's and staff. Please provide more than the usual 'AHS says so'. If they 'say so' please provide the written communications.

Attached are the last communications from Capital Care for reference. We are now into week four of the latest "outbreak" lockdown where residents are again relegated to their rooms. This is eerily reminiscent of the last lockdown; then, at the eleventh hour of a three week lockdown for staff testing asymptomatic positive, the centre was just about to re-open when someone reported a couple of residents displaying gastric issues. At that time, we contacted the Edmonton Zone health official directly who was responsible for the extension of the lockdown. It was immediately reversed after the health official admitted that she had not checked the file and was wrong in extending the lockdown.

Based on this current "outbreak" timing, had we not achieved the opening up on the holiday weekend of August 3rd, this would have ensured that the lockdown would never had ended making this the 8th week of closure. Some residents will, in actuality, be suffering from this as they didn't manage to avail themselves of that brief window of freedom in that week. If we are now in a position where endless lockdowns leave residents in unending isolation in what can only be described as an obscene carousel of injustice, then there is no hope.

According to the last online update (September 1st), Outdoor Visitation was to resume August 31st, 2020, despite the outbreak ending two days earlier. This communication also states, misleadingly, that "We are pleased to report that across our organization, all staff and students who tested positive for COVID-19 have recovered." To our knowledge, all staff, like before, tested asymptomatic using an unreliable test that AHS states cannot be used to infer an infection. No further testing (which would be just as unreliable) has been done. Under what criteria have you made this unsupported statement that appears more designed to further ongoing fear and confusion than provide accurate information? How does someone's health status improve from asymptomatic?

According to the timing of the student last being on site (and the August 27th email from Redacted (attached)), the "outbreak" was over August 29th. There is no explanation online or in the communications for any date change. Do we presume that outdoor and offsite visits are now permitted and the outbreak is actually over? If so, the staff are not aware of this, communication at all levels being a consistent failure for all concerned, residents, staff and families. If not, please explain the circumstances which have determined yet another extension of lockdown and why this has not been officially communicated. Turnaround for testing is supposed to be 24hrs as a target, with 72hrs as a maximum under an accelerated program for long term care. We are way beyond that now.

We have repeatedly asked for the name of the Edmonton Zone Officer responsible for this latest lockdown. This has been met by comments ranging from silence to "I don't know. But I'll get back to you tomorrow" from you, Redacted Sadly, tomorrow never comes. We are more than prepared, researched and able to address those who are mandating these measures which are far more dangerous than a virus to residents and staff. You have residents and staff in this facility struggling to survive in these oppressive and appalling conditions. We have no idea how you sleep at night. As we have noted in writing many times, there will be accountability for this in the future.

We are hearing from staff overwhelmed by their working conditions. Of residents crying after seeing their family members after weeks of separation. The endless and onerous changes, all in the name of "safety" are anything but. Essential medical care is being delayed and denied. Every manner of appointment in and out of the centre is being denied. And that is before we even begin to address the social impacts, critical to the wellbeing of these vulnerable souls.

We are now hearing from family members whose loved ones no longer want to live like this. They are begging to end their life rather than continue to suffer in this never ending horror show.

For the record, this is a tragedy on a human scale like never seen before…

Please note again that you continue to insist you must follow AHS guidelines but also MUST follow Order 29-2020 (now incorporated into the PHA). As we have pointed out, the requirement to follow the PHA is a legal requirement that you and AHS continue to fail to adhere to.

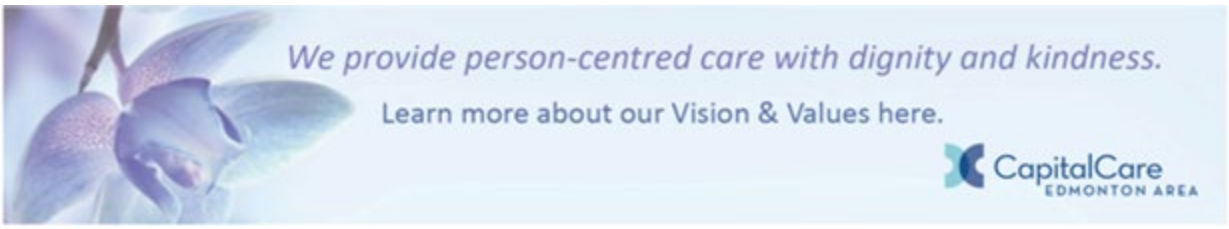
We await your full response to the above and prior unanswered emails.

Karen and David on behalf of Redacted
David T. Dickson
Consulting C.I.O.
Business/Enterprise Architect
Management/Legal Consultant
www.dksdata.com

From: Redacted < Redacted capitalcare.net>
Sent: Wednesday, August 26, 2020 11:57 AM
To: Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: RE: Response to outstanding questions - Redacted and the residents in Dickinsfield

Hello,
I have received your email. We acknowledge that we are facing many challenges as we navigate through this COVID-19 pandemic and that residents, families and staff are affected by the changes and measures we must put in place. As we make all efforts to balance resident quality of life with safety, we must follow the CMOH orders which are legislated and the Infection, Prevention and Control measures as directed during an outbreak.

Redacted Site Director|CapitalCare Dickinsfield Campus
780.371.6525



From: Karen Dickson [mailto:karen.dickson@dksdata.com]
Sent: Tuesday, August 25, 2020 8:30 AM
To: Redacted < Redacted capitalcare.net>; Redacted < Redacted capitalcare.net>
Cc: Redacted <Redacted capitalcare.net>; Janice Harrington <Janice.Harrington@albertahealthadvocates.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted Dr. < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted < Redacted albertahealthservices.ca>; Redacted <Redacted gmail.com>; DKSDATA <DKSDATA@GMAIL.COM>; David Dickson <david.dickson@dksdata.com>
Subject: Response to outstanding questions - Redacted and the residents in Dickinsfield
Importance: High

We are still waiting for the name of the MOH responsible for managing this current “outbreak” and on responses from our previous emails. Note that you had indicated the outbreak was being handled, not by a Doctor but by an AHS ‘Program Manager’. How is this appropriate considering the new and insane protocols that have now been implemented? Should you be unable to provide answers to the specific questions, we would like them to be answered by a senior member of Capital Care’s leadership team and AHS. The health and welfare of residents, staff and families is the focus of these questions and answers are imperative.

I visited Mum ([Redacted] yesterday 24th August, and she is notably despondent at what is now the third lockdown and limitation of her care needs. These lockdowns are beginning to tell on her emotionally and physically. When I saw her last week, she barely waved at me from the window, her head in her hands. It is agonizing and heartbreaking to endure. She is unable to receive her full physio program, has been denied what were weekly massages for what is now six months, (essential for mobility and pain relief since her stroke), is unable to have her hair cut and has been isolated again from her whole family for another 10 day period. Yet again, this has been from staff members taking tests and getting asymptomatic positive results which AHS, along with the rest of the scientific and health community KNOWS are so unreliable and unfit for purpose that they CANNOT be used to infer ANY infection. Note, no residents, despite six or more highly invasive rounds of testing, have come back positive. Yet many are detained and isolated in their rooms for days at a time in conditions worse than those provided to prisoners who are at least afforded an hour’s exercise a day (even when in lockdown). There will be NO END to these cycling lockdowns, imprisoning and segregating the most vulnerable. I remain at a loss as to how this qualifies as appropriate and considered risk management. I would argue vehemently that the negative impacts are far outweighing any risk from the virus.

I arrived yesterday at lunchtime and was devastated to see every resident (Mum included) at a ‘socially distanced’ table. The isolation and sadness was visible. It was awful. When these residents would be deemed cohorts, I have to ask what reason dictates they be distanced from the only source of companionship they have left? This is downright cruelty. In fact, I will boldly state this is manifestly Munchausen’s by Proxy. While in the centre, a member of staff I spoke to, like most, was wearing both a face shield and mask. She said the residents are increasingly upset and have been asking her when they are going to be taking off the masks… she noted that that was BEFORE shields/goggles have been added. It was clear from the discussion that the PPE is becoming increasingly difficult for the residents to live with. She also said the face shields are very hard to wear as the glare from them is blinding. This is a safety risk for both the staff and the residents. As David mentioned, when shields were suggested for drivers picking up residents, PPE worn like this is highly inappropriate and dangerous. I should also add, I saw one staff member in the centre with her googles in her hand. When I asked her why, if this is so serious and now required PPE, she was not wearing said equipment, her reply was that she was “taking a break” from them. The endless contradictions, inconsistencies and unmanageable protocols which are hopelessly being implemented are serving no useful purpose whatsoever. At some point, there will be an accident by their over/misuse.

When I left, Mum wanted to follow me down to the foyer. I noted to the staff member that I assumed this was not an option due to the other floors not even allowing access to people deemed low risk. I assumed that Mum would be confined to the third floor as the lower floors were more severely impacted by the lockdown, either in part or as a whole. I was told “No.. your Mum goes all over the place, wherever she wants, just not offsite.” So residents are free to roam the centre in areas where apparently asymptomatic staff have frequented and which are locked down to DSP’s but there is no risk to them? Again, I can’t begin to fathom the rationale which I believe is sadly lacking at best and non-existent at worst.

The endless paradoxes serve only to cast doubt on the entire handling of COVID19 and all its insane and contradictory measures not supported by ANY science. As it relates to care centres, almost everything that has been done has put residents in danger of more serious injury, illness and death way beyond anything this ILI could have posed.

I still can’t believe what we are documenting as the new “best practice”. These measures guarantee chaos, a negative result and are devastating.

From the email yesterday, it looks like you have now opened all of Floor 2 but Main is still closed. I would like to know why. The email on Friday noted that only Floor 3 and part of Floor 2 would be opening. What changed over the week-end between these two emails?

What both saddens and angers me the most is that you will likely take none of the human tragedy of this email on board. Instead, you will hone in on staff comments for “correction”. You will dismiss what is of ultimate importance, the health and welfare of your residents and staff. We are living in a time of dictatorship from the top, where true care for those most vulnerable has been abandoned in favour of a ruthless regime, the sole focus of which is a perfectly treatable virus. No one in a senior position can ignore this and simply say they are following orders without question. I do know though that at some point, the growing weight of evidence as it relates to the care home response will bear witness to an unmitigated tragedy and those responsible or complicit will be held to account.

I would appreciate a reply at your earliest convenience.

Karen

David & Karen Dickson

Attachments

CapitalCare Update -September 4, 2020

CapitalCare EDMONTON AREA

September 4, 2020

Dear CapitalCare Residents and Families:

We are pleased to report that currently there are no confirmed cases of COVID-19 at any of our centres.

Centre updates

CapitalCare Norwood is no longer under investigation with enhanced surveillance. Visitation continues and admissions are occurring.

Visitation for designated support persons (DSPs) has resumed at **CapitalCare Dickinsfield**. As a DSP, you must remain in the room of your resident while visiting.

At **CapitalCare Strathcona,** pre-arranged indoor and outdoor visitation at all three houses (Heritage, Harvest, and Laurier) has resumed.

The YMCA day care at the **Kipnes Centre for Veterans (KCV)** has opened again. Updates have been made to the program space to ensure that the day care functions completely independent of the KCV centre. The day care has a separate entrance from the rest of the building and inter-generational activities are on hold at this time.

Visitation Update: Quick tips to make the most of your visits

1. Before coming in for a visit, check the “Centres” page on the CapitalCare website. This page provides the most up-to-date information about visitation at your centre.

2. To make visits safer for everyone, avoid creating congestion at the front entrance or screening station.

- Keep a distance of at least 6 feet (about 2 arms’ length) from other people waiting to enter the building or be screened, and
- If possible, wait in your car and do not enter the building until you can comfortably practice physical distancing at the front entrance or screening station.

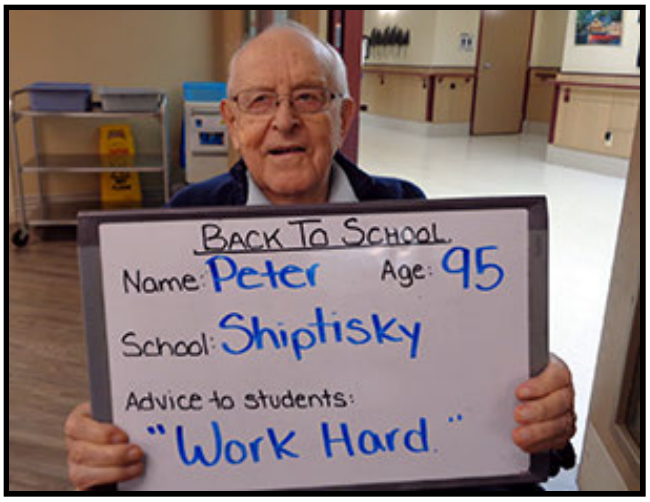
3. COVID-19 has changed many things in our lives including how we connect with those we love. Even though visits look and feel a little different we can still receive great joy and feel connected. Just saying ‘Hi’ and seeing someone can sometimes be enough but don’t hesitate to be creative with your visits.
Here are a few ideas:

- bring something with you to talk about
- have an activity to do
- have questions prepared to talk about
- bring some pictures that are blown up
- share your local travel or summer staycation news
- bring a whiteboard and play games such as x’s and o’s or hangman
- listening to music
- If on a Zoom or a Skype call, feel free to cook ‘together’ and visit while you are cooking your favorite recipe or share a tour of your own home.

CapitalCare COVID-19 status updates are posted on the COVID-19 News page.

For current Alberta case count and additional case information, please visit Alberta.ca/Covid19.

Activities at the Centres



School is back in session and as residents at CapitalCare Strathcona reminisced about their school days, they decided to share some advice to students returning to school this week.

CapitalCare Lynnwood brought Heritage Days to the centre celebrating everyone's heritages from around the world! Recreation made delicious food, shared great stories and listened to music from all around the world.

More photos of centre activities are on Facebook

Alberta Health Services

Greater Edmonton Health Advisory Council Engagement Event

Join us for a virtual conversation and facilitated Panel Q&A about AHS' response to Seniors Health during COVID-19 in the Greater Edmonton Area.

Thursday, September 10 @ 6:00 p.m. to 7:30 p.m.

To register, https://sept10-greater-edmonton-hac-event.eventbrite.ca

To learn more about AHS' Health Advisory Councils visit:
www.ahs.ca/advisorycouncils

Helping You Connect

CapitalCare FOUNDATION

Did you know we've partnered with Skip The Depot , a bottle collection service that will let you donate your bottle refund directly to us! Click below to learn more.

SKIP THE DEPOT

The **Hearts for Healthcare** window decals are really making a difference. Send your messages in and give CapitalCare staff virtual gratitude through your inspiring messages!

SEND A HEART

Make a connection by sending a positive message to a resident living at CapitalCare Centres. Choose a postcard templates to send a special message.

SEND A POSTCARD

GET SOCIAL WITH US:

From: Danielle Smith < Redacted gmail.com>
Sent: Sunday, September 6, 2020 8:03 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: Re: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

I think you need to send this to the Justice Centre for Constitutional Freedom. They have taken on access cases in Ontario (I've seen several press releases) but I've not seen a case here. Maybe you could start one.
If it matters, I agree with your analysis of the risk.
It is clear COVID is more deadly to frail elderly people in care. But being imprisoned without human contact is equally deadly.
Let me know how it turns out.
Danielle

Sent from my iPhone

On Sep 5, 2020, at 9:33 AM, David Dickson <david.dickson@dksdata.com> wrote:

Two of seven.

Please treat as confidential.

From: David Dickson
Sent: August 12, 2020 10:46 AM
To: Dane.Lloyd@parl.gc.ca; SpruceGrove.StonyPlain@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca
Cc: Ziad.Aboultaif@parl.gc.ca; Scott.Aitchison@parl.gc.ca; Dan.Albas@parl.gc.ca; Omar.Alghabra@parl.gc.ca; Leona.Alleslev@parl.gc.ca; Dean.Allison@parl.gc.ca; William.Amos@parl.gc.ca; Anita.Anand@parl.gc.ca; Gary.Anandasangaree@parl.gc.ca; Charlie.Angus@parl.gc.ca; Mel.Arnold@parl.gc.ca; René.Arseneault@parl.gc.ca; Chandra.Arya@parl.gc.ca; Niki.Ashton@parl.gc.ca; Jenica.Atwin@parl.gc.ca; Taylor.Bachrach@parl.gc.ca; Vance.Badawey@parl.gc.ca; Larry.Bagnell@parl.gc.ca; Navdeep.Bains@parl.gc.ca; Yvan.Baker@parl.gc.ca; Tony.Baldinelli@parl.gc.ca; John.Barlow@parl.gc.ca; Michael.Barrett@parl.gc.ca; Xavier.Barsalou-Duval@parl.gc.ca; Jaime.Battiste@parl.gc.ca; Mario.Beaulieu@parl.gc.ca; Terry.Beech@parl.gc.ca; Rachel.Bendayan@parl.gc.ca; Carolyn.Bennett@parl.gc.ca; Bob.Benzen@parl.gc.ca; Candice.Bergen@parl.gc.ca; Stéphane.Bergeron@parl.gc.ca; Luc.Berthold@parl.gc.ca; Sylvie.Bérubé@parl.gc.ca; Lyne.Bessette@parl.gc.ca; James.Bezan@parl.gc.ca; Marie-Claude.Bibeau@parl.gc.ca; Chris.Bittle@parl.gc.ca; Daniel.Blaikie@parl.gc.ca; Bill.Blair@parl.gc.ca; Yves-François.Blanchet@parl.gc.ca; Maxime.Blanchette-Joncas@parl.gc.ca; Rachel.Blaney@parl.gc.ca; Steven.Blaney@parl.gc.ca; Kelly.Block@parl.gc.ca; Kody.Blois@parl.gc.ca; Michel.Boudrias@parl.gc.ca; Alexandre.Boulerice@parl.gc.ca; Richard.Bragdon@parl.gc.ca; John.Brassard@parl.gc.ca; Bob.Bratina@parl.gc.ca; Élisabeth.Brière@parl.gc.ca; Alexis.Brunelle-Duceppe@parl.gc.ca; Blaine.Calkins@parl.gc.ca; Richard.Cannings@parl.gc.ca; Jim.Carr@parl.gc.ca; Colin.Carrie@parl.gc.ca; Sean.Casey@parl.gc.ca; Louise.Chabot@parl.gc.ca; Bardish.Chagger@parl.gc.ca; François-Philippe.Champagne@parl.gc.ca; Martin.Champoux@parl.gc.ca; Louise.Charbonneau@parl.gc.ca; Shaun.Chen@parl.gc.ca; Kenny.Chiu@parl.gc.ca; Michael.Chong@parl.gc.ca; Laurel.Collins@parl.gc.ca; Michael.Cooper@parl.gc.ca; Serge.Cormier@parl.gc.ca; James.Cumming@parl.gc.ca; Julie.Dabrusin@parl.gc.ca; Marc.Dalton@parl.gc.ca; Pam.Damoff@parl.gc.ca; Raquel.Dancho@parl.gc.ca; Scot.Davidson@parl.gc.ca; Don.Davies@parl.gc.ca; Claude.DeBellefeuille@parl.gc.ca; Gérard.Deltell@parl.gc.ca; Chris.d'Entremont@parl.gc.ca; Caroline.Desbiens@parl.gc.ca; Luc.Desilets@parl.gc.ca; Sukh.Dhaliwal@parl.gc.ca; Anju.Dhillon@parl.gc.ca; Kerry.Diotte@parl.gc.ca; Todd.Doherty@parl.gc.ca; Han.Dong@parl.gc.ca; Terry.Dowdall@parl.gc.ca; Earl.Dreeshen@parl.gc.ca; Francis.Drouin@parl.gc.ca; Emmanuel.Dubourg@parl.gc.ca; Redacted Yves.Duclos@parl.gc.ca; Terry.Duguid@parl.gc.ca; Eric.Duncan@parl.gc.ca; Kirsty.Duncan@parl.gc.ca; Scott.Duvall@parl.gc.ca; Julie.Dzerowicz@parl.gc.ca; Wayne.Easter@parl.gc.ca; Ali.Ehsassi@parl.gc.ca; Fayçal.El-Khoury@parl.gc.ca; Neil.Ellis@parl.gc.ca; Dave.Epp@parl.gc.ca; Nathaniel.Erskine-Smith@parl.gc.ca; Rosemarie.Falk@parl.gc.ca; Ted.Falk@parl.gc.ca; Ed.Fast@parl.gc.ca; Greg.Fergus@parl.gc.ca;

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Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Thank you yet again Dane for another 'pass the buck' response, dismissing the concerns of your constituents. I have now included the MLA's as you suggested. I also added in all the MP's as this is a local, provincial and federal matter as regards Long Term Care. Maybe one of them, unlike you, has the moral fortitude to step up and do more than send out lip service emails. I know they have been talking at caucus about the items in my research for many months but are continually shut down by our Premier and Deena Hinshaw.

Please note, the issues raised here are happening everywhere in Canada as you well know and concede in your email. That makes this a FEDERAL ISSUE, not just a provincial one.

The boilerplate response again about treatments and testing is getting tiring. You really should get another script or have someone actually read the research. To do any less is nothing less than gross negligence. "caring [sic] out testing

with clinically and scientifically proven methods" (or even carrying) is completely incorrect. As indicted below, the testing is widely inaccurate and unfit for purpose. This has even been admitted on camera by Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health on July 31st, 2020. (https://youtu.be/bbwMo7IbXbw). Long Term Care Centers are being shut across the country for isolated asymptomatic voluntary tests in a sea of negative results i.e. where there is no COVID. Why is this not something you are raising in Parliament and beyond? Is that not a FEDERAL MATTER?

Maybe even talk to Doctors who are being threatened daily for trying to treat cases early instead of forcing patients into isolation to get too sick to treat. Maybe you could look into where all millions of FEDERALLY donated doses of Hydroxychloroquine have gone? If it doesn't work, why have all the governments stock piled these donations? That is an actual FEDERAL matter!

On long term care facilities, our mother has been in this one for 10 years without incident. It is not the facility that is the issue but the protocols handed down from Dr Tam and the Federal Government that have been adopted in lockstep across each province. That again IS A FEDERAL MATTER.

So, on the FEDERAL MATTERS, what are you doing? What have you done? What questions have you asked since I provided the material that was of FEDERAL INTEREST?

How many more will die on your watch while you regurgitate this government approved drivel?

