

From: Info OMB <info@ombudsman.ab.ca>

Sent: Tuesday, July 18, 2023 4:07 PM

To: David Dickson <david.dickson@dksdata.com>

Subject: RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Good afternoon David,

The Ombudsman is authorized by the *Ombudsman Act* to investigate complaints about the administrative fairness of: Alberta government departments, agencies, boards, commissions; municipal government; designated professional organizations; and the Patient Concerns Resolution Process (PCRP) of Alberta Health Services (AHS).

The Ombudsman's jurisdiction specific to AHS is restricted to the PCRP. This means you must attempt to resolve your complaint first with the Patient Relations Department of AHS before involving our office. As a result, your case is now closed. Should you wish to pursue your complaint with the PCRP, contact information is as follows:

Patient Relations Department

Alberta Health Services

10030 – 107 Street, Suite 300

Edmonton, AB T5J 3E4

Phone: 1-855-550-2555

Fax: 1-877-871-4340

Website: <http://www.albertahealthservices.ca/about/patientfeedback.aspx>

If you are dissatisfied with the actions or decisions of the Patient Relations Department, your concern must be elevated in writing to the Patient Concerns Officer (PCO) at the address noted above.

If you receive a decision from the PCO you believe is unfair, you may write to the Ombudsman again to explain why you believe your patient concern was not handled fairly and request an investigation. If you do write to the Ombudsman again, please provide details of the outcome including a copy of any correspondence you receive. The Ombudsman will then determine if he can investigate your complaint.

Regarding any complaints about a health college, you must raise your complaints through the respective colleges first, before writing to the Ombudsman. I refer you to the colleges' complaint processes for more information.

College or Registered Nurses of Alberta

Website: <https://www.nurses.ab.ca/protect-the-public/complaints/>

College of Licensed Practical Nurses of Alberta

Website: <https://www.clpna.com/complaints/>

I trust this is of assistance.

Sincerely,

[redacted]

Senior Investigator

9925 – 109 Street NW, Suite 700

Edmonton, Alberta T5K 2J8

Phone: [redacted]

Toll Free: [redacted]

Email: info@ombudsman.ab.ca

www.ombudsman.ab.ca



Note: Any materials prepared as a result of a complaint submitted to the Ombudsman, including the complaint itself, and any material produced by the Ombudsman, such as this email, cannot be used in any other proceedings, including before a board or court. This applies whether you or the Ombudsman have possession of any of these materials.

From: David Dickson <david.dickson@dksdata.com>

Sent: Monday, July 17, 2023 3:20 PM

To: Info OMB <info@ombudsman.ab.ca>

Subject: RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Many thanks [redacted],

I know parts of this involve the College of Registered Nurses, College of Licensed Practical Nurses, AHS and Capital Care specifically. I have proof in the documents relating to these groups (and more). Would that help you?

I even tried the HQCA and not their problem. Any suggestions who would? I know this should be a police matter, but while the lies continue no Police officer would touch it (I would have when I was in uniform, but sadly this is a different world).

David

PRIVACY NOTICE: This e-mail message and any attachments are intended only for the named recipient(s) above and may contain information that is privileged confidential and/or exempt from disclosure under applicable law. If you have received this message in error or are not the named recipient(s) please immediately 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: Info OMB <info@ombudsman.ab.ca>

Sent: Monday, July 17, 2023 2:39 PM

To: David Dickson <david.dickson@dksdata.com>

Subject: RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Good afternoon David,

I acknowledge receipt of your email. As per section 12(1) of the *Ombudsman Act*, the Ombudsman has no jurisdiction to investigate complaints about other legislative offices, as they do not fit the legal definition of a department, agency, board, commission, municipality, or professional organization.

I do understand your passion about this matter and believe there is some kind of wrongdoing. However, we cannot investigate your concerns.

Sincerely,

[redacted]

From: David Dickson <david.dickson@dksdata.com>

Sent: Tuesday, July 11, 2023 2:11 PM

To: Info OMB <info@ombudsman.ab.ca>; Office of the Premier <Premier@gov.ab.ca>;

Andrew.Boitchenko@assembly.ab.ca; Drayton Valley-Devon <draytonvalley.devon@assembly.ab.ca>;

Sharif.haji@assembly.ab.ca; Edmonton-Decore <Edmonton.Decore@assembly.ab.ca>; Health Minister

<Health.Minister@gov.ab.ca>; Ministry of Justice <ministryofjustice@gov.ab.ca>

Cc: info <info@oag.ab.ca>

Subject: RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Importance: High

Good afternoon [redacted],

I am following up on the matter reference #23-02483. Your office responded that I had addressed the complaint to the correct party i.e. the OAG's office. The OAG responded that they don't accept complaints from the public and are not accountable to the public, only to the Legislative Assembly. I have contacted our MLA's, the Premier's office, Minister of Justice, and Minister Health multiple times and they continue to refuse to speak to us about this matter.

As you do take up complaints against the government and the contents of the complaint to the OAG specifically outline provable wrongdoings by the government, I would request this matter be addressed by your office without further delay.

I have included our MLA's, the OAG, the Premier, Health Minister and Justice Minister for their information and response.

Considering the escalating All Cause Mortality that appears worse in Alberta (per capita) than most of Canada, this matter is of considerable public interest. This is especially concerning due to the provable lies and other misinformation from the government since 2020 that continues to this day. In addition, it is now clear that the government is deleting the very data that demonstrates these wrongdoings.

See: <https://dksdata.com/ExcessDeaths>

Below is the frankly unbelievable response from the OAG who has been clearly informed he provided false information in his public report. To ignore that fact is clear malfeasance in office. I hope that that part will be taken up by the Justice Minister immediately.

Start of OAG response

From: info info@oag.ab.ca

Sent: Wednesday, July 5, 2023 2:39 PM

To: David Dickson david.dickson@dksdata.com

Subject: Response from the Office of the Auditor General - RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Hello Mr. Dickson,

We appreciate attention to our reports from concerned Albertans. Thank you for your submissions.

We cannot provide the responses you seek, make referrals to law enforcement officials nor further the interests connected to your submissions through judicial processes. Please refer to the [Auditor General Act](#) for the limits to the mandate and release of information from our office.

Further, the Auditor General Act provides for no process respecting complaints by private parties. The audits and reports of the Auditor General support the work of the Legislative Assembly of Alberta and it is to the Legislative Assembly that the Auditor General is formally accountable. Accordingly, this correspondence will represent the final response you will receive from our office on this matter.

We wish you the best in making positive change to lives of Albertans in your endeavours.

Regards,

[Redacted]

Engagement Coordinator

Office of the Auditor General of Alberta

8th Floor, 9925 - 109 Street

Edmonton, AB T5K 2J8

oag.ab.ca



Classification: Protected A

End of OAG response.

David

David T. Dickson

Disabled Police Officer (retired - injury on duty)

C.E.O. DKS DATA (www.dksdata.com)

Consulting C.I.O.

Management/Legal Consultant

Privacy and Cybersecurity Expert.

Cell: [redacted]

Fax: [redacted]

Email: david.dickson@dksdata.com

COVID 19 Information: <https://dksdata.com/COVID19>



Microsoft
Partner

"The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

Dante Alighieri

"So whoever knows the right thing to do and fails to do it, for him it is sin."

James 4:17

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)



<https://avoidabledeathawareness.com>

PRIVACY NOTICE: This e-mail message and any attachments are intended only for the named recipient(s) above and may contain information that is privileged confidential and/or exempt from disclosure under applicable law. If you have received this message in error or are not the named recipient(s) please immediately

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: Info OMB <info@ombudsman.ab.ca>

Sent: Wednesday, June 28, 2023 3:47 PM

To: David Dickson <david.dickson@dksdata.com>

Subject: RE: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Ombudsman complaint #23-02483

Good afternoon David Dickson,

The Alberta Ombudsman's office received your email below in which you complain about the Office of the Auditor General's 2020 report on the handling of COVID in Alberta Care Homes.