And yes we are mad at your lack of response. We voted for you and we WILL hold you accountable. Note that these comments are not just those of two sole voters but of a growing number in Alberta and beyond who are disgusted by responses such as this.

David

David T. Dickson
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<image001.jpg>

<image002.jpg>

From: Dane.Lloyd@parl.gc.ca <Dane.Lloyd@parl.gc.ca>
Sent: August 12, 2020 9:30 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

Dear Mr. Dickson,

Thank you for reaching out.

We receive hundreds of emails a day so it can take more than a week to receive a reply.

Testing for COVID-19 and quarantine procedures in the province of Alberta falls under the jurisdiction of the provincial government. As, the federal government representative I do not have a say of influence in their procedures and methods. As I stated in a previous email to you, public health officials are caring out testing with clinically and scientifically proven methods. If you would like to discuss the Alberta operating procedures I would encourage you to reach out to your MLA. If your require assistance in determining who that is my staff would be more than happy to assist you.

There are some opinions out which are exceptionally critical regarding the treatment of COVID-19; many of these statements have not been proven in a scientific or peer reviewed manner so we cannot operate of these assumptions until they have been thoroughly proven. IT is the responsibility of all government officials to ensure the health and safety of its citizens. Other treatment and testing options and research projects are being funded by the federal government, but this research doesn't happen overnight. As research progresses we will have a deeper understanding of COVID-19 and be able to expand our treatment options and procedures.

With regards to long-term care facilities, this is a very serious matter. It would be a very stressful situation for you to have a family member residing in a care facility during this time.

It is unfortunate that it took a pandemic to bring to light some of the appalling conditions that seniors and those who require specialized care had been living in. I find it disturbing that the situation got so bad that the military was called in to take-over the operations of these facilities. The entire experience is completely unacceptable, and it must be addresses in a swift manner.

The oversight of long-term care facilities in Canada mainly falls under the jurisdiction of the provincial governments, however, I do believe that there is a place for the federal government. We need to work together to form guiding principles which will create a system that provides safe and reliable care of some of our country's most vulnerable.

I also whole-heartedly support a joint federal and provincial investigation into the state of long-term care facilities across the country. I feel that this type of investigation is necessary for us to fully understand where the issues lie and where services need to be improved.

Any governments primary responsibility, be it federal or provincial, is to ensure the health and safety of all Canadians. In this situation, all levels of government failed these vulnerable persons and we need to ensure that a catastrophe like this never happens again. I would encourage you to reach out to your MLA to discuss this matter further as well.

Once again, thank you for taking the time to reach out and discuss this very serious matter and please feel free to contact me in the future.

Kind regards,

Dane Lloyd, M.P.
Sturgeon River – Parkland

From: David Dickson <david.dickson@dksdata.com>
Sent: August 11, 2020 7:00 PM
To: Lloyd, Dane - M.P. <Dane.Lloyd@parl.gc.ca>; janice.harrington@albertahealthadvocates.ca; Motz, Glen - M.P. <Glen.Motz@parl.gc.ca>; Sloan, Derek - M.P. <Derek.Sloan@parl.gc.ca>; Diotte, Kerry - M.P. <Kerry.Diotte@parl.gc.ca>
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

To all above and all your colleagues,

It has now been almost a week and not a single response from our member of Parliament (Dane Lloyd) or the two other members of Parliament included below who have been contacted on multiple occasions. Also, no response from the Alberta Health Advocate who is also aware of the many concerns regarding the handling of the below and the larger matter around the COVID response by the Alberta Government.

Today we were informed of another staff created outbreak at Capital Care Dickinsfield (CCD) putting this facility on another 2 week "outbreak" and subjecting the residents to a fourth (and who known how many more) high risk and questionable RC-PCR testing. Note that the same exact fact pattern as in our complaint below was used to extend another Capital Care facility (sudden gastric issues in residents on the day the lockdown should end). How many coincidences make a pattern? Now we assume this latest lockdown at CCD will be under the same incompetent management as before putting the health of residents in further jeopardy. As days pass, it is hard to believe that these processes are not designed to actually hurry along the deaths of these most precious members of society.

You ALL have a duty of care to the citizens of Alberta and none more so than the residents in long term care. Protocols put in place by Deena Hinshaw which have never been enacted before are responsible for avoidable deaths far outnumbering those from this virus. Your inaction is actively contributing to this. You may well remember Jerry Dunham who died unnecessarily in Medicine Hat. I am currently in contact with his family. Avoidable deaths will soon be front and centre, leaving deaths from this virus in the distance. It is a duty of office to ensure accountability and responsibility for actions taken which have life changing consequences for so many on a scale never witnessed before in history.

At what point will you come out of the shadows and stand up for the citizens of this province? There are Albertans dying due to these barbaric and unquestioned protocols that have no scientific basis whatsoever. People are terrified everyday with growing 'cases' but there is no mention that almost all are voluntary asymptomatic tests that have no value other than the fear mongering factor for the daily updates. Speaking of 'Cases' again. This short video explains how cases were being used to manipulate the public in March. Here we go yet again. https://youtu.be/dLWwSYTjiBA

Note that the current rate of positive tests ('Cases') is 1.85% of all tested. The number of reported deaths per test in the province is 0.0337%. False positive error rates are confirmed to be up to 50% putting the number of positive cases as within the margin of error of zero. Tests, even serology tests, can come back positive months after any infection has passed. Deaths are marked as COVID no matter the true cause. This, along with all the facts used to petrify the population, is not even being hidden. Yet it is ignored by ALL of you. Why is that?

At no time in history (since Nuremburg) have we been subject to experiments in public health at this level. Isolation/quarantine of healthy individuals removes, indeed negates, all human rights and restricts access to required health care (mental and physical) that has already resulted in many avoidable deaths. Many more will follow if this continues without challenge. The public is told that known treatments are either dangerous or don't work, when doctors are told that the real reason for withholding treatment is a lack of medication availability. Yet at the same time over 4 million doses of HCQ in Canada alone have been donated by the manufacturers specifically for COVID treatment. Where did those doses of medication go? Worldwide, this number of donated doses of medication exceeds 250 million. More than enough to have treated every person who has died multiple times over. Yet the treatment would have been useless as Deena Hinshaw and AHS deliberately force people to stay home until too sick to be treated properly. Then patients quite literally gasping their last, are consigned to the deadly ventilator after a mere 5 litres of O2 (10 in the Misericordia). No BPAP machine in hospitals was offered for fear of aerosolising the virus (despite protocols available in every hospital for MRSA patients that would negate that risk). Yet CPAP machines are still in use by paramedics in ambulances… I guess their lives are not worth as much as nurses and doctors… or is it something else? My own cardio thoracic surgeon assured me that this barbaric procedure would never happen in Alberta and certainly not in his hospital. He said it only happened for a short time in NY and Italy and no Doctor would ever do this here. Then I pointed out Dr. Darren Markland's tweets boasting about the use of ventilators for people with a respiratory disease. My doctor has not spoken to me since. Why is that?

I have spoken to doctors and nurses in Alberta who have been threatened to keep them quiet. People have died as a result. How is this not under investigation? And all this time, the prerequisite report that Deena Hinshaw quotes on all

her Orders as justification for everything that has transpired from the initial lockdown on is yet to be produced to the citizens of this Province. Why is that?

To Glen Motz (Retired Medicine Hat Senior Police Officer), Derek Sloan (Candidate for Leadership), Dane Lloyd, (Member of Parliament for my family and I here in Spruce Grove), and Janice Harrington, (Alberta Health Patient Advocate), we are adding onto this list… Kerry Diotte, (member for Edmonton Griesbach), the area covered by Dickinsfield Long Term Care facility where our mother is currently incarcerated once more… it is time for you to do something and question what is really happening here. As we move back to hearing about cases, just like at the beginning in March, how many of these are from the voluntary asymptomatic testing and how many are 'spontaneous' with no apparent cause or subsequent case?

Consider that all the 'cases' related to Dickinsfield were staff members, not residents. In the Southside Good Samaritan's Care Centre in Edmonton we have 67 cases (26 deaths) in residents and 19 cases in staff. All carers were wearing full PPE at all times and following strict protocols. All of the deaths are in those over 70 years with multiple life threatening co-morbidities. In fact, we have not had a reported death 'with' not 'of' COVID under the age of 70 since April 23rd, 2020. Yet we now require children over the age of 2 to be forced into masks in most cities. I have arrested people during my time as a police officer for less abusive behaviour to children. Yet now we follow the order of politicians who have admitted the decision was rendered based on a survey of 6,000 citizens where 51% opted for mandatory masks. This is nothing less than gross negligence on the part of politicians, police and health professionals.

As with every case in this self described 'most deadly virus in the history of the world', AHS forces people to stay home until the symptoms get too serious for any useful treatment protocols. When did we ever do that before? Are we actually trying to kill people? Where has all common sense gone? Note that compared to SARS and MERS, this mortality of this virus is not even close to the hype it has been given, even assuming the statistics were even close to true. Compared to TB, Ebola and other contagious viruses, it hardly registers at all. In fact, in March of 2020, the UK specifically dropped COVID from being listed as a Highly Contagious Infectious Disease because it was not deadly enough! Yet Canada and Alberta locked down anyway and continue to expand measures that become more bizarre by the day. It appears that Deena Hinshaw and the Government are trying to test the intelligence of people and continue to be surprised at how compliant these citizens will be no matter what they are asked to do.

Note, the average age of a person dying 'with' not 'of' COVID in the province is 83 as of today. Last week it went up to 84 years just for a week. The average life expectancy in the province is 81. Denna Hinshaw has even used the death of a 105 year old with more than three life threatening co-morbidities as a COVID death statistic to justify her actions. Although any death is sad, the most surprising part of the death of a 105 year old right now is the fact that they were 105!

Due to the inane, insane and immoral protocols under the direction of Deena Hinshaw et al, many Albertans have died on intubated ventilators which have NEVER been used for the treatment of a respiratory disease before - for good reason. Ventilators misused in this way are known to cause significant lung damage and death even in those with healthy lungs. How do I know? It happened to me, as Glen Motz is well aware from when I worked with him on the largest Police Project ever undertaken in this province.

As regards this and more, I am attaching my research AGAIN for Mr. Diotte and as a reminder to those who have already had it. Maybe now some of this will resonate more clearly with recent events. It should be noted that most of you have had my research for months, some without even an acknowledgement let alone a response.

This government and Deena Hinshaw never were competent to manage any health crisis. It is clear that their actions have resulted in the deaths of many Albertans and so much more besides. For anyone continuing to ignore this and hide behind politics, in the words of Dante Alighieri "The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

I hope one or more will take up the mantel for the sake of us all. Please contact me for further information. Note that all I have presented is verifiable, been peer reviewed by colleagues and other professionals worldwide along with those

here at home in Alberta. There is so much more to this story. It is way beyond time to start asking questions rather than blindly following 'Orders'.

David

David T. Dickson
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Email: *david.dickson@dksdata.com*
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<image002.jpg>

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: August 5, 2020 9:20 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>; Derek.Sloan@parl.gc.ca; Dane.Lloyd@parl.gc.ca; health.deputy-minister@gov.ab.ca; info@albertahealthadvocates.ca; Glen.Motz@parl.gc.ca; premier@gov.ab.ca
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; deena.hinshaw@ahs.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Dr. Redacted

The fact that you consider this was a matter for your sole attention, dismissing all others on the email, is indicative of the reason for the complaint. Add to that the fact that you appear to consider it so minor an irritation to you that you can swat it off as a patient complaint to be lost while the chaos under your direction continues, boggles the mind. I assure you that the residents and families do not consider this matter so irrelevant to be dismissed out of hand. Further, as you are well aware, the AHS patient relations department is absolutely not equipped to address such concerns.

The gravity of these concerns warrants more than a summary dismissal by the person who is the very subject of the concerns. This is even more concerning as the actions are indictive of violations of the health act.

I would appreciate some response from the Members of Parliament, Health Advocate's Office, Premiers Office, Health Minister and the office of the CMO, all of whom are included in this email and are directly responsible for the lives of Albertans impacted by this behavior.

David

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C.E.O. DKS DATA (www.dksdata.com**)**
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Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Redacted albertahealthservices.ca
To: david.dickson@dksdata.com, deena.hinshaw@gov.ab.ca, janice.harrington@albertahealthadvocates.ca, jason.kenney@gov.ab.ca
CC: dane.lloyd@parl.gc.ca, derek.sloan@parl.gc.ca, dksdata@gmail.com, glen.motz@parl.gc.ca, health.deputy-minister@gov.ab.ca, info@albertahealthadvocates.ca, karen.dickson@dksdata.com, premier@gov.ab.ca
Sent: Thursday, August 06, 2020 12:52:36 AM (GMT)
Subject: RE: RE: Visitation for Redacted

Mr. and Mrs. Dickson,

I regret to hear that you are not satisfied with the management of the Capital Care Dickinsfield outbreak and discussions with our AHS team were not able to resolve your concerns.

If you wish to request further investigation into these concerns, please contact our AHS Patient Relations Department: https://www.albertahealthservices.ca/about/patientfeedback.aspx

•Telephone: 1-855-550-2555
•Fax:1-877-871-4340
•Mailing address only:
c/o Patient Relations
10030 107 Street NW, Edmonton, AB T5J 3E4

Sincerely,

Dr. G. Redacted MD MSc FRCPC
Medical Officer of Health
Alberta Health Services – Edmonton Zone

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted

< Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> Redacted *thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*
>
> *Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf*
>
> *"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a **confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether**. "*
>
> *As per Redacted previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
> *Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.*

I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.

Thank you,

Dr. G. Redacted *MD MSc FRCPC*
Medical Officer of Health
Alberta Health Services – Edmonton Zone"

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.
    - Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.
- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**
        - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
    - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
    - When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order *"In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

> *"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."*
>
> *"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."*

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

> *"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."*

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is

now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275

residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

<image003.png>
We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

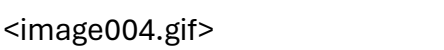
David & Karen Dickson

David T. Dickson
C.E.O. DKS DATA ***(***www.dksdata.com***)***
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>

Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential



You have received an email message secured by Private Post. Please open the file called Encrypted_Message.htm to read the message.

Mobile device users:
Forward this email to m@zd.trendmicro.com and receive URLs to view the message on mobile devices.

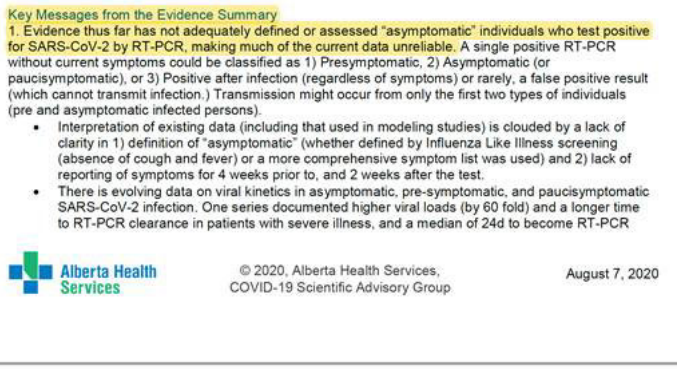
<A_SARS-COV-2-PrePrint.pdf>

From: David Dickson
Sent: Sunday, September 6, 2020 2:01 PM
To: Danielle Smith < Redacted gmail.com>
Subject: RE: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

Thanks for your response, Danielle.

As you can see from all I have sent, I have exhausted every avenue currently available to me. I hoped, based on what you talk about daily and how this impacts your fellow Albertans, you would be interested in pursuing this to shine some sunlight on this tragedy.

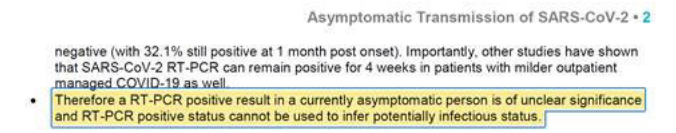
It might be time to consider why the RT-PCR tests being pushed at such a ferocious and irrational level when they are known to be useless. AHS themselves state in their own guidelines that these tests "CANNOT BE USED TO INFER **POTENTIALLY** INFECTIOUS STATUS". They don't even consider it valid as a presumption, let alone a confirmation! That test, known to have no value due to the large number of false positives, is being used to drive 'Cases'. These cases are being used to close businesses, care homes and destroy lives.
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-sag-asymptomatic-transmission-rapid-review.pdf



Key Messages from the Evidence Summary

1. Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable. A single positive RT-PCR without current symptoms could be classified as 1) Presymptomatic, 2) Asymptomatic (or paucisymptomatic), or 3) Positive after infection (regardless of symptoms) or rarely, a false positive result (which cannot transmit infection.) Transmission might occur from only the first two types of individuals (pre and asymptomatic infected persons).
   - Interpretation of existing data (including that used in modeling studies) is clouded by a lack of clarity in 1) definition of "asymptomatic" (whether defined by Influenza Like Illness screening (absence of cough and fever) or a more comprehensive symptom list was used) and 2) lack of reporting of symptoms for 4 weeks prior to, and 2 weeks after the test.
   - There is evolving data on viral kinetics in asymptomatic, pre-symptomatic, and paucisymptomatic SARS-CoV-2 infection. One series documented higher viral loads (by 60 fold) and a longer time to RT-PCR clearance in patients with severe illness, and a median of 24d to become RT-PCR

Alberta Health Services © 2020, Alberta Health Services, COVID-19 Scientific Advisory Group August 7, 2020



Asymptomatic Transmission of SARS-CoV-2 • 2

negative (with 32.1% still positive at 1 month post onset). Importantly, other studies have shown that SARS-CoV-2 RT-PCR can remain positive for 4 weeks in patients with milder outpatient managed COVID-19 as well.

- Therefore a RT-PCR positive result in a currently asymptomatic person is of unclear significance and RT-PCR positive status cannot be used to infer potentially infectious status.

These 'Cases' are also the criteria that drive the three levels of control on you, me and all other Albertans.
https://www.alberta.ca/maps/covid-19-status-map.htm

> ***"Open***
> *low level of risk, no additional restrictions in place* ***less than 50*** *active cases per 100,000*
> ***Watch***
> *the province is monitoring the risk and discussing with local government(s) and other community leaders the possible need for additional health measures at least 10 active cases and* ***more than 50 active cases per 100,000***
> ***Enhanced***
> *risk levels require enhanced public health measures to control the spread informed by local context"*

Due to the lack of follow up and automatic assumption that any symptom of COVID can only be COVID, we will see very few Flu cases this season as everything is assumed to be COVID. Unlike Flu, the protocol for COVID is to isolate and ignore. How many more will die of untreated bacterial pneumonia, PE (lung blood clot) and more due to this deliberate misdiagnosis in the coming months?

As we enter flu season, you might want to consider what is going to happen. We will enter a full lockdown unlike any we

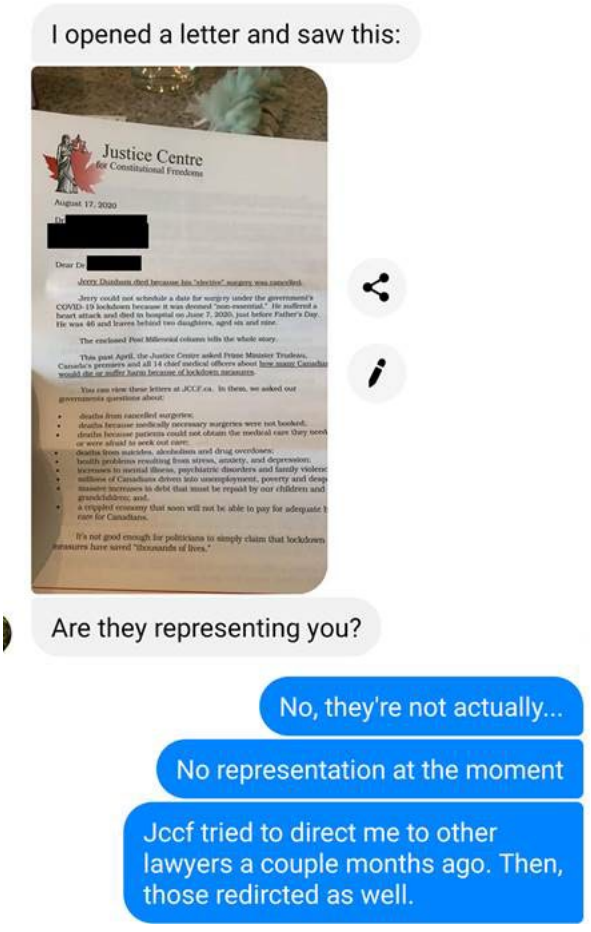
have seen to date. This will be enforced and the Government has made preparations for this. Why will they move us into lockdown? On top of the 50 or so per 100,000 false positives driven by the expansion of the testing program (as part of a deal to have Loblaws enforce masks on all their properties) we will have the usual 'Case' load of Flu. That ranges from 179 to 215 per 100,000 in the last few years (even with a vaccine that has been around for over a decade). Add that to the 50 PCR COVID 'Cases' and we are over 5 times that for a 'Watch' in Alberta. Think this government won't use this fear mongering to lock down the population? I know you know better than that.

(see page 3)
https://open.alberta.ca/dataset/9044e65d-a97e-43cb-8357-9c890422f069/resource/dcd1cc27-57c2-4cf4-8078-3869f19b6390/download/health-influenza-summary-report-2018-2019.pdf

Finally, I would suggest not promoting the JCCF. Unlike lawyers such as Redacted they are not what they promote. I have contacted them a number of times about this issue and the response is a joke (only not a funny one) – See attached.

They took Jerry Dunham's story and used it for fund raising, without telling the family. Their response to Jerry's partner and family was 'we can't help you'. Know how they found out about it? This is a message she shared with me in the last couple of weeks.

This is an ethical breach bordering on criminal (obtaining money by deception). I am doing what I can to help Krista and Jerry's children through this trying time for them… but again no-one seems to care. Note the Dr. who received this request for donations under false pretences was shocked to say the least, but not as much as poor Krista was.



I would like to think you would want to make a difference and hopefully by having this additional context, you will. You are a voice for Albertans right now and can reach the 'powers that be' in a way others cannot.

I can be reached anytime and will do whatever I can to get this story out. Again, a plea for help from the people in Care Homes and those dying and dead due to the avoidable atrocities this government has forced upon us with no actual scientific evidence to back up their actions.