The Ombudsman has no authority to investigate complaints about other legislative offices. The Ombudsman is authorized by the *Ombudsman Act* to investigate complaints about the administrative fairness of decisions made by: Alberta Government departments, agencies, boards, commissions; municipal governments; designated professional organizations; and the Patient Concerns Resolution Process of Alberta Health Services. As a result, the Ombudsman cannot investigate your complaint about the Office of the Auditor General and your case has been closed.

You have appropriately raised your concerns with the Auditor General directly. You may also wish to raise your concerns with your Member of the Legislative Assembly.

Sincerely,

[redacted]

Senior Investigator

9925 - 109 Street NW, Suite 700

Edmonton, Alberta T5K 2J8

Phone: [redacted]

Toll Free: [redacted]

Email: info@ombudsman.ab.ca

www.ombudsman.ab.ca



Note: Any materials prepared as a result of a complaint submitted to the Ombudsman, including the complaint itself, and any material produced by the Ombudsman, such as this email, cannot be used in any other proceedings, including before a board or court. This applies whether you or the Ombudsman have possession of any of these materials.

From: David Dickson <david.dickson@dksdata.com>

Sent: Tuesday, June 27, 2023 3:06 PM

To: info@oag.ab.ca; Info OMB <info@ombudsman.ab.ca>; Office of the Premier <Premier@gov.ab.ca>

Subject: Formal complaint re OAG 2020 report on the handling of COVID19 in Alberta Care Homes during 2020.

Importance: High

Dear Mr. Wylie,

I have written before and received no response. This is now a formal complaint regarding the February 2023 report on Care Homes during 2020 in Alberta. There are many issues with the report as outlined in the attached document (updated at the time you published the report). I have included the offices of the Premier and the Ombudsman in this communication.

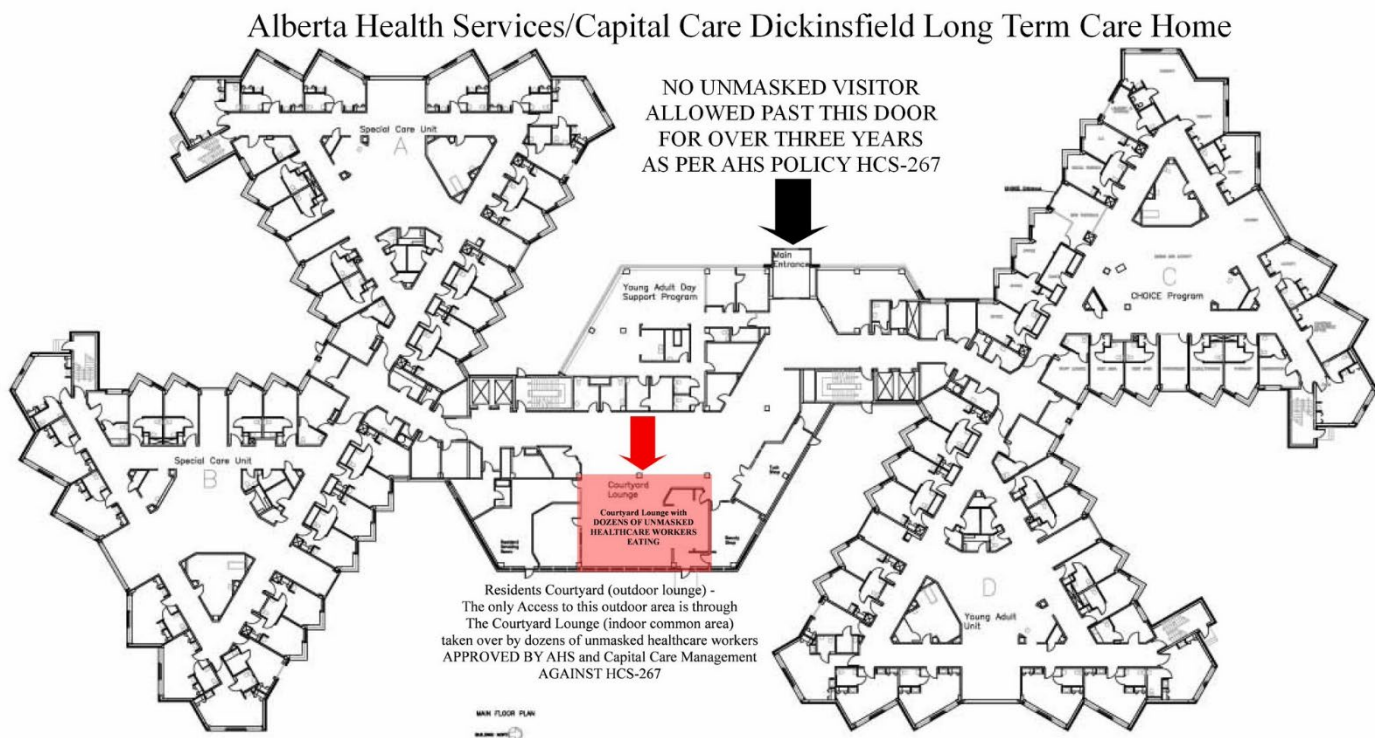
<https://dksdata.com/CareHomes/oag-covid19-cont-care-facilities-feb2023-Comments.pdf>
<https://dksdata.com/CareHomes/oag-covid19-cont-care-facilities-feb2023-CommentsAll.pdf>

**Note the comments in this document were made at the time of publication. Please use this email where details may differ due to the passage of time.*

I will focus on a few critical items that are without question. I do not know if you were misled or misinterpreted the information available, but this is a matter of the gravest importance. It needs addressing publicly and may need referring to the police and judiciary, without delay.

1. Serious issues with care management and COVID response in Care Homes in 2020 and beyond.
2. Number of deaths reported as related to COVID 19 in Care Homes in 2020.
3. Deleting of Government Data related to COVID 19 in a clear attempt to mislead the Alberta public.
4. Misreporting of data on COVID Cases and Deaths by the Alberta Government, Dr. Deena Hinshaw and Dr. Mark Joffe (amongst others).

I would like to briefly cover some of the more serious concerns, one of which I was able to confirm on my last visit to Capital Care Dickinsfield (June 26th, 2023). This relates to the treatment of Care Home residents, their Designated Support Persons and visitors. It recently came to my attention that in my mother in law's care home, the staff were allowed to use the main common area on the ground floor to eat and socialise, without being masked, in an open area adjacent to all main facilities, the main entrance and rear exit to the gardens. This central ground floor open area would be considered one of if not the highest traffic areas for staff, residents, DSP's and visitors in the facility.



Use of this area by unmasked staff was in direct conflict with Dr. Deena Hinshaw's Orders and the AHS Continuous Masking Directives (that were implemented at Capital Care Dickinsfield). We have been informed by the site director that AHS approved these breaches in multiple audits throughout COVID.