Thanks,

David

David T. Dickson
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Privacy and Cybersecurity Expert.
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Fax: Redacted
Email: *david.dickson@dksdata.com*

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: Danielle Smith < Redacted gmail.com>
Sent: September 6, 2020 8:03 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: Re: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

I think you need to send this to the Justice Centre for Constitutional Freedom. They have taken on access cases in Ontario (I've seen several press releases) but I've not seen a case here. Maybe you could start one.
If it matters, I agree with your analysis of the risk.
It is clear COVID is more deadly to frail elderly people in care. But being imprisoned without human contact is equally deadly.
Let me know how it turns out.
Danielle

Sent from my iPhone

On Sep 5, 2020, at 9:33 AM, David Dickson <david.dickson@dksdata.com> wrote:

Two of seven.

Please treat as confidential.

From: David Dickson
Sent: August 12, 2020 10:46 AM
To: Dane.Lloyd@parl.gc.ca; SpruceGrove.StonyPlain@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca
Cc: Ziad.Aboultaif@parl.gc.ca; Scott.Aitchison@parl.gc.ca; Dan.Albas@parl.gc.ca; Omar.Alghabra@parl.gc.ca; Leona.Alleslev@parl.gc.ca; Dean.Allison@parl.gc.ca; William.Amos@parl.gc.ca; Anita.Anand@parl.gc.ca; Gary.Anandasangaree@parl.gc.ca; Charlie.Angus@parl.gc.ca; Mel.Arnold@parl.gc.ca; René.Arseneault@parl.gc.ca; Chandra.Arya@parl.gc.ca; Niki.Ashton@parl.gc.ca; Jenica.Atwin@parl.gc.ca; Taylor.Bachrach@parl.gc.ca; Vance.Badawey@parl.gc.ca; Larry.Bagnell@parl.gc.ca; Navdeep.Bains@parl.gc.ca; Yvan.Baker@parl.gc.ca; Tony.Baldinelli@parl.gc.ca; John.Barlow@parl.gc.ca; Michael.Barrett@parl.gc.ca; Xavier.Barsalou-Duval@parl.gc.ca; Jaime.Battiste@parl.gc.ca; Mario.Beaulieu@parl.gc.ca; Terry.Beech@parl.gc.ca; Rachel.Bendayan@parl.gc.ca; Carolyn.Bennett@parl.gc.ca; Bob.Benzen@parl.gc.ca; Candice.Bergen@parl.gc.ca; Stéphane.Bergeron@parl.gc.ca; Luc.Berthold@parl.gc.ca; Sylvie.Bérubé@parl.gc.ca; Lyne.Bessette@parl.gc.ca; James.Bezan@parl.gc.ca; Marie-Claude.Bibeau@parl.gc.ca; Chris.Bittle@parl.gc.ca; Daniel.Blaikie@parl.gc.ca; Bill.Blair@parl.gc.ca; Yves-François.Blanchet@parl.gc.ca; Maxime.Blanchette-Joncas@parl.gc.ca; Rachel.Blaney@parl.gc.ca; Steven.Blaney@parl.gc.ca; Kelly.Block@parl.gc.ca; Kody.Blois@parl.gc.ca; Michel.Boudrias@parl.gc.ca; Alexandre.Boulerice@parl.gc.ca; Richard.Bragdon@parl.gc.ca; John.Brassard@parl.gc.ca; Bob.Bratina@parl.gc.ca; Élisabeth.Brière@parl.gc.ca; Alexis.Brunelle-Duceppe@parl.gc.ca; Blaine.Calkins@parl.gc.ca; Richard.Cannings@parl.gc.ca; Jim.Carr@parl.gc.ca; Colin.Carrie@parl.gc.ca; Sean.Casey@parl.gc.ca; Louise.Chabot@parl.gc.ca; Bardish.Chagger@parl.gc.ca; François-Philippe.Champagne@parl.gc.ca; Martin.Champoux@parl.gc.ca; Louise.Charbonneau@parl.gc.ca; Shaun.Chen@parl.gc.ca; Kenny.Chiu@parl.gc.ca; Michael.Chong@parl.gc.ca; Laurel.Collins@parl.gc.ca; Michael.Cooper@parl.gc.ca; Serge.Cormier@parl.gc.ca; James.Cumming@parl.gc.ca; Julie.Dabrusin@parl.gc.ca; Marc.Dalton@parl.gc.ca; Pam.Damoff@parl.gc.ca; Raquel.Dancho@parl.gc.ca; Scot.Davidson@parl.gc.ca; Don.Davies@parl.gc.ca; Claude.DeBellefeuille@parl.gc.ca; Gérard.Deltell@parl.gc.ca; Chris.d'Entremont@parl.gc.ca; Caroline.Desbiens@parl.gc.ca; Luc.Desilets@parl.gc.ca; Sukh.Dhaliwal@parl.gc.ca; Anju.Dhillon@parl.gc.ca; Kerry.Diotte@parl.gc.ca; Todd.Doherty@parl.gc.ca; Han.Dong@parl.gc.ca; Terry.Dowdall@parl.gc.ca; Earl.Dreeshen@parl.gc.ca; Francis.Drouin@parl.gc.ca; Emmanuel.Dubourg@parl.gc.ca; [Redacted]Yves.Duclos@parl.gc.ca; Terry.Duguid@parl.gc.ca; Eric.Duncan@parl.gc.ca; Kirsty.Duncan@parl.gc.ca; Scott.Duvall@parl.gc.ca; Julie.Dzerowicz@parl.gc.ca; Wayne.Easter@parl.gc.ca; Ali.Ehsassi@parl.gc.ca; Fayçal.El-Khoury@parl.gc.ca; Neil.Ellis@parl.gc.ca; Dave.Epp@parl.gc.ca; Nathaniel.Erskine-Smith@parl.gc.ca; Rosemarie.Falk@parl.gc.ca; Ted.Falk@parl.gc.ca; Ed.Fast@parl.gc.ca; Greg.Fergus@parl.gc.ca; Andy.Fillmore@parl.gc.ca; Kerry-Lynne.Findlay@parl.gc.ca; Diane.Finley@parl.gc.ca; Pat.Finnigan@parl.gc.ca; Darren.Fisher@parl.gc.ca; Peter.Fonseca@parl.gc.ca; Mona.Fortier@parl.gc.ca; Rhéal.Fortin@parl.gc.ca; Peter.Fragiskatos@parl.gc.ca; Sean.Fraser@parl.gc.ca; Chrystia.Freeland@parl.gc.ca; Hedy.Fry@parl.gc.ca; Cheryl.Gallant@parl.gc.ca; Marc.Garneau@parl.gc.ca; Randall.Garrison@parl.gc.ca; Marie-Hélène.Gaudreau@parl.gc.ca; Leah.Gazan@parl.gc.ca; Bernard.Généreux@parl.gc.ca; Garnett.Genuis@parl.gc.ca; Mark.Gerretsen@parl.gc.ca; Marilène.Gill@parl.gc.ca; Marilyn.Gladu@parl.gc.ca; Joël.Godin@parl.gc.ca; Karina.Gould@parl.gc.ca; Jacques.Gourde@parl.gc.ca; [Redacted]Gray@parl.gc.ca; Matthew.Green@parl.gc.ca; Steven.Guilbeault@parl.gc.ca; Patty.Hajdu@parl.gc.ca; Jasraj <Singh.Hallan@parl.gc.ca>; Rachael.Harder@parl.gc.ca; Ken.Hardie@parl.gc.ca; Jack.Harris@parl.gc.ca; Randy.Hoback@parl.gc.ca; Mark.Holland@parl.gc.ca; Anthony.Housefather@parl.gc.ca; Carol.Hughes@parl.gc.ca; Ahmed.Hussen@parl.gc.ca; Gudie.Hutchings@parl.gc.ca; Angelo.Iacono@parl.gc.ca; Helena.Jaczek@parl.gc.ca; Tamara.Jansen@parl.gc.ca; Matt.Jeneroux@parl.gc.ca; Gord.Johns@parl.gc.ca; Mélanie.Joly@parl.gc.ca; Yvonne.Jones@parl.gc.ca; Bernadette.Jordan@parl.gc.ca; Majid.Jowhari@parl.gc.ca; Peter.Julian@parl.gc.ca; Mike.Kelloway@parl.gc.ca; Pat.Kelly@parl.gc.ca; Peter.Kent@parl.gc.ca; Iqra.Khalid@parl.gc.ca; Kamal.Khera@parl.gc.ca; Robert.Kitchen@parl.gc.ca; Tom.Kmiec@parl.gc.ca; Annie.Koutrakis@parl.gc.ca; Michael.Kram@parl.gc.ca; Damien.Kurek@parl.gc.ca; Stephanie.Kusie@parl.gc.ca; Irek.Kusmierczyk@parl.gc.ca; Jenny.Kwan@parl.gc.ca; Mike.Lake@parl.gc.ca; Marie-France.Lalonde@parl.gc.ca; Emmanuella.Lambropoulos@parl.gc.ca; David.Lametti@parl.gc.ca; Kevin.Lamoureux@parl.gc.ca; Andréanne.Larouche@parl.gc.ca; Patricia.Lattanzio@parl.gc.ca; Stéphane.Lauzon@parl.gc.ca; Philip.Lawrence@parl.gc.ca; Dominic.LeBlanc@parl.gc.ca; Diane.Lebouthillier@parl.gc.ca; Paul.Lefebvre@parl.gc.ca; Richard.Lehoux@parl.gc.ca; Sébastien.Lemire@parl.gc.ca; Michael.Levitt@parl.gc.ca; Chris.Lewis@parl.gc.ca; Ron.Liepert@parl.gc.ca; Joël.Lightbound@parl.gc.ca; Dane.Lloyd@parl.gc.ca; Ben.Lobb@parl.gc.ca; Wayne.Long@parl.gc.ca; Lloyd.Longfield@parl.gc.ca; Tim.Louis@parl.gc.ca; Tom.Lukiwski@parl.gc.ca; Lawrence.MacAulay@parl.gc.ca; Alistair.MacGregor@parl.gc.ca; Dave.MacKenzie@parl.gc.ca;

Steven.MacKinnon@parl.gc.ca; Larry.Maguire@parl.gc.ca; James.Maloney@parl.gc.ca; Paul.Manly@parl.gc.ca; Simon.Marcil@parl.gc.ca; Richard.Martel@parl.gc.ca; Soraya.Martinez@parl.gc.ca; Brian.Masse@parl.gc.ca; Lindsay.Mathyssen@parl.gc.ca; Bryan.May@parl.gc.ca; Elizabeth.May@parl.gc.ca; Dan.Mazier@parl.gc.ca; Kelly.McCauley@parl.gc.ca; Phil.McColeman@parl.gc.ca; Karen.McCrimmon@parl.gc.ca; Ken.McDonald@parl.gc.ca; David.McGuinty@parl.gc.ca; John.McKay@parl.gc.ca; Catherine.McKenna@parl.gc.ca; Ron.McKinnon@parl.gc.ca; Greg.McLean@parl.gc.ca; Cathy.McLeod@parl.gc.ca; Michael.McLeod@parl.gc.ca; Heather.McPherson@parl.gc.ca; Eric.Melillo@parl.gc.ca; Alexandra.Mendès@parl.gc.ca; Marco.Mendicino@parl.gc.ca; Kristina.Michaud@parl.gc.ca; Marc.Miller@parl.gc.ca; Maryam.Monsef@parl.gc.ca; Rob.Moore@parl.gc.ca; Marty.Morantz@parl.gc.ca; Bill.Morneau@parl.gc.ca; Rob.Morrison@parl.gc.ca; Robert.Morrissey@parl.gc.ca; Glen.Motz@parl.gc.ca; Joyce.Murray@parl.gc.ca; John.Nater@parl.gc.ca; Mary.Ng@parl.gc.ca; Christine.Normandin@parl.gc.ca; Jennifer.O'Connell@parl.gc.ca; Robert.Oliphant@parl.gc.ca; Seamus.O'Regan@parl.gc.ca; Erin.O'Toole@parl.gc.ca; Jeremy.Patzer@parl.gc.ca; Pierre.Paul-Hus@parl.gc.ca; Monique.Pauzé@parl.gc.ca; Yves.Perron@parl.gc.ca; Ginette.Petitpas <Taylor@parl.gc.ca>; Louis.Plamondon@parl.gc.ca; Pierre.Poilievre@parl.gc.ca; Marcus.Powlowski@parl.gc.ca; Mumilaaq.Qaqqaq@parl.gc.ca; Carla.Qualtrough@parl.gc.ca; Yasmin.Ratansi@parl.gc.ca; Alain.Rayes@parl.gc.ca; Brad.Redekopp@parl.gc.ca; Geoff.Regan@parl.gc.ca; Scott.Reid@parl.gc.ca; Michelle.Rempel <Garner@parl.gc.ca>; Blake.Richards@parl.gc.ca; Yves.Robillard@parl.gc.ca; Pablo.Rodriguez@parl.gc.ca; Churence.Rogers@parl.gc.ca; Sherry.Romanado@parl.gc.ca; Lianne.Rood@parl.gc.ca; Anthony.Rota@parl.gc.ca; Alex.Ruff@parl.gc.ca; Jag.Sahota@parl.gc.ca; Ruby.Sahota@parl.gc.ca; Raj.Saini@parl.gc.ca; Harjit <S..Sajjan@parl.gc.ca>; Darrell.Samson@parl.gc.ca; Ramesh.Sangha@parl.gc.ca; Randeep.Sarai@parl.gc.ca; Bob.Saroya@parl.gc.ca; Simon-Pierre.Savard-Tremblay@parl.gc.ca; Francis.Scarpaleggia@parl.gc.ca; Andrew.Scheer@parl.gc.ca; Peter.Schiefke@parl.gc.ca; Jamie.Schmale@parl.gc.ca; Deb.Schulte@parl.gc.ca; Kyle.Seeback@parl.gc.ca; Marc.Serré@parl.gc.ca; Judy <A..Sgro@parl.gc.ca>; Brenda.Shanahan@parl.gc.ca; Terry.Sheehan@parl.gc.ca; Martin.Shields@parl.gc.ca; Nelly.Shin@parl.gc.ca; Doug.Shipley@parl.gc.ca; Maninder.Sidhu@parl.gc.ca; Sonia.Sidhu@parl.gc.ca; Gagan.Sikand@parl.gc.ca; Mario.Simard@parl.gc.ca; Scott.Simms@parl.gc.ca; Jagmeet.Singh@parl.gc.ca; Derek.Sloan@parl.gc.ca; Francesco.Sorbara@parl.gc.ca; Gerald.Soroka@parl.gc.ca; Sven.Spengemann@parl.gc.ca; Bruce.Stanton@parl.gc.ca; Warren.Steinley@parl.gc.ca; Gabriel.Ste-Marie@parl.gc.ca; Mark.Strahl@parl.gc.ca; Shannon.Stubbs@parl.gc.ca; David.Sweet@parl.gc.ca; Marwan.Tabbara@parl.gc.ca; Filomena.Tassi@parl.gc.ca; Luc.Thériault@parl.gc.ca; Alain.Therrien@parl.gc.ca; Corey.Tochor@parl.gc.ca; Justin.Trudeau@parl.gc.ca; Denis.Trudel@parl.gc.ca; Ryan.Turnbull@parl.gc.ca; Tim.Uppal@parl.gc.ca; Tony.Van <Bynen@parl.gc.ca>; Adam.van <Koeverden@parl.gc.ca>; Tako.Van <Popta@parl.gc.ca>; Dan.Vandal@parl.gc.ca; Anita.Vandenbeld@parl.gc.ca; Adam.Vaughan@parl.gc.ca; Karen.Vecchio@parl.gc.ca; Gary.Vidal@parl.gc.ca; Arnold.Viersen@parl.gc.ca; Julie.Vignola@parl.gc.ca; Arif.Virani@parl.gc.ca; Brad.Vis@parl.gc.ca; Cathay.Wagantall@parl.gc.ca; Chris.Warkentin@parl.gc.ca; Kevin.Waugh@parl.gc.ca; Len.Webber@parl.gc.ca; Patrick.Weiler@parl.gc.ca; Jonathan.Wilkinson@parl.gc.ca; John.Williamson@parl.gc.ca; Jody.Wilson-Raybould@parl.gc.ca; Alice.Wong@parl.gc.ca; Redacted Yip@parl.gc.ca; Kate.Young@parl.gc.ca; Calgary.Acadia@assembly.ab.ca; Calgary.Beddington@assembly.ab.ca; Calgary.Bow@assembly.ab.ca; Calgary.Buffalo@assembly.ab.ca; Calgary.Cross@assembly.ab.ca; Calgary.Currie@assembly.ab.ca; Calgary.East@assembly.ab.ca; Calgary.Edgemont@assembly.ab.ca; Calgary.Elbow@assembly.ab.ca; Calgary.Falconridge@assembly.ab.ca; Calgary.FishCreek@assembly.ab.ca; Calgary.Foothills@assembly.ab.ca; Calgary.Glenmore@assembly.ab.ca; Calgary.Hays@assembly.ab.ca; Calgary.Klein@assembly.ab.ca; Calgary.Lougheed@assembly.ab.ca; Calgary.McCall@assembly.ab.ca; Calgary.MountainView@assembly.ab.ca; Calgary.North@assembly.ab.ca; Calgary.NorthEast@assembly.ab.ca; Calgary.Northwest@assembly.ab.ca; Calgary.Peigan@assembly.ab.ca; Calgary.Shaw@assembly.ab.ca; Calgary.SouthEast@assembly.ab.ca; Calgary.Varsity@assembly.ab.ca; Calgary.West@assembly.ab.ca; Edmonton.BeverlyClareview@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca; Edmonton.CityCentre@assembly.ab.ca; Edmonton.Decore@assembly.ab.ca; Edmonton.Ellerslie@assembly.ab.ca; Edmonton.Glenora@assembly.ab.ca; Edmonton.Goldbar@assembly.ab.ca; Edmonton.HighlandsNorwood@assembly.ab.ca; Edmonton.Manning@assembly.ab.ca; Edmonton.McClung@assembly.ab.ca; Edmonton.Meadows@assembly.ab.ca; Edmonton.Millwoods@assembly.ab.ca; Edmonton.Northwest@assembly.ab.ca; Edmonton.Riverview@assembly.ab.ca; Edmonton.Rutherford@assembly.ab.ca; Edmonton.South@assembly.ab.ca; Edmonton.SouthWest@assembly.ab.ca; Edmonton.Strathcona@assembly.ab.ca; Edmonton.WestHenday@assembly.ab.ca; Edmonton.Whitemud@assembly.ab.ca; Airdrie.Cochrane@assembly.ab.ca; Airdrie.East@assembly.ab.ca; Athabasca.Barrhead.Westlock@assembly.ab.ca; Banff.Kananaskis@assembly.ab.ca;

Bonnyville.ColdLake.StPaul@assembly.ab.ca; Brooks.MedicineHat@assembly.ab.ca; Camrose@assembly.ab.ca; CentralPeace.Notley@assembly.ab.ca; Chestermere.Strathmore@assembly.ab.ca; Cypress.MedicineHat@assembly.ab.ca; DraytonValley.Devon@assembly.ab.ca; Drumheller.Stettler@assembly.ab.ca; FortMcMurray.LacLaBiche@assembly.ab.ca; FortMcMurray.WoodBuffalo@assembly.ab.ca; FortSaskatchewan.Vegreville@assembly.ab.ca; GrandePrairie@assembly.ab.ca; GrandePrairie.Wapiti@assembly.ab.ca; Highwood@assembly.ab.ca; Innisfail.SylvanLake@assembly.ab.ca; LacSteAnne.Parkland@assembly.ab.ca; Lacombe.Ponoka@assembly.ab.ca; Leduc.Beaumont@assembly.ab.ca; Lesser.SlaveLake@assembly.ab.ca; Lethbridge.East@assembly.ab.ca; Lethbridge.West@assembly.ab.ca; Livingstone.Macleod@assembly.ab.ca; Maskwacis.Wetaskiwin@assembly.ab.ca; Morinville.StAlbert@assembly.ab.ca; OldsDidsbury.ThreeHills@assembly.ab.ca; Peace.River@assembly.ab.ca; RedDeer.North@assembly.ab.ca; RedDeer.South@assembly.ab.ca; Rimbey.RockyMountainhouse.Sundre@assembly.ab.ca; Sherwood.Park@assembly.ab.ca; SpruceGrove.StonyPlain@assembly.ab.ca; St.Albert@assembly.ab.ca; Strathcona.Sherwoodpark@assembly.ab.ca; Taber.Warner@assembly.ab.ca; Vermilion.Lloydminster.Wainwright@assembly.ab.ca; West.Yellowhead@assembly.ab.ca; David.Yurdiga@parl.gc.ca; Salma.Zahid@parl.gc.ca; Lenore.Zann@parl.gc.ca; Bob.Zimmer@parl.gc.ca; Sameer.Zuberi@parl.gc.ca
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Thank you yet again Dane for another 'pass the buck' response, dismissing the concerns of your constituents. I have now included the MLA's as you suggested. I also added in all the MP's as this is a local, provincial and federal matter as regards Long Term Care. Maybe one of them, unlike you, has the moral fortitude to step up and do more than send out lip service emails. I know they have been talking at caucus about the items in my research for many months but are continually shut down by our Premier and Deena Hinshaw.

Please note, the issues raised here are happening everywhere in Canada as you well know and concede in your email. That makes this a FEDERAL ISSUE, not just a provincial one.

The boilerplate response again about treatments and testing is getting tiring. You really should get another script or have someone actually read the research. To do any less is nothing less than gross negligence. "caring [sic] out testing with clinically and scientifically proven methods" (or even carrying) is completely incorrect. As indicted below, the testing is widely inaccurate and unfit for purpose. This has even been admitted on camera by Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health on July 31st, 2020. (https://youtu.be/bbwMo7IbXbw). Long Term Care Centers are being shut across the country for isolated asymptomatic voluntary tests in a sea of negative results i.e. where there is no COVID. Why is this not something you are raising in Parliament and beyond? Is that not a FEDERAL MATTER?

Maybe even talk to Doctors who are being threatened daily for trying to treat cases early instead of forcing patients into isolation to get too sick to treat. Maybe you could look into where all millions of FEDERALLY donated doses of Hydroxychloroquine have gone? If it doesn't work, why have all the governments stock piled these donations? That is an actual FEDERAL matter!

On long term care facilities, our mother has been in this one for 10 years without incident. It is not the facility that is the issue but the protocols handed down from Dr Tam and the Federal Government that have been adopted in lockstep across each province. That again IS A FEDERAL MATTER.

So, on the FEDERAL MATTERS, what are you doing? What have you done? What questions have you asked since I provided the material that was of FEDERAL INTEREST?

How many more will die on your watch while you regurgitate this government approved drivel?

And yes we are mad at your lack of response. We voted for you and we WILL hold you accountable. Note that these comments are not just those of two sole voters but of a growing number in Alberta and beyond who are disgusted by responses such as this.

David

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com)
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Dane.Lloyd@parl.gc.ca <Dane.Lloyd@parl.gc.ca>
Sent: August 12, 2020 9:30 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

Dear Mr. Dickson,

Thank you for reaching out.

We receive hundreds of emails a day so it can take more than a week to receive a reply.

Testing for COVID-19 and quarantine procedures in the province of Alberta falls under the jurisdiction of the provincial government. As, the federal government representative I do not have a say of influence in their procedures and methods. As I stated in a previous email to you, public health officials are caring out testing with clinically and scientifically proven methods. If you would like to discuss the Alberta operating procedures I would encourage you to reach out to your MLA. If your require assistance in determining who that is my staff would be more than happy to assist you.

There are some opinions out which are exceptionally critical regarding the treatment of COVID-19; many of these statements have not been proven in a scientific or peer reviewed manner so we cannot operate of these assumptions until they have been thoroughly proven. IT is the responsibility of all government officials to ensure the health and safety of its citizens. Other treatment and testing options and research projects are being funded by the federal government, but this research doesn't happen overnight. As research progresses we will have a deeper understanding of COVID-19 and be able to expand our treatment options and procedures.

With regards to long-term care facilities, this is a very serious matter. It would be a very stressful situation for you to have a family member residing in a care facility during this time.

It is unfortunate that it took a pandemic to bring to light some of the appalling conditions that seniors and those who require specialized care had been living in. I find it disturbing that the situation got so bad that the military was called in to take-over the operations of these facilities. The entire experience is completely unacceptable, and it must be addresses in a swift manner.

The oversight of long-term care facilities in Canada mainly falls under the jurisdiction of the provincial governments, however, I do believe that there is a place for the federal government. We need to work together to form guiding principles which will create a system that provides safe and reliable care of some of our country's most vulnerable.

I also whole-heartedly support a joint federal and provincial investigation into the state of long-term care facilities across the country. I feel that this type of investigation is necessary for us to fully understand where the issues lie and where services need to be improved.

Any governments primary responsibility, be it federal or provincial, is to ensure the health and safety of all Canadians. In this situation, all levels of government failed these vulnerable persons and we need to ensure that a catastrophe like this never happens again. I would encourage you to reach out to your MLA to discuss this matter further as well.

Once again, thank you for taking the time to reach out and discuss this very serious matter and please feel free to contact me in the future.

Kind regards,

Dane Lloyd, M.P.
Sturgeon River – Parkland

From: David Dickson <david.dickson@dksdata.com>
Sent: August 11, 2020 7:00 PM
To: Lloyd, Dane - M.P. <Dane.Lloyd@parl.gc.ca>; janice.harrington@albertahealthadvocates.ca; Motz, Glen - M.P. <Glen.Motz@parl.gc.ca>; Sloan, Derek - M.P. <Derek.Sloan@parl.gc.ca>; Diotte, Kerry - M.P. <Kerry.Diotte@parl.gc.ca>
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

To all above and all your colleagues,

It has now been almost a week and not a single response from our member of Parliament (Dane Lloyd) or the two other members of Parliament included below who have been contacted on multiple occasions. Also, no response from the Alberta Health Advocate who is also aware of the many concerns regarding the handling of the below and the larger matter around the COVID response by the Alberta Government.

Today we were informed of another staff created outbreak at Capital Care Dickinsfield (CCD) putting this facility on another 2 week "outbreak" and subjecting the residents to a fourth (and who known how many more) high risk and questionable RC-PCR testing. Note that the same exact fact pattern as in our complaint below was used to extend another Capital Care facility (sudden gastric issues in residents on the day the lockdown should end). How many coincidences make a pattern? Now we assume this latest lockdown at CCD will be under the same incompetent management as before putting the health of residents in further jeopardy. As days pass, it is hard to believe that these processes are not designed to actually hurry along the deaths of these most precious members of society.

You ALL have a duty of care to the citizens of Alberta and none more so than the residents in long term care. Protocols put in place by Deena Hinshaw which have never been enacted before are responsible for avoidable deaths far outnumbering those from this virus. Your inaction is actively contributing to this. You may well remember Jerry Dunham who died unnecessarily in Medicine Hat. I am currently in contact with his family. Avoidable deaths will soon be front and centre, leaving deaths from this virus in the distance. It is a duty of office to ensure accountability and responsibility for actions taken which have life changing consequences for so many on a scale never witnessed before in history.

At what point will you come out of the shadows and stand up for the citizens of this province? There are Albertans dying

due to these barbaric and unquestioned protocols that have no scientific basis whatsoever. People are terrified everyday with growing 'cases' but there is no mention that almost all are voluntary asymptomatic tests that have no value other than the fear mongering factor for the daily updates. Speaking of 'Cases' again. This short video explains how cases were being used to manipulate the public in March. Here we go yet again. https://youtu.be/dLWwSYTjiBA

Note that the current rate of positive tests ('Cases') is 1.85% of all tested. The number of reported deaths per test in the province is 0.0337%. False positive error rates are confirmed to be up to 50% putting the number of positive cases as within the margin of error of zero. Tests, even serology tests, can come back positive months after any infection has passed. Deaths are marked as COVID no matter the true cause. This, along with all the facts used to petrify the population, is not even being hidden. Yet it is ignored by ALL of you. Why is that?

At no time in history (since Nuremburg) have we been subject to experiments in public health at this level. Isolation/quarantine of healthy individuals removes, indeed negates, all human rights and restricts access to required health care (mental and physical) that has already resulted in many avoidable deaths. Many more will follow if this continues without challenge. The public is told that known treatments are either dangerous or don't work, when doctors are told that the real reason for withholding treatment is a lack of medication availability. Yet at the same time over 4 million doses of HCQ in Canada alone have been donated by the manufacturers specifically for COVID treatment. Where did those doses of medication go? Worldwide, this number of donated doses of medication exceeds 250 million. More than enough to have treated every person who has died multiple times over. Yet the treatment would have been useless as Deena Hinshaw and AHS deliberately force people to stay home until too sick to be treated properly. Then patients quite literally gasping their last, are consigned to the deadly ventilator after a mere 5 litres of O2 (10 in the Misericordia). No BPAP machine in hospitals was offered for fear of aerosolising the virus (despite protocols available in every hospital for MRSA patients that would negate that risk). Yet CPAP machines are still in use by paramedics in ambulances… I guess their lives are not worth as much as nurses and doctors… or is it something else? My own cardio thoracic surgeon assured me that this barbaric procedure would never happen in Alberta and certainly not in his hospital. He said it only happened for a short time in NY and Italy and no Doctor would ever do this here. Then I pointed out Dr. Darren Markland's tweets boasting about the use of ventilators for people with a respiratory disease. My doctor has not spoken to me since. Why is that?

I have spoken to doctors and nurses in Alberta who have been threatened to keep them quiet. People have died as a result. How is this not under investigation? And all this time, the prerequisite report that Deena Hinshaw quotes on all her Orders as justification for everything that has transpired from the initial lockdown on is yet to be produced to the citizens of this Province. Why is that?

To Glen Motz (Retired Medicine Hat Senior Police Officer), Derek Sloan (Candidate for Leadership), Dane Lloyd, (Member of Parliament for my family and I here in Spruce Grove), and Janice Harrington, (Alberta Health Patient Advocate), we are adding onto this list… Kerry Diotte, (member for Edmonton Griesbach), the area covered by Dickinsfield Long Term Care facility where our mother is currently incarcerated once more… it is time for you to do something and question what is really happening here. As we move back to hearing about cases, just like at the beginning in March, how many of these are from the voluntary asymptomatic testing and how many are 'spontaneous' with no apparent cause or subsequent case?

Consider that all the 'cases' related to Dickinsfield were staff members, not residents. In the Southside Good Samaritan's Care Centre in Edmonton we have 67 cases (26 deaths) in residents and 19 cases in staff. All carers were wearing full PPE at all times and following strict protocols. All of the deaths are in those over 70 years with multiple life threatening co-morbidities. In fact, we have not had a reported death 'with' not 'of' COVID under the age of 70 since April 23rd, 2020. Yet we now require children over the age of 2 to be forced into masks in most cities. I have arrested people during my time as a police officer for less abusive behaviour to children. Yet now we follow the order of politicians who have admitted the decision was rendered based on a survey of 6,000 citizens where 51% opted for mandatory masks. This is nothing less than gross negligence on the part of politicians, police and health professionals.

As with every case in this self described 'most deadly virus in the history of the world', AHS forces people to stay home until the symptoms get too serious for any useful treatment protocols. When did we ever do that before? Are we

actually trying to kill people? Where has all common sense gone? Note that compared to SARS and MERS, this mortality of this virus is not even close to the hype it has been given, even assuming the statistics were even close to true. Compared to TB, Ebola and other contagious viruses, it hardly registers at all. In fact, in March of 2020, the UK specifically dropped COVID from being listed as a Highly Contagious Infectious Disease because it was not deadly enough! Yet Canada and Alberta locked down anyway and continue to expand measures that become more bizarre by the day. It appears that Deena Hinshaw and the Government are trying to test the intelligence of people and continue to be surprised at how compliant these citizens will be no matter what they are asked to do.

Note, the average age of a person dying 'with' not 'of' COVID in the province is 83 as of today. Last week it went up to 84 years just for a week. The average life expectancy in the province is 81. Denna Hinshaw has even used the death of a 105 year old with more than three life threatening co-morbidities as a COVID death statistic to justify her actions. Although any death is sad, the most surprising part of the death of a 105 year old right now is the fact that they were 105!

Due to the inane, insane and immoral protocols under the direction of Deena Hinshaw et al, many Albertans have died on intubated ventilators which have NEVER been used for the treatment of a respiratory disease before - for good reason. Ventilators misused in this way are known to cause significant lung damage and death even in those with healthy lungs. How do I know? It happened to me, as Glen Motz is well aware from when I worked with him on the largest Police Project ever undertaken in this province.

As regards this and more, I am attaching my research AGAIN for Mr. Diotte and as a reminder to those who have already had it. Maybe now some of this will resonate more clearly with recent events. It should be noted that most of you have had my research for months, some without even an acknowledgement let alone a response.

This government and Deena Hinshaw never were competent to manage any health crisis. It is clear that their actions have resulted in the deaths of many Albertans and so much more besides. For anyone continuing to ignore this and hide behind politics, in the words of Dante Alighieri "The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

I hope one or more will take up the mantel for the sake of us all. Please contact me for further information. Note that all I have presented is verifiable, been peer reviewed by colleagues and other professionals worldwide along with those here at home in Alberta. There is so much more to this story. It is way beyond time to start asking questions rather than blindly following 'Orders'.

David

David T. Dickson
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Privacy and Cybersecurity Expert.
Cell: Redacted
Fax: Redacted
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: August 5, 2020 9:20 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>; Derek.Sloan@parl.gc.ca; Dane.Lloyd@parl.gc.ca; health.deputy-minister@gov.ab.ca; info@albertahealthadvocates.ca; Glen.Motz@parl.gc.ca; premier@gov.ab.ca
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; deena.hinshaw@ahs.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Dr. Redacted

The fact that you consider this was a matter for your sole attention, dismissing all others on the email, is indicative of the reason for the complaint. Add to that the fact that you appear to consider it so minor an irritation to you that you can swat it off as a patient complaint to be lost while the chaos under your direction continues, boggles the mind. I assure you that the residents and families do not consider this matter so irrelevant to be dismissed out of hand. Further, as you are well aware, the AHS patient relations department is absolutely not equipped to address such concerns.

The gravity of these concerns warrants more than a summary dismissal by the person who is the very subject of the concerns. This is even more concerning as the actions are indictive of violations of the health act.

I would appreciate some response from the Members of Parliament, Health Advocate's Office, Premiers Office, Health Minister and the office of the CMO, all of whom are included in this email and are directly responsible for the lives of Albertans impacted by this behavior.

David

David T. Dickson
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Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

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From: Redacted albertahealthservices.ca
To: david.dickson@dksdata.com, deena.hinshaw@gov.ab.ca, janice.harrington@albertahealthadvocates.ca, jason.kenney@gov.ab.ca
CC: dane.lloyd@parl.gc.ca, derek.sloan@parl.gc.ca, dksdata@gmail.com, glen.motz@parl.gc.ca, health.deputy-minister@gov.ab.ca,

info@albertahealthadvocates.ca, karen.dickson@dksdata.com, premier@gov.ab.ca

Sent: Thursday, August 06, 2020 12:52:36 AM (GMT)

Subject: RE: RE: Visitation for Redacted

Mr. and Mrs. Dickson,

I regret to hear that you are not satisfied with the management of the Capital Care Dickinsfield outbreak and discussions with our AHS team were not able to resolve your concerns.

If you wish to request further investigation into these concerns, please contact our AHS Patient Relations Department: https://www.albertahealthservices.ca/about/patientfeedback.aspx

•Telephone: 1-855-550-2555
•Fax:1-877-871-4340
•Mailing address only:
c/o Patient Relations
10030 107 Street NW, Edmonton, AB T5J 3E4

Sincerely,

Dr. G. Redacted MD MSc FRCPC
Medical Officer of Health
Alberta Health Services – Edmonton Zone

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> *Redacted thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*
>
> *Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf*
>
> *"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a **confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether**. "*
>
> *As per Redacted previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
> *Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.*
>
> *I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.*
>
> *Thank you,*
>
> *Dr. G. Redacted MD MSc FRCPC*
> *Medical Officer of Health*
> *Alberta Health Services – Edmonton Zone"*

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.

- Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.

- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**
        - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
    - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
    - When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order *"In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."

"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the

previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275 residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

<image003.png>
We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

David & Karen Dickson

David T. Dickson
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Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

<image004.gif>

You have received an email message secured by Private Post.
Please open the file called Encrypted_Message.htm to read the message.

Mobile device users:
Forward this email to m@zd.trendmicro.com and receive URLs to view the message on mobile devices.

<A_SARS-COV-2-PrePrint.pdf>

Attachments

From: Redacted <Redacted jccf.ca>
Sent: Tuesday, July 7, 2020 9:28 AM
To: David Dickson <david.dickson@dksdata.com>
Cc: Redacted <Redacted jccf.ca>
Subject: Fw: Jerry Dunham and the MP for Medicine Hat
Sensitivity: Confidential

Hi David,

Thank you for writing again to the Justice Centre, and sharing your interesting report. We also prepared a couple of reports in May and June, arguing that the lockdown is unjustified. Here is the one for Ontario: https://www.jccf.ca/published_reports/unprecedented-and-unjustified-ontario-lockdown/

We have also commenced a number of lawsuits, sent demand letters, written countless other letters and articles, given speeches and news interviews, created podcasts, and responded to the inquiries of hundreds and hundreds of Canadians over the last few months. We have directly written to politicians, we have had meetings with government officials to get houses of worship open (in Ontario), and we are working on other potential court actions to hold our governments accountable and minimize the effects of the lockdown. We have used our resources to bring public awareness to long-term care concerns, political overreach, and other harms of the lockdown.

You indicated in one of your emails (below) that we have the resources and power to put an end to this. I'm not sure what else you think we should be doing, as a small legal team funded solely by donations, but I assure you that we are working extremely hard to do what we can under the circumstances. We are also limited by our mandate, which is to protect the Charter rights and freedoms of Canadians, so that means we can't sue governments for businesses being harmed by the lockdown, for example. The Charter also has limiting provisions which permit courts and governments to override those rights and freedoms in certain circumstances; so even where there are clear violations of rights, that doesn't necessarily translate into a successful court action. All of these things must be factored into the types of cases we can and should bring forward.

I encourage you to continue communicating your research and opinions (and feel free to share ours) with elected officials.

We greatly appreciate your faith in, and support of, the Justice Centre.

Best regards,

Redacted **D.S.** Redacted JD, BA

Justice Centre for Constitutional Freedoms
253-7620 Elbow Drive SW
Calgary, AB T2V 1K2

"Defending the constitutional freedoms of Canadians"

From: David Dickson <david.dickson@dksdata.com>
Sent: Friday, June 26, 2020 9:43 PM
To: Redacted <Redacted jccf.ca>; Redacted <Redacted jccf.ca>; JCCF Info <info@jccf.ca>
Subject: Jerry Dunham and the MP for Medicine Hat

Dear John Carpay et al,

I have written a few times about the issues related to the illegal lockdown and the impacts it has had on myself (a disabled retired police officer with ventilator induced pulmonary fibrosis) and my mother in law (a stroke victim effectively imprisoned in a care facility in Edmonton for the last three months).

I would still like to follow up on both of these items as we have suffered personally as a result of this. However, with the untimely death of Jerry Dunham, I feel there is more I can add to your cause to make a significant impact in this tragedy.

As you can see from the attached, I had reached out early on to the MP for Medicine Hat (Glen.Motz@parl.gc.ca) on April 3rd, April 6th, April 21st (complete research) with another follow up on April 26th of this year, all of which was ignored. Glen Motz is a retired Medicine Hat senior police officer that I once considered a colleague. Had he taken notice of the research and acted in regards to what was happening, he could probably have prevented the death of Jerry Dunham.

Note I have also sent this research to other MP's, MLA's and the Alberta Health Advocate among many other people.

The latest published copy is here. https://www.researchgate.net/publication/341713221_The_Best_Laid_Plans_COVID-19_A_SARS-COV-2_Story_A_SARS-CoV-2_Story_P_a_g_e_2_106

Please let me know how I can help before more people die unnecessarily. Those responsible must be held accountable.

David

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Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Cell: Redacted
Fax: Redacted
Email: *david.dickson@dksdata.com*

Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: Wednesday, April 15, 2020 11:30 AM
To: Redacted <Redacted jccf.ca>
Subject: RE: COVID 19 - a Second Opinion.
Importance: High

Many thanks for taking the time to reply, David,

The Government has enacted a lockdown based on false information designed to create panic. The current approach of dismissing known treatments (used on SARS, MERS and CV19) is beyond negligence. The improper and damaging protocols in place have directly caused the deaths of many already. I am in the crosshairs of this from every risk factor for CV19 but this goes far beyond just me. In my personal story linked below, I cover some of my challenges. These have given me a unique insight into the world's reaction to CV19. Despite this, it is not CV19 that worries me; it is the reaction and protocols that have been implemented that terrify me.

That being said, I have been significantly impacted by the lockdown measures. Just prior to this happening, along with my pre-existing conditions, I was diagnosed with pre-diabetes. I was directed to undertake an exercise regime by Alberta Health. The regime requires access to a swimming pool (my pre-existing conditions prevent me from doing even the simplest of exercises, walking). Now, that access has been denied without any just cause. The 'cause' relied upon by the government is a reporting of deaths for CV19 that has been deliberately skewed in a way that no other disease ever has.

My constitutional rights have been abused by the Government of Canada and Alberta. This has had a direct impact on my health and continues to put me at direct risk. I am but one of millions with similar issues as a result of this unnecessary lockdown.

Additionally, my mother in law suffered a severe stroke some 10 years ago. Prior to the CV19 reaction, she was receiving regular massage therapy in the care centre where she resides. She paid for this herself. It had been significantly beneficial to her health and wellbeing. That too has been stopped by the draconian steps taken by the government. In addition, with the lockdown, she now has no contact with her family. This is taking a severe toll on the mental health of both my mother in law and the whole family.

This whole situation is based on lies that after many months of investigation are so obvious and provable. Yet everyone is ignoring or oblivious to the reality. My articles to you were an attempt to clear the fog.

I have so much more to help with this matter and weep daily for the health and wellbeing of my fellow Canadians. This has to stop. The 'alleged' deaths 'OF' CV19 are actually deaths from significant co-morbidities, misreported as CV19 deaths (confirmed by my multiple contacts in the health system). This 'reporting' is being relied upon to justify government overreach that has not been seen in the world for a very long time. However, the damage to society and escalation in mental health issues resulting in a spike of suicides, impacts to patient follow ups causing minor health issues to become major (and potentially fatal), missed surgeries, medical treatments and appointments and so much more, has already eclipsed even the worst case scenarios of CV19.

At this time, with multiple safe, proven and used treatments that would prevent even a single death by a CV19 complication, we are letting people die every day in Canada. This is not just a fundamental breach of our constitutional rights, and human rights, but is now reaching a level of a crime against humanity. All in the name of an obvious government power grab.

Please help, before it is too late. I am just one disabled retired Police Officer desperately trying to wake the world up, to get people to look at what is really happening in plain sight.

You have the resources and the power to put an end to this, and also hold those accountable after the fact.

I am literally imploring you to get in touch.

David

David T. Dickson
C.E.O. DKS DATA (www.dksdata.com**)**
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Cell: Redacted
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Email: david.dickson@dksdata.com

my Linked in profile Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: Redacted <Redacted jccf.ca>
Sent: Tuesday, April 14, 2020 10:41 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: COVID 19 - a Second Opinion.

Hello David,

Thank you for sharing your articles with the Justice Centre.

The Justice Centre is deeply concerned about government actions that are being taken to deal with COVID-19.

Our laws allow for some government measures to infringe our rights and freedoms to meet external threats and internal threats. But the Canadian Charter of Rights and Freedoms and the rule of law still apply. The Charter requires that restrictions on our Charter freedoms of liberty, mobility, religion, association and peaceful assembly be imposed in the least restrictive manner possible, for the shortest amount of time possible.

To deal with the spread of COVID-19, under federal and provincial legislation, governments can restrict movement, shut down businesses, impose travel bans, control the distribution of essential goods and services. While quarantines and other emergency measures are meant to be temporary, there is no question that they deny freedom. These measures are also crippling Canada's economy, with long-lasting negative impact on the health and well-being of Canadians.

If a restriction on freedom is challenged in court, the onus is on the government to justify that restriction as reasonable, and to explain why that particular measure was chosen over other, less restrictive means that might achieve the same goal.

The Charter requires governments to think carefully about the public health benefits of restricting freedoms, and weigh those benefits against the harm of violating Charter rights and freedoms.