These were the very same directives and Orders that forced me, as a retired and disabled police officer, to have to sit in the car park every visit my wife made to see my mother-in-law. This included medical appointments with her doctor where I was duty bound to be part of her care as her medical proxy. Instead, I was left with no option but to sit outside and advocate blindly via a phone through three Alberta winters. In addition, my mother in law's partner, an eighty-year-old man with a heart condition, was accosted multiple times by staff for not wearing his mask 'properly'. On one occasion, he was publicly humiliated while in my mother in law's room by a large crowd of staff for not wearing a mask (despite this being allowed under the Directive and Orders due to my mother in law's communication challenges). Note that the presence of this large crowd including the site director's PA and many staff from other floors, constituted a breach of policy and Orders at this time. In addition to this, the center issued him with a notice saying as he had been 'caught' without a mask on, he was banned from all Capital Care facilities. This position was reversed when my wife and I pointed out they could not do this and that we would take the matter further if they persisted to persecute this gentleman. Note that this clear bullying of a vulnerable, elderly DSP also, by extension, impacted his partner, my mother-in-law, herself a resident of the facility who was present at the time. Sadly, she was unable to speak or otherwise communicate her distress as this played out in front of her. Unconscionable as this was on the part of the staff in question, this was the direct result of policies and Orders pushed on the facility in an inconsistent manner. This implementation of Orders and Directives caused untold distress and endangered residents and visitors alike, outside of any risk from a respiratory infection. These were not isolated incidents nor restricted to this facility, in our experience.

This is relevant to your report due to the sustained and improper treatment of DSP's and residents alike during COVID. This had a direct impact on the health and wellbeing of residents inside the Care Homes and the staff being forced to implement these inconsistent rules that were clearly not fully understood by staff.

When the information relating to the ongoing breaches in the use of the common area was recently brought up to the CEO at AHS, we were told this was something they would address with the Care Home, despite the Care Home having passed multiple AHS audits where the breach was known. It is clear from the amount of time this went on that the CEO and other senior members at AHS were not only aware but fully supported these clearly illegal actions.

June 8th, 2023, the Director at the AHS CEO's office wrote.

"I was away last week but on my return I did forward the last email you sent me to colleagues in the Edmonton Zone asking that they connect with Capital Care Dickinsfield for advice on the concerns raised by Mr. Dickson related to masking at the facility."

Just after this correspondence was communicated back to Capital Care Dickinsfield, masking was dropped in all AHS facilities (including Capital Care). This happened with no notice. Was this an attempt to hide the crimes that had been ongoing for three years? From my visit to the center for the first time in 1,193 days, I noted that the staff were not even informed of the change. Not that this is really a change as you will see in the links below regarding the more insidious and restrictive policies now in place. Timing, they say, is everything. Buried beneath the removal of masking in AHS facilities is a policy for unprecedented restrictions including daily testing, total isolation and continuous masking and goggles for nothing more than two residents or patients sneezing in a seven day period.

Masking FAQ (June 19th, 2023)

<https://albertahealthservices.ca/assets/info/ppih/if-ppih-continuous-masking-directive-faq.pdf>

Today, I went into the centre for the second time and was not surprised to find the senior staff are still unaware of the changes that were announced on June 16th, 2023, and implemented on June 19th, 2023 - in particular, the items outlined in the linked posters.

For staff, patients and visitors. (created June 16th, 2023. Last modified June 22nd, 2023)

<https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-masking-staff.pdf>

For patients/residents. (created June 20th, 2023)

<https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-masking-patient.pdf>

If implemented as written, no Care Home will ever be 'Off Outbreak' again. Yet Capital Care Dickinsfield is still unaware of these documents almost two weeks after they were announced. Unlike a Unit at the Peter Lougheed Hospital which implemented these barbaric and harmful policies in full force on June 19th, 2023.



Considering most, if not all, of the outbreaks (we are aware of) started with asymptomatic staff (confirmed in the attached documentation), it is not hard to infer that many, if not all, deaths that have been categorised as COVID could and should be associated with these AHS approved breaches of Dr. Deena Hinshaw's Orders and the AHS internal directives. It would be for AHS and all Care Homes to further prove they did not implement such illegal practices during the last three years in other locations, with equally devastating effects. If AHS and Capital Care believed their own propaganda and steps taken to isolate residents from loved ones, why would they approve such deadly behaviour every day? If they approved of this behaviour because they knew there was no risk, then they are culpable in every single avoidable death on their watch. Everyone from Dr. Deena Hinshaw to the Patient Advocate, every politician and all of the AHS and Capital Care senior staff were aware of these breaches, making them accessories to the crimes committed, no matter your opinion on COVID.