The benefits of restrictive measures might have mixed results on public health. Forced isolation may prevent community transmission of a virus, but forced isolation can also result in declining mental health, increased family violence, more depression and more suicides. Seniors who are isolated could also miss out on necessary medical care, resulting in deaths from causes other then COVID-19.

There is a growing possibility that the social and economic costs of shutting down the economy and restricting freedom outweigh public health benefits. Courts have the difficult responsibility of determining whether the government's cure causes more harm then the disease.

The Justice Centre's legal team is monitoring government action closely, and is ready – at the appropriate time, and if necessary – to challenge government action in court, where there is an extreme, unnecessary or unjustified infringement of fundamental Charter freedoms.

The radical step of court action would be preceded initially by correspondence, or by publicly calling on the government to reverse course, if time and circumstances so permitted. For ongoing updates from the Justice Centre that relate to Charter rights and freedoms, please visit: https://www.jccf.ca/in-the-news/covid-19/.

You and other citizens should not hesitate to contact your federal MP and your provincial elected representative to share your concerns. Citizen participation in the democratic process remains as important as ever. Moreover, you can easily contact your federal and provincial representatives without needing to visit their offices, or speak with them in person.

If you have been personally impacted by new legislation relating to the Covid-19 crisis, please complete an intake form: https://www.jccf.ca/get-help/. Our legal team will then review your case to determine if it is a matter within our mandate and will get back to you as soon as possible. Due to the large volume of correspondence that we are receiving, we cannot guarantee a time period as to when we will be able to respond, but we will do our best.

Again, thank you for contacting the Justice Centre and sharing your concerns and information.

Regards,
Redacted **JD**
Legal Assistant
Justice Centre for Constitutional Freedoms
#253, 7620 Elbow Drive SW
Calgary, AB, T2V 1K2

"Defending the constitutional freedoms of Canadians"

From: David Dickson <david.dickson@dksdata.com>
Sent: Saturday, April 11, 2020 12:21 PM
To: JCCF Info <info@jccf.ca>
Subject: FW: COVID 19 - a Second Opinion.

FAO: John Carpay

Good Afternoon, John,

I have just read your article in The Post Millenial 'The cost of the coronavirus cure could be deadlier than the disease' with great interest. It was heartening to see that someone in journalism is starting to ask the right questions, rather than repeating the talking points we see all day about the COVID 19 response.

The world needs a second opinion right now, not just Canada.

I have been tracking the current global crisis and a few things have been bothering me. Below are a series of short articles that summarize the tracking of COVID 19 and the way it is being reported. It is the reaction to COVID 19 poses an existential threat to society right now. We have triggered the global NBC (Nuclear, Biological, Chemical) emergency protocols for a treatable virus less dangerous than common seasonal flu.

From what I could see online, I feel we share some of the same concerns. I really value your expertise, knowledge, experience and input and I know you care more than most. If possible, please come back to me with feedback, good, bad or indifferent. This message has to be factual and correct. Lives are at stake here on a global scale.

As the media fiddles, we are watching Rome burn.

- The reality is **the reports are right about Hydroxychloroquine**.
  More details here: **How the humble Gin & Tonic may save the world from COVID 19**.
  https://www.linkedin.com/pulse/how-humble-gin-tonic-may-save-world-from-covid-19-dave-dickson-

- This plan is killing people. Inappropriately directed (CDC) use of ventilators are killing people. People need oxygen, not mechanical ventilation. CDC directions are causing deaths, not saving lives.
  More details here: **COVID 19 - The Spread of A Virus.** https://www.linkedin.com/pulse/spread-virus-dave-dickson-
- How do I know? I have lived the life we now live, every day, for a decade.
  More details here: **COVID 19 Risks - a Personal Message:** https://www.linkedin.com/pulse/covid-19-risks-personal-message-dave-dickson-

- Mainstream media is misleading the public regarding the numbers they are reporting. This is generating fear based on CDC directions and protocols.
  More details here: **COVID 19 – Is the lock down working?** https://www.linkedin.com/pulse/covid-19-lock-down-working-dave-dickson-

- This is part of a 'break the glass in case of emergency' plan developed in the 80's. This plan was triggered by the unusual reaction of China to COVID 19. Once it was started, it took on a life of its own. It can be stopped but it won't stop itself.
  More details here: **The Best Laid Plans. COVID-19:** https://www.linkedin.com/pulse/best-laid-plans-covid-19-dave-dickson-

We are counting test kits and creating panic while people die for no reason.
Counting Cars – How COVID 19 is being reported: https://www.youtube-nocookie.com/embed/QM79ybr7Y18

Can we help each other to put an end to this crisis before it is too late?

David

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Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Cell: Redacted

Fax: Redacted
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my LinkedIn profile Microsoft Partner

Some rules to live by:

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Go to work every day.
Always speak your mind.
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And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: Monday, September 7, 2020 7:11 PM
To: 'Danielle Smith' < Redacted gmail.com>
Subject: RE: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

Evening Danielle,

Just a quick update. Here is the latest in my research, peer reviewed by multiple Professors including Professor Dolores Cahill.

https://www.researchgate.net/publication/344159232_Winter_Is_Coming

Thanks,

David

David T. Dickson
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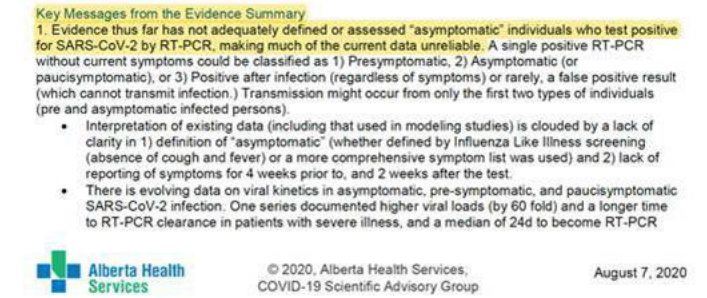
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

From: David Dickson
Sent: September 6, 2020 2:01 PM
To: Danielle Smith < Redacted gmail.com>
Subject: RE: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

Thanks for your response, Danielle.

As you can see from all I have sent, I have exhausted every avenue currently available to me. I hoped, based on what you talk about daily and how this impacts your fellow Albertans, you would be interested in pursuing this to shine some sunlight on this tragedy.

It might be time to consider why the RT-PCR tests being pushed at such a ferocious and irrational level when they are known to be useless. AHS themselves state in their own guidelines that these tests “CANNOT BE USED TO INFER **POTENTIALLY** INFECTIOUS STATUS”. They don’t even consider it valid as a presumption, let alone a confirmation! That test, known to have no value due to the large number of false positives, is being used to drive ‘Cases’. These cases are being used to close businesses, care homes and destroy lives.
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-sag-asymptomatic-transmission-rapid-review.pdf

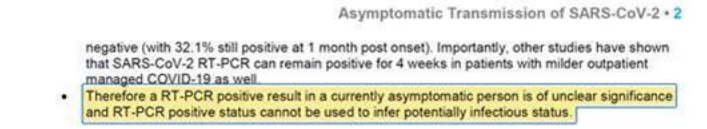


Key Messages from the Evidence Summary

1. Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable. A single positive RT-PCR without current symptoms could be classified as 1) Presymptomatic, 2) Asymptomatic (or paucisymptomatic), or 3) Positive after infection (regardless of symptoms) or rarely, a false positive result (which cannot transmit infection.) Transmission might occur from only the first two types of individuals (pre and asymptomatic infected persons).
   - Interpretation of existing data (including that used in modeling studies) is clouded by a lack of clarity in 1) definition of "asymptomatic" (whether defined by Influenza Like Illness screening (absence of cough and fever) or a more comprehensive symptom list was used) and 2) lack of reporting of symptoms for 4 weeks prior to, and 2 weeks after the test.
   - There is evolving data on viral kinetics in asymptomatic, pre-symptomatic, and paucisymptomatic SARS-CoV-2 infection. One series documented higher viral loads (by 60 fold) and a longer time to RT-PCR clearance in patients with severe illness, and a median of 24d to become RT-PCR

Alberta Health Services

August 7, 2020



Asymptomatic Transmission of SARS-CoV-2 • 2

negative (with 32.1% still positive at 1 month post onset). Importantly, other studies have shown that SARS-CoV-2 RT-PCR can remain positive for 4 weeks in patients with milder outpatient managed COVID-19 as well.

- Therefore a RT-PCR positive result in a currently asymptomatic person is of unclear significance and RT-PCR positive status cannot be used to infer potentially infectious status.

These 'Cases' are also the criteria that drive the three levels of control on you, me and all other Albertans.
https://www.alberta.ca/maps/covid-19-status-map.htm

> ***"Open***
> *low level of risk, no additional restrictions in place* ***less than 50*** *active cases per 100,000*
> ***Watch***
> *the province is monitoring the risk and discussing with local government(s) and other community leaders the possible need for additional health measures at least 10 active cases and* ***more than 50 active cases per 100,000***
> ***Enhanced***
> *risk levels require enhanced public health measures to control the spread informed by local context"*

Due to the lack of follow up and automatic assumption that any symptom of COVID can only be COVID, we will see very few Flu cases this season as everything is assumed to be COVID. Unlike Flu, the protocol for COVID is to isolate and ignore. How many more will die of untreated bacterial pneumonia, PE (lung blood clot) and more due to this deliberate misdiagnosis in the coming months?

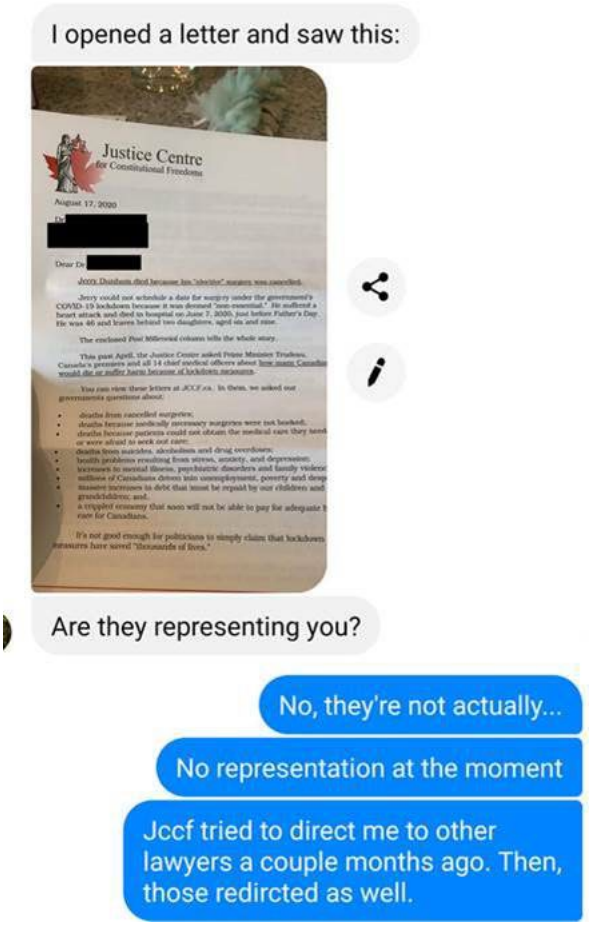
As we enter flu season, you might want to consider what is going to happen. We will enter a full lockdown unlike any we have seen to date. This will be enforced and the Government has made preparations for this. Why will they move us into lockdown? On top of the 50 or so per 100,000 false positives driven by the expansion of the testing program (as part of a deal to have Loblaws enforce masks on all their properties) we will have the usual 'Case' load of Flu. That ranges from 179 to 215 per 100,000 in the last few years (even with a vaccine that has been around for over a decade). Add that to the 50 PCR COVID 'Cases' and we are over 5 times that for a 'Watch' in Alberta. Think this government won't use this fear mongering to lock down the population? I know you know better than that.

(see page 3)
https://open.alberta.ca/dataset/9044e65d-a97e-43cb-8357-9c890422f069/resource/dcd1cc27-57c2-4cf4-8078-3869f19b6390/download/health-influenza-summary-report-2018-2019.pdf

Finally, I would suggest not promoting the JCCF. Unlike lawyers such as Redacted they are not what they promote. I have contacted them a number of times about this issue and the response is a joke (only not a funny one) – See attached.

They took Jerry Dunham's story and used it for fund raising, without telling the family. Their response to Jerry's partner and family was 'we can't help you'. Know how they found out about it? This is a message she shared with me in the last couple of weeks.

This is an ethical breach bordering on criminal (obtaining money by deception). I am doing what I can to help Krista and Jerry's children through this trying time for them… but again no-one seems to care. Note the Dr. who received this request for donations under false pretences was shocked to say the least, but not as much as poor Krista was.



I would like to think you would want to make a difference and hopefully by having this additional context, you will. You are a voice for Albertans right now and can reach the 'powers that be' in a way others cannot.

I can be reached anytime and will do whatever I can to get this story out. Again, a plea for help from the people in Care Homes and those dying and dead due to the avoidable atrocities this government has forced upon us with no actual scientific evidence to back up their actions.

Thanks,

David

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Privacy and Cybersecurity Expert.
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Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: Danielle Smith < Redacted gmail.com>
Sent: September 6, 2020 8:03 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: Re: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

I think you need to send this to the Justice Centre for Constitutional Freedom. They have taken on access cases in Ontario (I've seen several press releases) but I've not seen a case here. Maybe you could start one.
If it matters, I agree with your analysis of the risk.
It is clear COVID is more deadly to frail elderly people in care. But being imprisoned without human contact is equally deadly.
Let me know how it turns out.
Danielle

Sent from my iPhone

On Sep 5, 2020, at 9:33 AM, David Dickson <david.dickson@dksdata.com> wrote:

Two of seven.

Please treat as confidential.

From: David Dickson
Sent: August 12, 2020 10:46 AM
To: Dane.Lloyd@parl.gc.ca; SpruceGrove.StonyPlain@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca
Cc: Ziad.Aboultaif@parl.gc.ca; Scott.Aitchison@parl.gc.ca; Dan.Albas@parl.gc.ca; Omar.Alghabra@parl.gc.ca; Leona.Alleslev@parl.gc.ca; Dean.Allison@parl.gc.ca; William.Amos@parl.gc.ca; Anita.Anand@parl.gc.ca; Gary.Anandasangaree@parl.gc.ca; Charlie.Angus@parl.gc.ca; Mel.Arnold@parl.gc.ca; René.Arseneault@parl.gc.ca; Chandra.Arya@parl.gc.ca; Niki.Ashton@parl.gc.ca; Jenica.Atwin@parl.gc.ca; Taylor.Bachrach@parl.gc.ca; Vance.Badawey@parl.gc.ca; Larry.Bagnell@parl.gc.ca; Navdeep.Bains@parl.gc.ca; Yvan.Baker@parl.gc.ca; Tony.Baldinelli@parl.gc.ca; John.Barlow@parl.gc.ca; Michael.Barrett@parl.gc.ca; Xavier.Barsalou-Duval@parl.gc.ca; Jaime.Battiste@parl.gc.ca; Mario.Beaulieu@parl.gc.ca; Terry.Beech@parl.gc.ca; Rachel.Bendayan@parl.gc.ca; Carolyn.Bennett@parl.gc.ca; Bob.Benzen@parl.gc.ca; Candice.Bergen@parl.gc.ca; Stéphane.Bergeron@parl.gc.ca; Luc.Berthold@parl.gc.ca; Sylvie.Bérubé@parl.gc.ca; Lyne.Bessette@parl.gc.ca; James.Bezan@parl.gc.ca; Marie-Claude.Bibeau@parl.gc.ca; Chris.Bittle@parl.gc.ca; Daniel.Blaikie@parl.gc.ca; Bill.Blair@parl.gc.ca; Yves-François.Blanchet@parl.gc.ca; Maxime.Blanchette-Joncas@parl.gc.ca; Rachel.Blaney@parl.gc.ca; Steven.Blaney@parl.gc.ca; Kelly.Block@parl.gc.ca; Kody.Blois@parl.gc.ca; Michel.Boudrias@parl.gc.ca;

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Bernard.Généreux@parl.gc.ca; Garnett.Genuis@parl.gc.ca; Mark.Gerretsen@parl.gc.ca; Marilène.Gill@parl.gc.ca; Marilyn.Gladu@parl.gc.ca; Joël.Godin@parl.gc.ca; Karina.Gould@parl.gc.ca; Jacques.Gourde@parl.gc.ca; Redacted Gray@parl.gc.ca; Matthew.Green@parl.gc.ca; Steven.Guilbeault@parl.gc.ca; Patty.Hajdu@parl.gc.ca; Jasraj <Singh.Hallan@parl.gc.ca>; Rachael.Harder@parl.gc.ca; Ken.Hardie@parl.gc.ca; Jack.Harris@parl.gc.ca; Randy.Hoback@parl.gc.ca; Mark.Holland@parl.gc.ca; Anthony.Housefather@parl.gc.ca; Carol.Hughes@parl.gc.ca; Ahmed.Hussen@parl.gc.ca; Gudie.Hutchings@parl.gc.ca; Angelo.Iacono@parl.gc.ca; Helena.Jaczek@parl.gc.ca; Tamara.Jansen@parl.gc.ca; Matt.Jeneroux@parl.gc.ca; Gord.Johns@parl.gc.ca; Mélanie.Joly@parl.gc.ca; Yvonne.Jones@parl.gc.ca; Bernadette.Jordan@parl.gc.ca; Majid.Jowhari@parl.gc.ca; Peter.Julian@parl.gc.ca; Mike.Kelloway@parl.gc.ca; Pat.Kelly@parl.gc.ca; Peter.Kent@parl.gc.ca; Iqra.Khalid@parl.gc.ca; Kamal.Khera@parl.gc.ca; Robert.Kitchen@parl.gc.ca; Tom.Kmiec@parl.gc.ca; Annie.Koutrakis@parl.gc.ca; Michael.Kram@parl.gc.ca; Damien.Kurek@parl.gc.ca; Stephanie.Kusie@parl.gc.ca; Irek.Kusmierczyk@parl.gc.ca; Jenny.Kwan@parl.gc.ca; Mike.Lake@parl.gc.ca; Marie-France.Lalonde@parl.gc.ca; Emmanuella.Lambropoulos@parl.gc.ca; David.Lametti@parl.gc.ca; Kevin.Lamoureux@parl.gc.ca; Andréanne.Larouche@parl.gc.ca; Patricia.Lattanzio@parl.gc.ca; Stéphane.Lauzon@parl.gc.ca; Philip.Lawrence@parl.gc.ca; Dominic.LeBlanc@parl.gc.ca; Diane.Lebouthillier@parl.gc.ca; Paul.Lefebvre@parl.gc.ca; Richard.Lehoux@parl.gc.ca; Sébastien.Lemire@parl.gc.ca; Michael.Levitt@parl.gc.ca; Chris.Lewis@parl.gc.ca; Ron.Liepert@parl.gc.ca; Joël.Lightbound@parl.gc.ca; Dane.Lloyd@parl.gc.ca; Ben.Lobb@parl.gc.ca; Wayne.Long@parl.gc.ca; Lloyd.Longfield@parl.gc.ca; Tim.Louis@parl.gc.ca; Tom.Lukiwski@parl.gc.ca; Lawrence.MacAulay@parl.gc.ca; Alistair.MacGregor@parl.gc.ca; Dave.MacKenzie@parl.gc.ca; Steven.MacKinnon@parl.gc.ca; Larry.Maguire@parl.gc.ca; James.Maloney@parl.gc.ca; Paul.Manly@parl.gc.ca; 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Erin.O'Toole@parl.gc.ca; Jeremy.Patzer@parl.gc.ca; Pierre.Paul-Hus@parl.gc.ca; Monique.Pauzé@parl.gc.ca; Yves.Perron@parl.gc.ca; Ginette.Petitpas <Taylor@parl.gc.ca>; Louis.Plamondon@parl.gc.ca; Pierre.Poilievre@parl.gc.ca; Marcus.Powlowski@parl.gc.ca; Mumilaaq.Qaqqaq@parl.gc.ca; Carla.Qualtrough@parl.gc.ca; Yasmin.Ratansi@parl.gc.ca; Alain.Rayes@parl.gc.ca; Brad.Redekopp@parl.gc.ca; Geoff.Regan@parl.gc.ca;

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Derek.Sloan@parl.gc.ca; Francesco.Sorbara@parl.gc.ca; Gerald.Soroka@parl.gc.ca; Sven.Spengemann@parl.gc.ca; Bruce.Stanton@parl.gc.ca; Warren.Steinley@parl.gc.ca; Gabriel.Ste-Marie@parl.gc.ca; Mark.Strahl@parl.gc.ca; Shannon.Stubbs@parl.gc.ca; David.Sweet@parl.gc.ca; Marwan.Tabbara@parl.gc.ca; Filomena.Tassi@parl.gc.ca; Luc.Thériault@parl.gc.ca; Alain.Therrien@parl.gc.ca; Corey.Tochor@parl.gc.ca; Justin.Trudeau@parl.gc.ca; Denis.Trudel@parl.gc.ca; Ryan.Turnbull@parl.gc.ca; Tim.Uppal@parl.gc.ca; Tony.Van <Bynen@parl.gc.ca>; Adam.van <Koeverden@parl.gc.ca>; Tako.Van <Popta@parl.gc.ca>; Dan.Vandal@parl.gc.ca; Anita.Vandenbeld@parl.gc.ca; Adam.Vaughan@parl.gc.ca; Karen.Vecchio@parl.gc.ca; Gary.Vidal@parl.gc.ca; Arnold.Viersen@parl.gc.ca; Julie.Vignola@parl.gc.ca; Arif.Virani@parl.gc.ca; Brad.Vis@parl.gc.ca; Cathay.Wagantall@parl.gc.ca; Chris.Warkentin@parl.gc.ca; Kevin.Waugh@parl.gc.ca; Len.Webber@parl.gc.ca; Patrick.Weiler@parl.gc.ca; Jonathan.Wilkinson@parl.gc.ca; John.Williamson@parl.gc.ca; Jody.Wilson-Raybould@parl.gc.ca; Alice.Wong@parl.gc.ca; [Redacted]Yip@parl.gc.ca; Kate.Young@parl.gc.ca; Calgary.Acadia@assembly.ab.ca; Calgary.Beddington@assembly.ab.ca; Calgary.Bow@assembly.ab.ca; Calgary.Buffalo@assembly.ab.ca; Calgary.Cross@assembly.ab.ca; Calgary.Currie@assembly.ab.ca; Calgary.East@assembly.ab.ca; Calgary.Edgemont@assembly.ab.ca; Calgary.Elbow@assembly.ab.ca; Calgary.Falconridge@assembly.ab.ca; Calgary.FishCreek@assembly.ab.ca; Calgary.Foothills@assembly.ab.ca; Calgary.Glenmore@assembly.ab.ca; Calgary.Hays@assembly.ab.ca; Calgary.Klein@assembly.ab.ca; Calgary.Lougheed@assembly.ab.ca; Calgary.McCall@assembly.ab.ca; Calgary.MountainView@assembly.ab.ca; Calgary.North@assembly.ab.ca; Calgary.NorthEast@assembly.ab.ca; Calgary.Northwest@assembly.ab.ca; Calgary.Peigan@assembly.ab.ca; Calgary.Shaw@assembly.ab.ca; Calgary.SouthEast@assembly.ab.ca; Calgary.Varsity@assembly.ab.ca; Calgary.West@assembly.ab.ca; Edmonton.BeverlyClareview@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca; Edmonton.CityCentre@assembly.ab.ca; Edmonton.Decore@assembly.ab.ca; Edmonton.Ellerslie@assembly.ab.ca; Edmonton.Glenora@assembly.ab.ca; Edmonton.Goldbar@assembly.ab.ca; Edmonton.HighlandsNorwood@assembly.ab.ca; Edmonton.Manning@assembly.ab.ca; Edmonton.McClung@assembly.ab.ca; Edmonton.Meadows@assembly.ab.ca; Edmonton.Millwoods@assembly.ab.ca; Edmonton.Northwest@assembly.ab.ca; Edmonton.Riverview@assembly.ab.ca; Edmonton.Rutherford@assembly.ab.ca; Edmonton.South@assembly.ab.ca; Edmonton.SouthWest@assembly.ab.ca; Edmonton.Strathcona@assembly.ab.ca; Edmonton.WestHenday@assembly.ab.ca; Edmonton.Whitemud@assembly.ab.ca; Airdrie.Cochrane@assembly.ab.ca; Airdrie.East@assembly.ab.ca; Athabasca.Barrhead.Westlock@assembly.ab.ca; Banff.Kananaskis@assembly.ab.ca; Bonnyville.ColdLake.StPaul@assembly.ab.ca; Brooks.MedicineHat@assembly.ab.ca; Camrose@assembly.ab.ca; CentralPeace.Notley@assembly.ab.ca; Chestermere.Strathmore@assembly.ab.ca; Cypress.MedicineHat@assembly.ab.ca; DraytonValley.Devon@assembly.ab.ca; Drumheller.Stettler@assembly.ab.ca; FortMcMurray.LacLaBiche@assembly.ab.ca; FortMcMurray.WoodBuffalo@assembly.ab.ca; FortSaskatchewan.Vegreville@assembly.ab.ca; GrandePrairie@assembly.ab.ca; GrandePrairie.Wapiti@assembly.ab.ca; Highwood@assembly.ab.ca; Innisfail.SylvanLake@assembly.ab.ca; LacSteAnne.Parkland@assembly.ab.ca; Lacombe.Ponoka@assembly.ab.ca; Leduc.Beaumont@assembly.ab.ca; Lesser.SlaveLake@assembly.ab.ca; Lethbridge.East@assembly.ab.ca; Lethbridge.West@assembly.ab.ca; Livingstone.Macleod@assembly.ab.ca; Maskwacis.Wetaskiwin@assembly.ab.ca; Morinville.StAlbert@assembly.ab.ca; OldsDidsbury.ThreeHills@assembly.ab.ca; Peace.River@assembly.ab.ca; RedDeer.North@assembly.ab.ca; RedDeer.South@assembly.ab.ca; Rimbey.RockyMountainhouse.Sundre@assembly.ab.ca; Sherwood.Park@assembly.ab.ca; SpruceGrove.StonyPlain@assembly.ab.ca; St.Albert@assembly.ab.ca; Strathcona.Sherwoodpark@assembly.ab.ca; Taber.Warner@assembly.ab.ca; Vermilion.Lloydminster.Wainwright@assembly.ab.ca; West.Yellowhead@assembly.ab.ca; David.Yurdiga@parl.gc.ca; Salma.Zahid@parl.gc.ca; Lenore.Zann@parl.gc.ca; Bob.Zimmer@parl.gc.ca; Sameer.Zuberi@parl.gc.ca

Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Thank you yet again Dane for another 'pass the buck' response, dismissing the concerns of your constituents. I have now included the MLA's as you suggested. I also added in all the MP's as this is a local, provincial and federal matter as regards Long Term Care. Maybe one of them, unlike you, has the moral fortitude to step up and do more than send out lip service emails. I know they have been talking at caucus about the items in my research for many months but are continually shut down by our Premier and Deena Hinshaw.

Please note, the issues raised here are happening everywhere in Canada as you well know and concede in your email. That makes this a FEDERAL ISSUE, not just a provincial one.

The boilerplate response again about treatments and testing is getting tiring. You really should get another script or have someone actually read the research. To do any less is nothing less than gross negligence. "caring [sic] out testing with clinically and scientifically proven methods" (or even carrying) is completely incorrect. As indicted below, the testing is widely inaccurate and unfit for purpose. This has even been admitted on camera by Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health on July 31st, 2020. (https://youtu.be/bbwMo7IbXbw). Long Term Care Centers are being shut across the country for isolated asymptomatic voluntary tests in a sea of negative results i.e. where there is no COVID. Why is this not something you are raising in Parliament and beyond? Is that not a FEDERAL MATTER?

Maybe even talk to Doctors who are being threatened daily for trying to treat cases early instead of forcing patients into isolation to get too sick to treat. Maybe you could look into where all millions of FEDERALLY donated doses of Hydroxychloroquine have gone? If it doesn't work, why have all the governments stock piled these donations? That is an actual FEDERAL matter!

On long term care facilities, our mother has been in this one for 10 years without incident. It is not the facility that is the issue but the protocols handed down from Dr Tam and the Federal Government that have been adopted in lockstep across each province. That again IS A FEDERAL MATTER.

So, on the FEDERAL MATTERS, what are you doing? What have you done? What questions have you asked since I provided the material that was of FEDERAL INTEREST?

How many more will die on your watch while you regurgitate this government approved drivel?

And yes we are mad at your lack of response. We voted for you and we WILL hold you accountable. Note that these comments are not just those of two sole voters but of a growing number in Alberta and beyond who are disgusted by responses such as this.

David

David T. Dickson
C.E.O. DKS DATA *(*www.dksdata.com*)*
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Dane.Lloyd@parl.gc.ca <Dane.Lloyd@parl.gc.ca>
Sent: August 12, 2020 9:30 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

Dear Mr. Dickson,

Thank you for reaching out.

We receive hundreds of emails a day so it can take more than a week to receive a reply.

Testing for COVID-19 and quarantine procedures in the province of Alberta falls under the jurisdiction of the provincial government. As, the federal government representative I do not have a say of influence in their procedures and methods. As I stated in a previous email to you, public health officials are caring out testing with clinically and scientifically proven methods. If you would like to discuss the Alberta operating procedures I would encourage you to reach out to your MLA. If your require assistance in determining who that is my staff would be more than happy to assist you.

There are some opinions out which are exceptionally critical regarding the treatment of COVID-19; many of these statements have not been proven in a scientific or peer reviewed manner so we cannot operate of these assumptions until they have been thoroughly proven. IT is the responsibility of all government officials to ensure the health and safety of its citizens. Other treatment and testing options and research projects are being funded by the federal government, but this research doesn't happen overnight. As research progresses we will have a deeper understanding of COVID-19 and be able to expand our treatment options and procedures.

With regards to long-term care facilities, this is a very serious matter. It would be a very stressful situation for you to have a family member residing in a care facility during this time.

It is unfortunate that it took a pandemic to bring to light some of the appalling conditions that seniors and those who require specialized care had been living in. I find it disturbing that the situation got so bad that the military was called in to take-over the operations of these facilities. The entire experience is completely unacceptable, and it must be addresses in a swift manner.

The oversight of long-term care facilities in Canada mainly falls under the jurisdiction of the provincial governments, however, I do believe that there is a place for the federal government. We need to work together to form guiding principles which will create a system that provides safe and reliable care of some of our country's most vulnerable.

I also whole-heartedly support a joint federal and provincial investigation into the state of long-term care facilities across the country. I feel that this type of investigation is necessary for us to fully understand where the issues lie and where services need to be improved.

Any governments primary responsibility, be it federal or provincial, is to ensure the health and safety of all Canadians. In this situation, all levels of government failed these vulnerable persons and we need to ensure that a catastrophe like this never happens again. I would encourage you to reach out to your MLA to discuss this matter further as well.

Once again, thank you for taking the time to reach out and discuss this very serious matter and please feel free to contact me in the future.

Kind regards,

Dane Lloyd, M.P.
Sturgeon River – Parkland

From: David Dickson <david.dickson@dksdata.com>
Sent: August 11, 2020 7:00 PM
To: Lloyd, Dane - M.P. <Dane.Lloyd@parl.gc.ca>; janice.harrington@albertahealthadvocates.ca; Motz, Glen - M.P. <Glen.Motz@parl.gc.ca>; Sloan, Derek - M.P. <Derek.Sloan@parl.gc.ca>; Diotte, Kerry - M.P. <Kerry.Diotte@parl.gc.ca>
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

To all above and all your colleagues,

It has now been almost a week and not a single response from our member of Parliament (Dane Lloyd) or the two other members of Parliament included below who have been contacted on multiple occasions. Also, no response from the Alberta Health Advocate who is also aware of the many concerns regarding the handling of the below and the larger matter around the COVID response by the Alberta Government.

Today we were informed of another staff created outbreak at Capital Care Dickinsfield (CCD) putting this facility on another 2 week "outbreak" and subjecting the residents to a fourth (and who known how many more) high risk and questionable RC-PCR testing. Note that the same exact fact pattern as in our complaint below was used to extend another Capital Care facility (sudden gastric issues in residents on the day the lockdown should end). How many coincidences make a pattern? Now we assume this latest lockdown at CCD will be under the same incompetent management as before putting the health of residents in further jeopardy. As days pass, it is hard to believe that these processes are not designed to actually hurry along the deaths of these most precious members of society.

You ALL have a duty of care to the citizens of Alberta and none more so than the residents in long term care. Protocols put in place by Deena Hinshaw which have never been enacted before are responsible for avoidable deaths far outnumbering those from this virus. Your inaction is actively contributing to this. You may well remember Jerry Dunham who died unnecessarily in Medicine Hat. I am currently in contact with his family. Avoidable deaths will soon be front and centre, leaving deaths from this virus in the distance. It is a duty of office to ensure accountability and responsibility for actions taken which have life changing consequences for so many on a scale never witnessed before in history.

At what point will you come out of the shadows and stand up for the citizens of this province? There are Albertans dying due to these barbaric and unquestioned protocols that have no scientific basis whatsoever. People are terrified everyday with growing 'cases' but there is no mention that almost all are voluntary asymptomatic tests that have no value other than the fear mongering factor for the daily updates. Speaking of 'Cases' again. This short video explains how cases were being used to manipulate the public in March. Here we go yet again. https://youtu.be/dLWwSYTjiBA

Note that the current rate of positive tests ('Cases') is 1.85% of all tested. The number of reported deaths per test in the province is 0.0337%. False positive error rates are confirmed to be up to 50% putting the number of positive cases as within the margin of error of zero. Tests, even serology tests, can come back positive months after any infection has passed. Deaths are marked as COVID no matter the true cause. This, along with all the facts used to petrify the population, is not even being hidden. Yet it is ignored by ALL of you. Why is that?

At no time in history (since Nuremburg) have we been subject to experiments in public health at this level. Isolation/quarantine of healthy individuals removes, indeed negates, all human rights and restricts access to required health care (mental and physical) that has already resulted in many avoidable deaths. Many more will follow if this continues without challenge. The public is told that known treatments are either dangerous or don't work, when doctors are told that the real reason for withholding treatment is a lack of medication availability. Yet at the same time over 4 million doses of HCQ in Canada alone have been donated by the manufacturers specifically for COVID treatment. Where did those doses of medication go? Worldwide, this number of donated doses of medication exceeds 250 million. More

than enough to have treated every person who has died multiple times over. Yet the treatment would have been useless as Deena Hinshaw and AHS deliberately force people to stay home until too sick to be treated properly. Then patients quite literally gasping their last, are consigned to the deadly ventilator after a mere 5 litres of O2 (10 in the Misericordia). No BPAP machine in hospitals was offered for fear of aerosolising the virus (despite protocols available in every hospital for MRSA patients that would negate that risk). Yet CPAP machines are still in use by paramedics in ambulances… I guess their lives are not worth as much as nurses and doctors… or is it something else? My own cardio thoracic surgeon assured me that this barbaric procedure would never happen in Alberta and certainly not in his hospital. He said it only happened for a short time in NY and Italy and no Doctor would ever do this here. Then I pointed out Dr. Darren Markland's tweets boasting about the use of ventilators for people with a respiratory disease. My doctor has not spoken to me since. Why is that?

I have spoken to doctors and nurses in Alberta who have been threatened to keep them quiet. People have died as a result. How is this not under investigation? And all this time, the prerequisite report that Deena Hinshaw quotes on all her Orders as justification for everything that has transpired from the initial lockdown on is yet to be produced to the citizens of this Province. Why is that?

To Glen Motz (Retired Medicine Hat Senior Police Officer), Derek Sloan (Candidate for Leadership), Dane Lloyd, (Member of Parliament for my family and I here in Spruce Grove), and Janice Harrington, (Alberta Health Patient Advocate), we are adding onto this list… Kerry Diotte, (member for Edmonton Griesbach), the area covered by Dickinsfield Long Term Care facility where our mother is currently incarcerated once more… it is time for you to do something and question what is really happening here. As we move back to hearing about cases, just like at the beginning in March, how many of these are from the voluntary asymptomatic testing and how many are 'spontaneous' with no apparent cause or subsequent case?

Consider that all the 'cases' related to Dickinsfield were staff members, not residents. In the Southside Good Samaritan's Care Centre in Edmonton we have 67 cases (26 deaths) in residents and 19 cases in staff. All carers were wearing full PPE at all times and following strict protocols. All of the deaths are in those over 70 years with multiple life threatening co-morbidities. In fact, we have not had a reported death 'with' not 'of' COVID under the age of 70 since April 23rd, 2020. Yet we now require children over the age of 2 to be forced into masks in most cities. I have arrested people during my time as a police officer for less abusive behaviour to children. Yet now we follow the order of politicians who have admitted the decision was rendered based on a survey of 6,000 citizens where 51% opted for mandatory masks. This is nothing less than gross negligence on the part of politicians, police and health professionals.

As with every case in this self described 'most deadly virus in the history of the world', AHS forces people to stay home until the symptoms get too serious for any useful treatment protocols. When did we ever do that before? Are we actually trying to kill people? Where has all common sense gone? Note that compared to SARS and MERS, this mortality of this virus is not even close to the hype it has been given, even assuming the statistics were even close to true. Compared to TB, Ebola and other contagious viruses, it hardly registers at all. In fact, in March of 2020, the UK specifically dropped COVID from being listed as a Highly Contagious Infectious Disease because it was not deadly enough! Yet Canada and Alberta locked down anyway and continue to expand measures that become more bizarre by the day. It appears that Deena Hinshaw and the Government are trying to test the intelligence of people and continue to be surprised at how compliant these citizens will be no matter what they are asked to do.

Note, the average age of a person dying 'with' not 'of' COVID in the province is 83 as of today. Last week it went up to 84 years just for a week. The average life expectancy in the province is 81. Denna Hinshaw has even used the death of a 105 year old with more than three life threatening co-morbidities as a COVID death statistic to justify her actions. Although any death is sad, the most surprising part of the death of a 105 year old right now is the fact that they were 105!

Due to the inane, insane and immoral protocols under the direction of Deena Hinshaw et al, many Albertans have died on intubated ventilators which have NEVER been used for the treatment of a respiratory disease before - for good reason. Ventilators misused in this way are known to cause significant lung damage and death even in those with healthy lungs. How do I know? It happened to me, as Glen Motz is well aware from when I worked with him on the largest Police Project ever undertaken in this province.

As regards this and more, I am attaching my research AGAIN for Mr. Diotte and as a reminder to those who have already had it. Maybe now some of this will resonate more clearly with recent events. It should be noted that most of you have had my research for months, some without even an acknowledgement let alone a response.

This government and Deena Hinshaw never were competent to manage any health crisis. It is clear that their actions have resulted in the deaths of many Albertans and so much more besides. For anyone continuing to ignore this and hide behind politics, in the words of Dante Alighieri "The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

I hope one or more will take up the mantel for the sake of us all. Please contact me for further information. Note that all I have presented is verifiable, been peer reviewed by colleagues and other professionals worldwide along with those here at home in Alberta. There is so much more to this story. It is way beyond time to start asking questions rather than blindly following 'Orders'.

David

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Privacy and Cybersecurity Expert.
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Fax: Redacted
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Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: August 5, 2020 9:20 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>; Derek.Sloan@parl.gc.ca; Dane.Lloyd@parl.gc.ca; health.deputy-minister@gov.ab.ca; info@albertahealthadvocates.ca; Glen.Motz@parl.gc.ca; premier@gov.ab.ca
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; deena.hinshaw@ahs.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Dr. Redacted

The fact that you consider this was a matter for your sole attention, dismissing all others on the email, is indicative of the reason for the complaint. Add to that the fact that you appear to consider it so minor an irritation to you that you can swat it off as a patient complaint to be lost while the chaos under your direction continues, boggles the mind. I assure you that the residents and families do not consider this matter so irrelevant to be dismissed out of hand. Further, as you are well aware, the AHS patient relations department is absolutely not equipped to address such concerns.

The gravity of these concerns warrants more than a summary dismissal by the person who is the very subject of the concerns. This is even more concerning as the actions are indictive of violations of the health act.

I would appreciate some response from the Members of Parliament, Health Advocate's Office, Premiers Office, Health Minister and the office of the CMO, all of whom are included in this email and are directly responsible for the lives of Albertans impacted by this behavior.

David

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Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

From: Redacted albertahealthservices.ca
To: david.dickson@dksdata.com, deena.hinshaw@gov.ab.ca, janice.harrington@albertahealthadvocates.ca, jason.kenney@gov.ab.ca
CC: dane.lloyd@parl.gc.ca, derek.sloan@parl.gc.ca, dksdata@gmail.com, glen.motz@parl.gc.ca, health.deputy-minister@gov.ab.ca, info@albertahealthadvocates.ca, karen.dickson@dksdata.com, premier@gov.ab.ca
Sent: Thursday, August 06, 2020 12:52:36 AM (GMT)
Subject: RE: RE: Visitation for Redacted

Mr. and Mrs. Dickson,

I regret to hear that you are not satisfied with the management of the Capital Care Dickinsfield outbreak and discussions with our AHS team were not able to resolve your concerns.

If you wish to request further investigation into these concerns, please contact our AHS Patient Relations Department: https://www.albertahealthservices.ca/about/patientfeedback.aspx

•Telephone: 1-855-550-2555
•Fax:1-877-871-4340
•Mailing address only:
c/o Patient Relations
10030 107 Street NW, Edmonton, AB T5J 3E4

Sincerely,

Dr. G. Redacted MD MSc FRCPC
Medical Officer of Health
Alberta Health Services – Edmonton Zone

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> Redacted *thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*
>
> *Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf*

"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a ***confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether****. "*

As per Redacted *previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.

I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.

Thank you,

Dr. G. Redacted *MD MSc FRCPC*
Medical Officer of Health
Alberta Health Services – Edmonton Zone"

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.
    - Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.
- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**
        - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the

resident, following all Public Health guidance and operator requirements for access to symptomatic residents.

- Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
- When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order "*In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident*".

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

> *"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."*
>
> *"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."*

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275 residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

<image003.png>
We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

David & Karen Dickson

David T. Dickson
C.E.O. DKS DATA ***(***www.dksdata.com***)***
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*

<image002.jpg>

From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

<image004.gif>

You have received an email message secured by Private Post.
Please open the file called Encrypted_Message.htm to read the message.

Mobile device users:
Forward this email to m@zd.trendmicro.com and receive URLs to view the message on mobile devices.

<A_SARS-COV-2-PrePrint.pdf>

From: David Dickson
Sent: Friday, October 7, 2022 1:54 PM
To: Danielle Smith < Redacted gmail.com>; Danielle Smith <danielle@daniellesmith.ca>
Subject: RE: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

Congratulations Danielle, will you actually do something now?
You ignored my email in 2020 regarding the care homes and Jerry Dunham. Will you act now or is it just all for show?
You do know that all the restrictions are still in place for Care Homes (and hospitals). That this 'Focussed Protection' approach is what killed most of the people in Alberta (before the vaccine took hold).

CANADA APPROVES PFIZER AGAIN.

12 years old and up (meaning 'nearly 12' in Canada!).

" a thorough and independent scientific review of the evidence..." - 8 MICE AND THEY ALL CAUGHT COVID WHEN EXPOSED!
https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2022-09-01/06-COVID-Miller-508.pdf

Everything "is expected..." because they do not know.

"MOSTLY MILD side effects"

Like the other approvals I fought against last year. "more data from...real-world use..."

REAL WORLD USE IS EXPERIMENTATION WITHOUT CONSENT ON THE POPULATION. THIS IS A CRIME.

I filed this into Court in Alberta in October 2021 regarding the 5-11 Pfizer shot.
"Real-world evidence in large pediatric populations is required to provide risk estimates of myocarditis/pericarditis and any other AE..."
https://dksdata.com/Court/DavidDicksonPackage/25-AffidavitInResponse_Filed_Redacted.pdf

WHERE WERE YOU, DANIELLE SMITH !? YOU GOT ALL THE INFORMATION ALL THE WAY BACK TO 2020 AS YOU KNOW.

https://covid-vaccine.canada.ca/comirnaty/product-details

https://www.canada.ca/en/health-canada/news/2022/10/health-canada-authorizes-covid-19-vaccine-booster-targeting-the-omicron-ba4ba5-subvariants.html

David

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Microsoft Partner

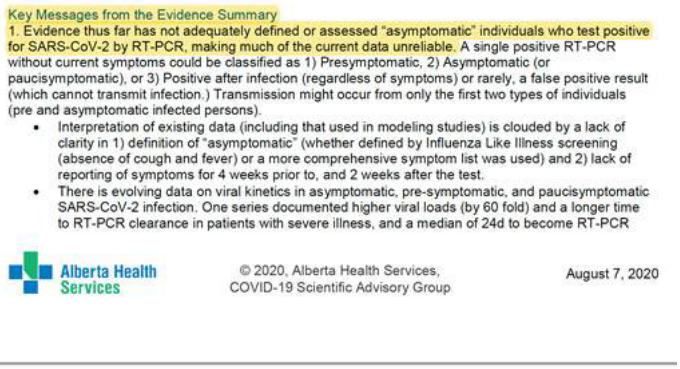
notify the sender and delete this e-mail message. Note: DKS DATA is not a Law firm and does not provide Legal Advice but can provide business advice on legal topics. If you require Legal Advice we can recommend one of our partnering Law Firms.