As can be seen in the communications from 2020 we have included, is AHS and Capital Care actively refused on site access for residents' Primary Care Physicians on multiple occasions. This led to delayed treatments and ultimately the untimely death of more than one resident in our experience.

Note that although this particular facility has the lowest number of Influenza Like Illness Deaths (including COVID) during the last three years than would be normal in a single year, they have experienced the largest number of deaths overall year on year for other causes which are directly associated with the COVID response in many cases.

In your report, you identify 1,530 COVID 19 deaths in Alberta in 2020. Your report also identifies more than 8,300 COVID cases and 1,000 COVID deaths in 2020 in Care Homes. I won't go into detail in this cover email regarding the concerns of identifying a COVID Case, but I do have a concern about the over 1,000 COVID deaths which you state account for 65% of the 2020 COVID deaths in Alberta.

Alberta Health has published two sets of Data on COVID Cases and Deaths, outside of the media releases used, as the primary source for COVID information early in 2020. From May 2020 until June 14th, 2023, a comprehensive download file of Cases and Deaths was available from the Alberta Health website using the link;
<https://www.alberta.ca/data/stats/covid-19-alberta-statistics-data.csv>.

This data in this file appears to have been the source of your information for total Deaths and Cases. Until October 10th, 2022, this file was easily available to all Albertans from a button on the data page of the Alberta Health COVID website. Although the button was removed from the webpage, the data remained available from the underlying link for those aware of its location.

I had been using that download file to analyse the data reported by Alberta Health for nearly three years. Your report confirmed a concern I had with the data. In that file is a field called "Date Reported". There was no definition of "Date Reported" anywhere, but analysis of the data and comparing it to the media reports suggested this was the initial date a COVID Case was reported in the system. That Case could initially be 'Active', then either "Died" or "Recovered". Later, the Active and Recovered were merged into a single "N/A" status which obfuscated some critical information. As this change happened after the period of your report, this change of status is a secondary concern. The real issue is how the "Date Reported" was used for your report in particular.

For the reporting in the media and to Health Canada (until August 2022), it was clear that the "Date Reported" was the COVID Case date. The Deaths, on the other hand, were collated as they were reported i.e., the file date. However, these reported Deaths still reflected their original Active Case state date as "Date Reported" in the file. As there could be a gap between files, that death date could be a period of days between the last report and the current report. This file also had several 'reclassifications' (as Dr. Hinshaw called them), where a confirmed reported COVID Death was later 'reclassified' as not COVID and thus removed from the download file. To date, that number of 'reclassifications' stands at 399 CONFIRMED Covid Deaths, later removed from the reporting, many from 2020.

The issue with your report is that the data has to be sorted by "Date Reported" as the Date of Death to match the total deaths of 1,530 for 2020. The actual number at the time of publication was 1,533 (not 1,530 as per your report). This three Death discrepancy may be related to the date you obtained the data. Deaths were still being added and removed from the 2020 data as late as 2023, with the longest period being 857 days between changes. However, this meant that the media reports were now false in relation to Cases and Deaths which put the initial State of Emergency and whole COVID response into question. This was further complicated by the ongoing media and internal AHS reporting that suggested the "Date Reported" was not the Date of Death. As the data in Health Canada's reporting matched the reported 1,046 deaths in 2020 (as late as August 2022), it is clear there is an issue with the numbers you used in this report.

To clarify this concern, I sent a number of requests to the Health Ministry and Premier's Officer regarding this data and the "Date Reported". I received no reply. I then met with my MLA, Mr. Mark Smith. He agreed I could ask two questions of the Health Minister. Those questions are outlined in the email linked here:

<https://dksdata.com/Court/ToMLA-MarkSmith.pdf>

<https://dksdata.com/Court/AlbertaHealthMinisterApril282023.pdf>

The relevant question for your report was, what does the "Date Reported" date mean in the Alberta Health download file? The response I got a few weeks later added further concerns to all the above. The Health Minister did not answer my very clear question on what the date referred to, but instead pointed me to another chart on the Health Ministry COVID website at: <https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#severe-outcomes>.