From: David Dickson
Sent: September 6, 2020 2:01 PM
To: Danielle Smith < Redacted gmail.com>
Subject: RE: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

Thanks for your response, Danielle.

As you can see from all I have sent, I have exhausted every avenue currently available to me. I hoped, based on what you talk about daily and how this impacts your fellow Albertans, you would be interested in pursuing this to shine some sunlight on this tragedy.

It might be time to consider why the RT-PCR tests being pushed at such a ferocious and irrational level when they are known to be useless. AHS themselves state in their own guidelines that these tests "CANNOT BE USED TO INFER **POTENTIALLY** INFECTIOUS STATUS". They don't even consider it valid as a presumption, let alone a confirmation! That test, known to have no value due to the large number of false positives, is being used to drive 'Cases'. These cases are being used to close businesses, care homes and destroy lives.
https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-sag-asymptomatic-transmission-rapid-review.pdf

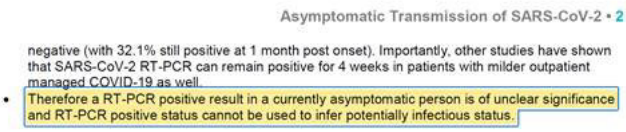


Key Messages from the Evidence Summary

1. Evidence thus far has not adequately defined or assessed "asymptomatic" individuals who test positive for SARS-CoV-2 by RT-PCR, making much of the current data unreliable. A single positive RT-PCR without current symptoms could be classified as 1) Presymptomatic, 2) Asymptomatic (or paucisymptomatic), or 3) Positive after infection (regardless of symptoms) or rarely, a false positive result (which cannot transmit infection.) Transmission might occur from only the first two types of individuals (pre and asymptomatic infected persons).
   - Interpretation of existing data (including that used in modeling studies) is clouded by a lack of clarity in 1) definition of "asymptomatic" (whether defined by Influenza Like Illness screening (absence of cough and fever) or a more comprehensive symptom list was used) and 2) lack of reporting of symptoms for 4 weeks prior to, and 2 weeks after the test.
   - There is evolving data on viral kinetics in asymptomatic, pre-symptomatic, and paucisymptomatic SARS-CoV-2 infection. One series documented higher viral loads (by 60 fold) and a longer time to RT-PCR clearance in patients with severe illness, and a median of 24d to become RT-PCR

Alberta Health Services

August 7, 2020



negative (with 32.1% still positive at 1 month post onset). Importantly, other studies have shown that SARS-CoV-2 RT-PCR can remain positive for 4 weeks in patients with milder outpatient managed COVID-19 as well.

- Therefore a RT-PCR positive result in a currently asymptomatic person is of unclear significance and RT-PCR positive status cannot be used to infer potentially infectious status.

These 'Cases' are also the criteria that drive the three levels of control on you, me and all other Albertans.
https://www.alberta.ca/maps/covid-19-status-map.htm

> ***"Open***
> *low level of risk, no additional restrictions in place* ***less than 50*** *active cases per 100,000*
> ***Watch***
> *the province is monitoring the risk and discussing with local government(s) and other community leaders the possible need for additional health measures at least 10 active cases and* ***more than 50 active cases per 100,000***
> ***Enhanced***
> *risk levels require enhanced public health measures to control the spread informed by local context"*

Due to the lack of follow up and automatic assumption that any symptom of COVID can only be COVID, we will see very few Flu cases this season as everything is assumed to be COVID. Unlike Flu, the protocol for COVID is to isolate and ignore. How many more will die of untreated bacterial pneumonia, PE (lung blood clot) and more due to this deliberate misdiagnosis in the coming months?

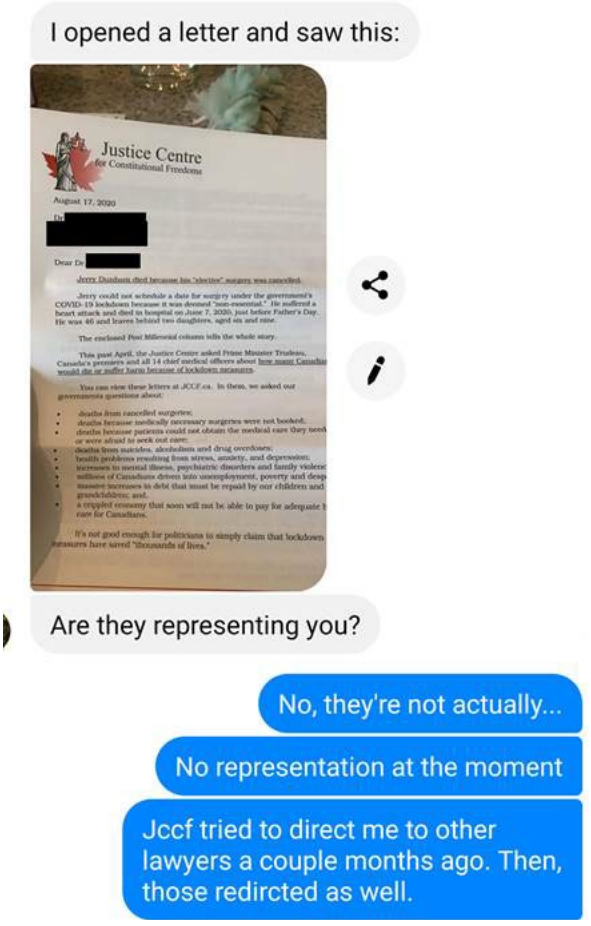
As we enter flu season, you might want to consider what is going to happen. We will enter a full lockdown unlike any we have seen to date. This will be enforced and the Government has made preparations for this. Why will they move us into lockdown? On top of the 50 or so per 100,000 false positives driven by the expansion of the testing program (as part of a deal to have Loblaws enforce masks on all their properties) we will have the usual 'Case' load of Flu. That ranges from 179 to 215 per 100,000 in the last few years (even with a vaccine that has been around for over a decade). Add that to the 50 PCR COVID 'Cases' and we are over 5 times that for a 'Watch' in Alberta. Think this government won't use this fear mongering to lock down the population? I know you know better than that.

(see page 3)
https://open.alberta.ca/dataset/9044e65d-a97e-43cb-8357-9c890422f069/resource/dcd1cc27-57c2-4cf4-8078-3869f19b6390/download/health-influenza-summary-report-2018-2019.pdf

Finally, I would suggest not promoting the JCCF. Unlike lawyers such as Redacted they are not what they promote. I have contacted them a number of times about this issue and the response is a joke (only not a funny one) – See attached.

They took Jerry Dunham's story and used it for fund raising, without telling the family. Their response to Jerry's partner and family was 'we can't help you'. Know how they found out about it? This is a message she shared with me in the last couple of weeks.

This is an ethical breach bordering on criminal (obtaining money by deception). I am doing what I can to help Krista and Jerry's children through this trying time for them… but again no-one seems to care. Note the Dr. who received this request for donations under false pretences was shocked to say the least, but not as much as poor Krista was.



I would like to think you would want to make a difference and hopefully by having this additional context, you will. You are a voice for Albertans right now and can reach the 'powers that be' in a way others cannot.

I can be reached anytime and will do whatever I can to get this story out. Again, a plea for help from the people in Care Homes and those dying and dead due to the avoidable atrocities this government has forced upon us with no actual scientific evidence to back up their actions.

Thanks,

David

David T. Dickson
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Management/Legal Consultant
Privacy and Cybersecurity Expert.
Cell: Redacted
Fax: Redacted
Email: david.dickson@dksdata.com

my LinkedIn profile Microsoft Partner

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: Danielle Smith < Redacted gmail.com>
Sent: September 6, 2020 8:03 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: Re: Visitation for Redacted - COVID 19 and Care Homes - A plea for help

I think you need to send this to the Justice Centre for Constitutional Freedom. They have taken on access cases in Ontario (I've seen several press releases) but I've not seen a case here. Maybe you could start one.
If it matters, I agree with your analysis of the risk.
It is clear COVID is more deadly to frail elderly people in care. But being imprisoned without human contact is equally deadly.
Let me know how it turns out.
Danielle

Sent from my iPhone

On Sep 5, 2020, at 9:33 AM, David Dickson <david.dickson@dksdata.com> wrote:

Two of seven.

Please treat as confidential.

From: David Dickson
Sent: August 12, 2020 10:46 AM
To: Dane.Lloyd@parl.gc.ca; SpruceGrove.StonyPlain@assembly.ab.ca; Edmonton.Castledowns@assembly.ab.ca
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Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Thank you yet again Dane for another 'pass the buck' response, dismissing the concerns of your constituents. I have now included the MLA's as you suggested. I also added in all the MP's as this is a local, provincial and federal matter as regards Long Term Care. Maybe one of them, unlike you, has the moral fortitude to step up and do more than send out lip service emails. I know they have been talking at caucus about the items in my research for many months but are continually shut down by our Premier and Deena Hinshaw.

Please note, the issues raised here are happening everywhere in Canada as you well know and concede in your email. That makes this a FEDERAL ISSUE, not just a provincial one.

The boilerplate response again about treatments and testing is getting tiring. You really should get another script or have someone actually read the research. To do any less is nothing less than gross negligence. "caring [sic] out testing with clinically and scientifically proven methods" (or even carrying) is completely incorrect. As indicted below, the testing is widely inaccurate and unfit for purpose. This has even been admitted on camera by Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health on July 31st, 2020. (https://youtu.be/bbwMo7IbXbw). Long Term Care Centers are being shut across the country for isolated asymptomatic voluntary tests in a sea of negative results i.e. where there is no COVID. Why is this not something you are raising in Parliament and beyond? Is that not a FEDERAL MATTER?

Maybe even talk to Doctors who are being threatened daily for trying to treat cases early instead of forcing patients into isolation to get too sick to treat. Maybe you could look into where all millions of FEDERALLY donated doses of Hydroxychloroquine have gone? If it doesn't work, why have all the governments stock piled these donations? That is an actual FEDERAL matter!

On long term care facilities, our mother has been in this one for 10 years without incident. It is not the facility that is the issue but the protocols handed down from Dr Tam and the Federal Government that have been adopted in lockstep across each province. That again IS A FEDERAL MATTER.

So, on the FEDERAL MATTERS, what are you doing? What have you done? What questions have you asked since I provided the material that was of FEDERAL INTEREST?

How many more will die on your watch while you regurgitate this government approved drivel?

And yes we are mad at your lack of response. We voted for you and we WILL hold you accountable. Note that these comments are not just those of two sole voters but of a growing number in Alberta and beyond who are disgusted by responses such as this.

David

David T. Dickson
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<image001.jpg>

<image002.jpg>

From: Dane.Lloyd@parl.gc.ca <Dane.Lloyd@parl.gc.ca>
Sent: August 12, 2020 9:30 AM
To: David Dickson <david.dickson@dksdata.com>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

Dear Mr. Dickson,

Thank you for reaching out.

We receive hundreds of emails a day so it can take more than a week to receive a reply.

Testing for COVID-19 and quarantine procedures in the province of Alberta falls under the jurisdiction of the provincial government. As, the federal government representative I do not have a say of influence in their procedures and methods. As I stated in a previous email to you, public health officials are caring out testing with clinically and scientifically proven methods. If you would like to discuss the Alberta operating procedures I would encourage you to reach out to your MLA. If your require assistance in determining who that is my staff would be more than happy to assist you.

There are some opinions out which are exceptionally critical regarding the treatment of COVID-19; many of these statements have not been proven in a scientific or peer reviewed manner so we cannot operate of these assumptions until they have been thoroughly proven. IT is the responsibility of all government officials to ensure the health and safety of its citizens. Other treatment and testing options and research projects are being funded by the federal government, but this research doesn't happen overnight. As research progresses we will have a deeper understanding of COVID-19 and be able to expand our treatment options and procedures.

With regards to long-term care facilities, this is a very serious matter. It would be a very stressful situation for you to have a family member residing in a care facility during this time.

It is unfortunate that it took a pandemic to bring to light some of the appalling conditions that seniors and those who require specialized care had been living in. I find it disturbing that the situation got so bad that the military was called in to take-over the operations of these facilities. The entire experience is completely unacceptable, and it must be addresses in a swift manner.

The oversight of long-term care facilities in Canada mainly falls under the jurisdiction of the provincial governments, however, I do believe that there is a place for the federal government. We need to work together to form guiding principles which will create a system that provides safe and reliable care of some of our country's most vulnerable.

I also whole-heartedly support a joint federal and provincial investigation into the state of long-term care facilities across the country. I feel that this type of investigation is necessary for us to fully understand where the issues lie and where services need to be improved.

Any governments primary responsibility, be it federal or provincial, is to ensure the health and safety of all Canadians. In this situation, all levels of government failed these vulnerable persons and we need to ensure that a catastrophe like this never happens again. I would encourage you to reach out to your MLA to discuss this matter further as well.

Once again, thank you for taking the time to reach out and discuss this very serious matter and please feel free to contact me in the future.

Kind regards,

Dane Lloyd, M.P.
Sturgeon River – Parkland

From: David Dickson <david.dickson@dksdata.com>
Sent: August 11, 2020 7:00 PM
To: Lloyd, Dane - M.P. <Dane.Lloyd@parl.gc.ca>; janice.harrington@albertahealthadvocates.ca; Motz, Glen - M.P. <Glen.Motz@parl.gc.ca>; Sloan, Derek - M.P. <Derek.Sloan@parl.gc.ca>; Diotte, Kerry - M.P. <Kerry.Diotte@parl.gc.ca>
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

To all above and all your colleagues,

It has now been almost a week and not a single response from our member of Parliament (Dane Lloyd) or the two other members of Parliament included below who have been contacted on multiple occasions. Also, no response from the Alberta Health Advocate who is also aware of the many concerns regarding the handling of the below and the larger matter around the COVID response by the Alberta Government.

Today we were informed of another staff created outbreak at Capital Care Dickinsfield (CCD) putting this facility on another 2 week "outbreak" and subjecting the residents to a fourth (and who known how many more) high risk and questionable RC-PCR testing. Note that the same exact fact pattern as in our complaint below was used to extend another Capital Care facility (sudden gastric issues in residents on the day the lockdown should end). How many coincidences make a pattern? Now we assume this latest lockdown at CCD will be under the same incompetent management as before putting the health of residents in further jeopardy. As days pass, it is hard to believe that these processes are not designed to actually hurry along the deaths of these most precious members of society.

You ALL have a duty of care to the citizens of Alberta and none more so than the residents in long term care. Protocols put in place by Deena Hinshaw which have never been enacted before are responsible for avoidable deaths far outnumbering those from this virus. Your inaction is actively contributing to this. You may well remember Jerry Dunham who died unnecessarily in Medicine Hat. I am currently in contact with his family. Avoidable deaths will soon be front and centre, leaving deaths from this virus in the distance. It is a duty of office to ensure accountability and responsibility for actions taken which have life changing consequences for so many on a scale never witnessed before in history.

At what point will you come out of the shadows and stand up for the citizens of this province? There are Albertans dying

due to these barbaric and unquestioned protocols that have no scientific basis whatsoever. People are terrified everyday with growing 'cases' but there is no mention that almost all are voluntary asymptomatic tests that have no value other than the fear mongering factor for the daily updates. Speaking of 'Cases' again. This short video explains how cases were being used to manipulate the public in March. Here we go yet again. https://youtu.be/dLWwSYTjiBA

Note that the current rate of positive tests ('Cases') is 1.85% of all tested. The number of reported deaths per test in the province is 0.0337%. False positive error rates are confirmed to be up to 50% putting the number of positive cases as within the margin of error of zero. Tests, even serology tests, can come back positive months after any infection has passed. Deaths are marked as COVID no matter the true cause. This, along with all the facts used to petrify the population, is not even being hidden. Yet it is ignored by ALL of you. Why is that?

At no time in history (since Nuremburg) have we been subject to experiments in public health at this level. Isolation/quarantine of healthy individuals removes, indeed negates, all human rights and restricts access to required health care (mental and physical) that has already resulted in many avoidable deaths. Many more will follow if this continues without challenge. The public is told that known treatments are either dangerous or don't work, when doctors are told that the real reason for withholding treatment is a lack of medication availability. Yet at the same time over 4 million doses of HCQ in Canada alone have been donated by the manufacturers specifically for COVID treatment. Where did those doses of medication go? Worldwide, this number of donated doses of medication exceeds 250 million. More than enough to have treated every person who has died multiple times over. Yet the treatment would have been useless as Deena Hinshaw and AHS deliberately force people to stay home until too sick to be treated properly. Then patients quite literally gasping their last, are consigned to the deadly ventilator after a mere 5 litres of O2 (10 in the Misericordia). No BPAP machine in hospitals was offered for fear of aerosolising the virus (despite protocols available in every hospital for MRSA patients that would negate that risk). Yet CPAP machines are still in use by paramedics in ambulances… I guess their lives are not worth as much as nurses and doctors… or is it something else? My own cardio thoracic surgeon assured me that this barbaric procedure would never happen in Alberta and certainly not in his hospital. He said it only happened for a short time in NY and Italy and no Doctor would ever do this here. Then I pointed out Dr. Darren Markland's tweets boasting about the use of ventilators for people with a respiratory disease. My doctor has not spoken to me since. Why is that?

I have spoken to doctors and nurses in Alberta who have been threatened to keep them quiet. People have died as a result. How is this not under investigation? And all this time, the prerequisite report that Deena Hinshaw quotes on all her Orders as justification for everything that has transpired from the initial lockdown on is yet to be produced to the citizens of this Province. Why is that?

To Glen Motz (Retired Medicine Hat Senior Police Officer), Derek Sloan (Candidate for Leadership), Dane Lloyd, (Member of Parliament for my family and I here in Spruce Grove), and Janice Harrington, (Alberta Health Patient Advocate), we are adding onto this list… Kerry Diotte, (member for Edmonton Griesbach), the area covered by Dickinsfield Long Term Care facility where our mother is currently incarcerated once more… it is time for you to do something and question what is really happening here. As we move back to hearing about cases, just like at the beginning in March, how many of these are from the voluntary asymptomatic testing and how many are 'spontaneous' with no apparent cause or subsequent case?

Consider that all the 'cases' related to Dickinsfield were staff members, not residents. In the Southside Good Samaritan's Care Centre in Edmonton we have 67 cases (26 deaths) in residents and 19 cases in staff. All carers were wearing full PPE at all times and following strict protocols. All of the deaths are in those over 70 years with multiple life threatening co-morbidities. In fact, we have not had a reported death 'with' not 'of' COVID under the age of 70 since April 23rd, 2020. Yet we now require children over the age of 2 to be forced into masks in most cities. I have arrested people during my time as a police officer for less abusive behaviour to children. Yet now we follow the order of politicians who have admitted the decision was rendered based on a survey of 6,000 citizens where 51% opted for mandatory masks. This is nothing less than gross negligence on the part of politicians, police and health professionals.

As with every case in this self described 'most deadly virus in the history of the world', AHS forces people to stay home until the symptoms get too serious for any useful treatment protocols. When did we ever do that before? Are we

actually trying to kill people? Where has all common sense gone? Note that compared to SARS and MERS, this mortality of this virus is not even close to the hype it has been given, even assuming the statistics were even close to true. Compared to TB, Ebola and other contagious viruses, it hardly registers at all. In fact, in March of 2020, the UK specifically dropped COVID from being listed as a Highly Contagious Infectious Disease because it was not deadly enough! Yet Canada and Alberta locked down anyway and continue to expand measures that become more bizarre by the day. It appears that Deena Hinshaw and the Government are trying to test the intelligence of people and continue to be surprised at how compliant these citizens will be no matter what they are asked to do.

Note, the average age of a person dying 'with' not 'of' COVID in the province is 83 as of today. Last week it went up to 84 years just for a week. The average life expectancy in the province is 81. Denna Hinshaw has even used the death of a 105 year old with more than three life threatening co-morbidities as a COVID death statistic to justify her actions. Although any death is sad, the most surprising part of the death of a 105 year old right now is the fact that they were 105!

Due to the inane, insane and immoral protocols under the direction of Deena Hinshaw et al, many Albertans have died on intubated ventilators which have NEVER been used for the treatment of a respiratory disease before - for good reason. Ventilators misused in this way are known to cause significant lung damage and death even in those with healthy lungs. How do I know? It happened to me, as Glen Motz is well aware from when I worked with him on the largest Police Project ever undertaken in this province.

As regards this and more, I am attaching my research AGAIN for Mr. Diotte and as a reminder to those who have already had it. Maybe now some of this will resonate more clearly with recent events. It should be noted that most of you have had my research for months, some without even an acknowledgement let alone a response.

This government and Deena Hinshaw never were competent to manage any health crisis. It is clear that their actions have resulted in the deaths of many Albertans and so much more besides. For anyone continuing to ignore this and hide behind politics, in the words of Dante Alighieri "The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

I hope one or more will take up the mantel for the sake of us all. Please contact me for further information. Note that all I have presented is verifiable, been peer reviewed by colleagues and other professionals worldwide along with those here at home in Alberta. There is so much more to this story. It is way beyond time to start asking questions rather than blindly following 'Orders'.

David

David T. Dickson
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Consulting C.I.O.
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Privacy and Cybersecurity Expert.
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Fax: Redacted
Email: *david.dickson@dksdata.com*
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<image002.jpg>

Some rules to live by:
Always do the best you can by your family.
Go to work every day.
Always speak your mind.
Never hurt anyone that doesn't deserve it.
And never take anything from the bad guys.
(Mel Gibson: Edge of Darkness 2010)

From: David Dickson
Sent: August 5, 2020 9:20 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>; Derek.Sloan@parl.gc.ca; Dane.Lloyd@parl.gc.ca; health.deputy-minister@gov.ab.ca; info@albertahealthadvocates.ca; Glen.Motz@parl.gc.ca; premier@gov.ab.ca
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; deena.hinshaw@ahs.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: RE: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Dr. Redacted

The fact that you consider this was a matter for your sole attention, dismissing all others on the email, is indicative of the reason for the complaint. Add to that the fact that you appear to consider it so minor an irritation to you that you can swat it off as a patient complaint to be lost while the chaos under your direction continues, boggles the mind. I assure you that the residents and families do not consider this matter so irrelevant to be dismissed out of hand. Further, as you are well aware, the AHS patient relations department is absolutely not equipped to address such concerns.

The gravity of these concerns warrants more than a summary dismissal by the person who is the very subject of the concerns. This is even more concerning as the actions are indictive of violations of the health act.

I would appreciate some response from the Members of Parliament, Health Advocate's Office, Premiers Office, Health Minister and the office of the CMO, all of whom are included in this email and are directly responsible for the lives of Albertans impacted by this behavior.

David

David T. Dickson
C.E.O. DKS DATA *(*www.dksdata.com*)*
Consulting C.I.O.
Management/Legal Consultant
Privacy and Cybersecurity Expert.
Email: *david.dickson@dksdata.com*
<image001.jpg>

<image002.jpg>

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From: Redacted albertahealthservices.ca
To: david.dickson@dksdata.com, deena.hinshaw@gov.ab.ca, janice.harrington@albertahealthadvocates.ca, jason.kenney@gov.ab.ca
CC: dane.lloyd@parl.gc.ca, derek.sloan@parl.gc.ca, dksdata@gmail.com, glen.motz@parl.gc.ca, health.deputy-minister@gov.ab.ca,

info@albertahealthadvocates.ca, karen.dickson@dksdata.com, premier@gov.ab.ca

Sent: Thursday, August 06, 2020 12:52:36 AM (GMT)

Subject: RE: RE: Visitation for Redacted

Mr. and Mrs. Dickson,

I regret to hear that you are not satisfied with the management of the Capital Care Dickinsfield outbreak and discussions with our AHS team were not able to resolve your concerns.

If you wish to request further investigation into these concerns, please contact our AHS Patient Relations Department: https://www.albertahealthservices.ca/about/patientfeedback.aspx

•Telephone: 1-855-550-2555
•Fax:1-877-871-4340
•Mailing address only:
c/o Patient Relations
10030 107 Street NW, Edmonton, AB T5J 3E4

Sincerely,

Dr. G. Redacted MD MSc FRCPC
Medical Officer of Health
Alberta Health Services – Edmonton Zone

From: David Dickson
Sent: August 5, 2020 5:54 PM
To: janice.harrington@albertahealthadvocates.ca; deena.hinshaw@gov.ab.ca; jason.kenney@gov.ab.ca; Redacted < Redacted albertahealthservices.ca>
Cc: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>; Redacted <Redacted capitalcare.net>; Derek.Sloan@parl.gc.ca; Glen.Motz@parl.gc.ca; Dane.Lloyd@parl.gc.ca; premier@gov.ab.ca; health.deputy-minister@gov.ab.ca; deena.hinshaw@ahs.ca; info@albertahealthadvocates.ca; Redacted < Redacted capitalcare.net>; dksdata@gmail.com
Subject: FW: RE: Visitation for Redacted
Importance: High
Sensitivity: Confidential

Firstly, Karen and I would like to thank all the front line staff at Capital Care Dickinsfield ("CCD") for their patience and efforts during these trying times and throughout the last 10 years.

Now however, we must address the communication below (and attached) and the issues related to the handling of this 'outbreak' at CCD. This has adversely and directly impacted not just the 275 at risk residents but also staff and loved ones which combined totals over 1,000 people.

On Saturday August 1st, 2020 Dr. Redacted sent the following in response to our ongoing concerns. The secure email suggests it was sent only to myself and Karen but this was encapsulated in the email below that confirms it was also sent to Redacted and Redacted We have added some other relevant parties to this email due to the concerns it raises.

We have added highlighting to the text below but the **emphasis** was placed by Dr. Redacted We are not sure at this time if Dr. Redacted misunderstands the Order or has deliberately attempted to deceive with the editing.

The yellow is a section taken out of context from the top of the section in the order. The green is a main bullet point that contains a critical statement about not restricting access and sets the subject as "Designated family/support persons", not "An operator" and the misrepresentation is trying to suggest. The blue text, **emphasised** by Dr. Redacted is a sub bullet point of the green, specifically identifying the subject "Designated family/support persons" for the following 'their', *"(led by **their** own discretion) but will not prohibit **their** presence altogether".*

Either way, both would suggest a serious issue with the continued handling of the safety of so many at risk residents of care homes during outbreaks.

> *"Hi all,*
>
> *Redacted thank you for sending these emails confirming that Capital Care Dickinsfield has made reasonable efforts to accommodate safe visits for designate family support members to the site while on outbreak.*
>
> *Mr. Dickson, as discussed during our phone conversation on Wednesday, as per CMOH order 29: https://open.alberta.ca/dataset/f075e30e-7ba1-4520-abe1-fb6076889cd4/resource/6d280e9e-2f25-4929-b6ca-51188151523e/download/health-cmoh-record-of-decision-cmoh-29-2020.pdf*
>
> *"An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site […]Designated family/support persons shall never be overly restricted in their access to the resident(s) they support. For greater clarity, a **confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether**. "*
>
> *As per Redacted previous email, the facility has scheduled a visit for Monday and are willing to arrange a visit on Saturday as well.*
> *Given the context of the outbreak, I am in full support of limiting visitation schedules to ensure the safety of the residents until the outbreak is over.*
>
> *I understand that this COVID outbreak is a difficult time for both residents and families, but ask for your patience during what we hope are the final days of the facility's outbreak and visitation restrictions.*
>
> *Thank you,*
>
> *Dr. G. Redacted MD MSc FRCPC*
> *Medical Officer of Health*
> *Alberta Health Services – Edmonton Zone"*

To clarify what Dr. Redacted misrepresented in her email communication, we have attached the full text of the Order she referenced, but here is the actual section Dr. Redacted decided to edit and emphasise. Note that contrary to the attempt by Dr. Redacted to infer the subject of the third person possessive adjective (their) being CCD, it is actually referring to the subject immediately prior in the sentence and paragraph bullet point. Essentially the 'their' is the "Designated family/support person". In this case, that is Redacted Redacted long time partner for more than a decade, Redacted and now includes her daughter, Karen Dickson.

Deceptively, by design or through negligence, Dr. Redacted attempted to suggest that "their own discretion" related to the operator where it clearly related to the "Designated family/support persons".

Restricted Access

- Restrictions such as duration and frequency limits on visits must only happen when reasonable attempts have been made by an operator to consider and offer alternative options.

- Any limits must be determined in consultation with the resident or alternative decision maker and family. If limits conflict with a person's schedule, alternative options must be provided.

- An operator may temporarily restrict access (e.g. no social visits where once permitted) in situations where a risk tolerance assessment indicates increased risk of exposure to COVID-19, such as: an increase in local community COVID-19 cases, confirmed site outbreak, or other situations that may limit the ability of an operator to safely have more people on site.
    - All restrictions must be in collaboration13 with residents and families and may include consultation with an organizational/agency executive or zone Medical Officers of Health, where appropriate14.
        - Collaboration with the site's Resident and Family Council is encouraged where a Council is established and representative of residents and families as a collective.
    - Any restrictions must not exceed 14 days without re-evaluation.
    - **Designated family/support persons shall never be overly restricted in their access to the resident(s) they support.**
        - **For greater clarity, a confirmed site outbreak may impact a designated family/support person's standing schedule (led by their own discretion) but will not prohibit their presence altogether.**
        - In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident, following all Public Health guidance and operator requirements for access to symptomatic residents.
    - Examples of restricted access include only allowing designated family/support persons, reducing number of persons permitted at one time, and limiting the number of additional people on site at any one time.
    - When access is restricted, an **operator** must continue to support virtual connection when physical presence of a designated family/support person is not possible.

Even when a resident HAS COVID, the statement by Dr. Redacted *"I am in full support of limiting visitation schedules",* is contrary to the order *"In situations where a resident has COVID-19, the operator and designated family/support persons must collaboratively arrange viable and feasible options for continued access to the resident"*.

To fully understand the impact, we must look at the context of the 'outbreak' at CCD. At no time since the first restriction placed on the Province by Dr. Hinshaw in early March 2020 have any residents contracted SARS-CoV-2. In mid June of this month, the majority of staff and residents at Dickinsfield were tested for SARS-CoV-2 despite no symptoms or expectations of an infection. This was raised as a concern at the time due to the known rate of false positives (and negatives) in the RC-PCR test. In fact, Dr. Barbara Yaffe, Ontario Government Associate Chief Medical Officer of Health, last week mentioned the error rate for false positives being almost 50%. We have seen from the CDC and heard from Doctors at AHS, that it is known to have a high error rate. However, this rate of positive errors along with the CDC confirmation that tests can be positive for up to 90 days after a infection is even more alarming considering the current situation.

By the third week of March, all test results had come back negative. Then, on or around 8th July, 2020, an asymptomatic member of staff from the second floor of Dickinsfield took a voluntary SARS-CoV-2 test which subsequently came back positive on or around 10th July, 2020. On Saturday 11th July, 2020 another round of asymptomatic testing was performed starting with the second floor residents. This was completed with no further consent (informed or otherwise) being obtained. This is an obvious concern as consent for an invasive procedure such as this must be obtained from all residents or their PoA. This requirement was confirmed in a call with Dr. Redacted From Saturday 11th July, 2020 until Tuesday 14th July, 2020, essential visitors continued to visit the center without any knowledge of a potential outbreak or a confirmed positive test of a staff member. This is obviously another concern.

At 4:16 pm on Tuesday 14th July, 2020 a bulk email (*"CapitalCare 14072020.pdf"*) was circulated from CCD stating;

"On July 13, we received lab confirmation that a CapitalCare Dickinsfield staff member tested positive for COVID-19. The staff member had been off work for the prior week, and remains off; however, Dickinsfield has been placed on outbreak precautions, as per the guidance of the Medical Officer of Health and AHS guidelines..."

"Additionally, all residents and staff within the Dickinsfield centre will be tested for COVID-19, beginning tomorrow."

This raised a number of concerns as consent is required for any testing for SARS-CoV-2. This also suggested an issue with the reported timelines.

- If the positive test was not received until July 13th, 2020, why was non consensual asymptomatic testing being performed on July 11th, 2020?
- If a positive test was known prior to this testing, then why was no one informed earlier, people allowed onsite without notification and the email notification stating July 13th, 2020 provided?

Upon receipt of this communication, we contacted CCD in writing and by phone pointing out the concern as regards the requirement to obtain informed consent. In response to our concerns, a further email was sent on Thursday 16th July, 2020 (*"CapitalCare 16072020.pdf"*) clarifying;

"On-site testing of consenting residents and staff began yesterday as per the direction of the Medical Officer of Health."

Immediately, all indoor scheduled essential quality of life visits by a "designated essential visitor" were cancelled with no options for alternate accommodations.

- We are reliably informed that a third round of testing was performed on residents in or around July 15th-July 18th, 2020, again without prior informed consent? Why was that?

Further to this, we were informed just before the first outbreak was due to be lifted on July 24th, 2020 that a second member of staff, unconnected to the first member of staff, had also had a positive result from a voluntary asymptomatic test. This staff member had also not been on site for over a week. We have two unexplainable (untraceable) asymptomatic voluntary tests in a center with not a single resident or working staff member testing positive in what is now up to three asymptomatic testing runs in less than a month. These tests, as well as being unreliable, are highly invasive and not without risk. This continued asymptomatic testing without any informed consent is very worrying, especially when triggered by asymptomatic voluntary testing with a positive result with no known tracible origin, or subsequent related cases. These appear more likely to be false positives at this point than actual infections.

- Is AHS going to continue to put these centers on such increased stress that, in of itself, is doing serious harm to the residents' physical and mental health, without apparent due cause? It is likely that this is going to result in more avoidable deaths and maladies than it could ever prevent. We, like many other family members and loved ones, have seen a marked deterioration in our loved one during these times.

Then on July 30th, 2020 we received another call from CCD to say that Redacted had fallen again at 11:30 pm on the evening of July 30th, 2020. As this was the second fall in a week for Redacted we were very concerned. Further, due to the Orders of Dr. Hinshaw, Karen, Redacted daughter and PoA, had not physically been allowed into the center for over 4 months. In consultation with the LPN on duty, who was unable to glean the reasoning for Redacted fall from Redacted we immediately drove out to the site, from Devon, to assist in communicating with Redacted As Redacted had a full left aphasic stroke a decade ago, it had already been identified that both Karen and Redacted (her partner) direct contact with Redacted was critical to her physical and mental health. As Dr. Hinshaw's Order 14-2020 only allowed one designated essential visitor on site to see Redacted we had designated Redacted to be that nominated person. At this critical time though, Redacted was not available. With the permission of Redacted (under Order 29-2020) and in consultation with the direct carer at CCD, Karen went in and saw her Mum. Karen was very concerned about what had happened. Redacted was visibly and audibly upset about the continued isolation in the center. In addition, further bruising was found on Redacted from this and the

previous fall. Note that this is highly unusual and appears related to Redacted stress regarding the additional restrictions placed on the center by Dr. Redacted

To make matters worse, we had made arrangements, as other family members had, to finally spend some time with Redacted starting the day the current asymptomatic, untraceable outbreak ended. Then last week during a number of calls and emails, we received one contradicting message after another. This appears to have been the case for other family members also. Some thought the outbreak was over on Saturday, others due to an email or other communications thought it was over Monday or Tuesday of the following week. After some discussions and emails with CCD staff, we discovered that another unrelated staff member, who had been offsite for over 10 days, had reported that their son had tested positive. We were informed by Dr. Redacted that she was waiting for the test back from this staff member to see if the staff was positive for COVID. We enquired directly with Dr. Redacted why this test had not already come back considering the enhanced testing protocol timelines provided by AHS for care centers under outbreak. She stated she would speak with Redacted from CCD and we were told by both that we would receive a call back. We didn't. We were also told by CCD staff that the outbreak had been extended for 24 hours to cover this additional staff member's time since last they were onsite. So, Dr. Redacted extended an outbreak on the most important summer long weekend, negatively impacting approximately 1,000 Albertans. We are still not aware if that staff member was even tested or if the decision was just to negatively impact all these people with no additional information.

Restrictions were placed on the centre and Karen, like so many others, was unable to take Redacted out of the center on Saturday August 1st, 2020. When Karen arrived at the center that day, Redacted was visibly agitated at being told she was unable again to leave the center and while Karen was there she was unable to even leave her room. Prisoners are given more rights than this. Eventually Karen calmed Redacted down after explaining what was happening and telling her that she would most likely be able to come out on Monday August 3rd, 2020 as per the discussion we had had with Redacted

Now we move to Monday August 3rd, 2020. As requested, Karen called the center to confirm Redacted would be able to have an offsite visit and get the much break, away from the center, so critical to her physical and mental wellbeing. On calling CCD, we were informed that the 'outbreak' had been extended because of two residents developing diarrhea. We have been dealing with CCD for over a decade since Redacted moved there and for all that time the care has been exemplary. However, the very nature of the facility and the residents who need such care leads to very frequent gastric issues for residents, including Redacted From constipation to diarrhea, these are caused by issues with medication, food, other maladies and, in many cases, lack of mobility. This is not unusual. It would be surprising if this or one of the many other symptoms common with care center residents' daily existence even before COVID had not been seen in one of the 275 residents during the three week outbreak! In fact, this reaction to symptoms was something that concerned us so much that we specifically enquired multiple times if anyone developing a symptom such as this would trigger another outbreak closing down the whole center? As we head back to school and into flu season, this is especially concerning as it could result in residents facing endless lockdowns. We were assured by Redacted that this would not happen and the protocol for a resident with symptoms is to isolate that resident only. This appears to have not been the case on Monday August 3rd, 2020.

Karen spent her short visit in Jeans' room trying to placate Redacted who, after three weeks of life restricted to the centre, was ready to wheel herself out. I, David, was forced to resolve the issue by phone from the car park. Eventually I spoke to Redacted a nurse with AHS who had extended the outbreak based on a reporting of these sudden gastric symptoms right at the end of the outbreak. During the call, it became obvious that Ms. Redacted was missing critical information regarding the outbreak and had still decided to extend it anyway. Hopefully the calls with her are recorded as I would certainly like to review them with someone in authority. When challenged that she had made a decision without all the facts, thus impacting over a thousand people, Redacted threatened (and on the first call did), hang up the phone very abruptly. This is a wholly unacceptable response. Then she called back and apologised. She said after checking the information, she had made a mistake, had informed the center the outbreak had been lifted **again** and that the center was now on active investigation due to the two cases of diarrhea. Had Karen and I not intervened and pushed back to force AHS to do their job and actually check the facts, this center, 275 residents, all staff, family and loved ones would have been negatively impacted for many more days. THIS IS NOT OUR JOB!

Dr. Redacted was in charge of the outbreak. She has confirmed in her email that even since the initiation of Order 29-2020, she still stands by her approach to remove essential/designated visitor access during an outbreak. As Order 29-2020 clearly states, this restriction is not just discouraged but is expressly prohibited. However, this decision, as can be seen by Dr. Redacted response, was fully supported by her, despite being contrary to the Order she has misrepresented above. It is a serious concern for someone managing outbreaks in the Edmonton zone to be expressly going directly against Orders, made law, from Dr. Hinshaw. As Dr. Hinshaw has acknowledged and further clarified, these visits to residents are critical under normal circumstances but in instances of restriction being implemented these designated indoor visits are even more critical;

> *"To offset the negative consequences to residents due to the prolonged visitor restrictions in these settings, access to support from designated persons (other than staff) is supported as essential to maintaining the resident's mental and physical health, while still retaining necessary safety precautions."*

Based on this, the comments by Dr. Redacted and the misrepresentation of Dr. Hinshaw's Orders, we have grave concerns as regards the continued involvement of Dr. Redacted in the management of any outbreaks in Alberta. Considering the intense physical and mental strains placed on the residents, staff and loved ones during these outbreaks, the potential life changing impacts from this position, either through misunderstanding or deliberate misrepresentation, cannot be ignored by AHS or the Government.

Cancelled visits falling into this category included the scheduled visit for Redacted at 1pm on Monday July 20th, 2020. As a result, Redacted was denied her direct essential quality of life visits for two weeks on the direction of Dr. Redacted under this outbreak. During this time, Redacted suffered multiple apparent falls during which she sustained significant bruising. Note that this is not an isolated incident as other residents and loved ones have even more concerning experiences during this time.

One final point regarding both the unreasonable restriction placed by Dr. Redacted and the two sudden unrelated diarrhea cases in the center is a decision made by Dr. Redacted to allow 'outdoor visits' during an outbreak in the latter half of last week. These types of visits are explicitly prohibited during an outbreak under Order 14-2020 and 29-2020. The reason for this is the apparent much higher risk of non designated unscreened 'visitors' (not wearing PPE) vs. the limited designated persons, screened and wearing PPE. To this point, there hasn't been a single case (symptomatic or asymptomatic) of SARS-CoV-2 in the CCD residents since the inception of restrictions by Dr. Hinshaw in early March, 2020.

CCD offered to assist in these visits for the benefit of all the residents and family. Due to the information outlined above, the suggestion by CCD to support outdoor visits would seem reasonable for the mental and physical benefit of the residents. The authority for this decision at the time was Dr. Redacted However, if Dr. Redacted thought this outbreak was of so little risk that outdoor visits, specifically prohibited under Order 14-2020 and 29-2020, were acceptable, why did she, at the same time, consider this so serious that she had to extend a lockdown by 24 hours and block designated visits explicitly demanded in Order 29-2020? Note that this centre had had all residents and staff tested multiple times, all negative. Only two staff members, not onsite for over three weeks, voluntarily tested asymptomatically positive with no cause of origin or subsequent infection. So why did Dr. Redacted break (and still support the breaking) of these Orders to the detriment of the entire facility? If any other member of the public committed such a heinous act against one of these Orders, they would be liable for up to a $500,000 fine. As this is the action of a Dr. in charge of so many outbreaks in the city, where a number of Albertans have died, both with and without COVID, we have to question her suitability to continue in this role.

Shown here from the AHS website are all recent deaths in the Edmonton Zone, part of Dr. Redacted responsibility. These show that all recent deaths in this zone are related to elderly at risk persons with multiple known and some undiagnosed comorbidities. The result of these deaths has increased the average age of death from 83 to 84 in the last week alone. Every passing is extremely sad but we must ensure the safety of all these most precious people beyond the narrow focus of COVID, especially as we move into another flu season. As such, mistakes like we have seen in CCD under asymptomatic outbreak which have added undue pressure on these centers and all involved will be no doubt be deadly, if this has not already been the case. AHS and the Government cannot allow this to continue.

<image003.png>
We would request a formal investigation be started as regards the management of this outbreak and the actions of Dr. Redacted and maybe other Zone Managers if they are following the same mantra. This is for the safety of all Albertans but especially those most vulnerable in the care of AHS. On behalf of Redacted we would also ask that a formal enquiry be started as regards her denial of access to her critical direct essential quality of life visit in the hopes that this will never happen again.

Hopefully all parties have learnt from this episode. However, without a review and documentation of lessons learnt, we fear this will continue to be repeated and more of our most vulnerable Albertans will suffer and be lost unnecessarily.

David & Karen Dickson

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<image001.jpg>

<image002.jpg>

From: Redacted < Redacted albertahealthservices.ca>
Sent: July 31, 2020 7:47 PM
To: Redacted < Redacted capitalcare.net>; Karen Dickson <karen.dickson@dksdata.com>; DKSDATA <DKSDATA@GMAIL.COM>
Cc: David Dickson <david.dickson@dksdata.com>; Redacted < Redacted capitalcare.net>
Subject: RE: RE: Visitation for Redacted
Sensitivity: Confidential

<image004.gif>

You have received an email message secured by Private Post.
Please open the file called Encrypted_Message.htm to read the message.

Mobile device users:
Forward this email to m@zd.trendmicro.com and receive URLs to view the message on mobile devices.

<A_SARS-COV-2-PrePrint.pdf>