I have completed a full analysis of that data (initially published in December 2020 and still published there today). This is not as detailed as the download file. To the very minute (yes, the very minute) I received the response from the Health Minister's office, the data in that chart, Health Canada's data and the download file suddenly all matched on the total reported COVID deaths. This had **NEVER** happened in over three years of reporting. However, even though the totals suddenly matched, the detailed breakdown of data reported did not. Dates did not align in any of the views of the data. They still don't. This sudden alignment of total deaths cannot be dismissed so easily as a coincidence, especially as **this data has matched (only by total deaths) in every update since**.

Now to the main concern. Using this data, we have two primary issues. First is the reporting by Dr. Joffe and Dr. Hinshaw on March 26th, 2020, that there had been 29 reported COVID deaths in the province. The download file only agreed with that if the file was sorted the way you reported it. However, if the data was sorted the way Health Canada reported the totals for 2020, the number of deaths was much lower at that time. As the Health Minister had dismissed the download file as not the source of truth for Reported Deaths, we had an even greater problem. The chart reported showed one COVID death reported at that time. This remains that way in that particular chart of data as of today.

Now on to the deaths in your report. Health Canada and the download file suggest 1,046 deaths not 1,530 as you

reported. As such, if there were over 1,000 COVID deaths in the Care Homes, that would have been almost every single reported COVID death in 2020 in Alberta. Considering how access to the Care Homes was so restricted, this seems to be a major concern. For example, I had not been able to enter my mother in law's Care Home for 1,193 days due to my medical condition not allowing me to wear a mask. This brings the opening concern in this letter to the forefront. Capital Care and AHS broke the rules throughout COVID 19, while using those self-same rules to abuse residents, visitors and patients every day for over three years and counting.

Considering the significant jump in All Cause Mortality (way beyond COVID deaths) that continues to rise at levels never before seen in this province, by the government's own data, the failure is clear. The only logical conclusion is that the response killed people in Care Homes. It still is.

<https://dksdata.com/Care>

<https://dksdata.com/AlbertaDead>

<https://dksdata.com/COVID19>

<https://dksdata.com/ONSDATA>

Now if we look at the only remaining data published by Alberta Health, we see the government is insisting that there were 1,213 COVID deaths reported in 2020. Not 1,046 (as per the media and Health Canada) and not 1,530 as per your report. Considering this data was reported and used to implement unprecedented restrictions on the population which resulted in significant avoidable harms, I would expect this would be a concern for your office. In addition, this erroneous data was used improperly to terrify a population with vaccinated vs. unvaccinated statistics. This manipulated data was then deployed to coerce people into uninformed consent to the COVID 19 vaccines. As this is outside the scope of your report, I will leave that discussion to other parties.

Further, something else missing from your report is the fact that residents were regularly confined to their rooms without essential personal care or other basic needs for up to 24 hours a day, for days on end. In many cases, this was due to manufactured reasons such as the resident being a 'close contact' with an asymptomatic staff member or when a COVID case was transferred into their shared room. This further artificially inflated the already questionable Case numbers, which in turn impacted the COVID Death numbers reported. These ongoing isolations resulted in conditions such as osteomyelitis (from untended wounds after being left sitting or lying), blood clots (from immobility), untreated primary or secondary bacterial pneumonia and more. This ultimately led to many avoidable deaths. Further, your report fails to mention, let alone quantify, the number of symptomatic COVID patients who were transported from outside the facilities into the Care Homes and into shared rooms with residents who were not sick. As mentioned, this forced that healthy resident to be isolated for two weeks or more for being a manufactured 'close contact'. During that time, these residents were constantly tested and not allowed to leave their room. How many cases reported as COVID and deaths did this cause? Note that AHS has a documented process to do this because it was that commonplace. All of this was known by the most senior staff at AHS/Capital Care and even by the now Premier Danielle Smith as early as 2020.

<https://dksdata.com/Court/EmailstoDanielleSmithandtheJCCF-2020.pdf>

<https://thenationaltelegraph.com/regional/the-alberta-government-has-turned-care-homes-into-outbreak-centres>

Lastly, as you will see from the attached, we had multiple breaches of Dr. Hinshaw's Orders by the Zone Medical Officer refusing critical access to Care Home residents during outbreaks. In fact, the Edmonton Zone Medical Officer in charge wanted to refuse all access to visitors and DSP's contrary to Dr. Hinshaw's explicit Orders on this matter. This meant that much needed assistance and critical oversight from family was denied resulting in further issues of poor care, suffering and potentially death. In the case of my mother-in-law, she had multiple falls and was left more than once without a shower due to the restrictions in place. These restrictions were artificially extended multiple times. On one such occasion, I intervened when AHS tried to extend an already prolonged lockdown of the facility without due cause. I noticed that your report failed to mention how most of the outbreaks were initiated by asymptomatic staff voluntarily testing positive. One outbreak in Dickinsfield was extended because a staff member (who had not been on site for many days) was considered a close contact because of her young son's questionable COVID status. Bearing in mind the fact that at the beginning of August 2020, the Alberta Scientific Advisory Group stated that an asymptomatic PCR test could not be used to indicate a positive Case, it would appear that many of these lockdowns in care homes were actually illegal. The resulting harms and deaths must be accounted for by these actions. This brings us back to the opening point again.

On behalf of my disabled mother-in-law (Jean Hale) for whom I am medical proxy and my wife, who is her Power of Attorney, we would like some answers regarding your report. This report includes clear misinformation which was used to implement policies with devastating consequences that will resonate for a long time to come. Further, your report appears to condone these failed policies by way of its misinformation.

For more please see the below links to previous correspondence.

Links for reference.

Note that some information in these previous correspondence may or may not be relevant to this report but are included for completeness of the file.

Other correspondence waiting for a response:

<https://dksdata.com/Court/ToAlbertaPoliticians2023-06-23.pdf>
<https://dksdata.com/Court/ToAlbertaPoliticians2023-06-22.pdf>
<https://dksdata.com/Court/ToAlbertaPoliticians2023-06-21.pdf>
<https://dksdata.com/Court/ToAlbertaPoliticians2023-06-15.pdf>
<https://dksdata.com/Court/ToAlbertaPoliticians2023-06-13.pdf>
<https://dksdata.com/Court/ToAlbertaPremier2023-06-09.pdf>
<https://dksdata.com/Court/ToAlbertaHealthMinisterandJusticeMinister2023-06-09.pdf>
<https://dksdata.com/Court/ToAlbertaPremier2023-06-08.pdf>
<https://dksdata.com/Court/ToAlbertaPremier2023-06-07.pdf>
<https://dksdata.com/Court/ToAlbertaPremierandMedia2023-06-05.pdf>
<https://dksdata.com/Court/ToAlberterPremier2023-06-04.pdf>
https://dksdata.com/Court/ToAlbertaPremier2023-05-31_Redacted.pdf
https://dksdata.com/Court/ToAlbertaPremierMay262023_Redacted.pdf
<https://dksdata.com/Court/AlbertaHealthMinisterApril282023.pdf>
<https://dksdata.com/Court/CapitalCareandRAH-Masks.pdf>
<https://dksdata.com/Court/CapitalCare.pdf>
https://dksdata.com/Court/ToAlbertaPremierMarch302023_Redacted.pdf
<https://dksdata.com/Court/ToMLA-MarkSmith.pdf>
<https://dksdata.com/Court/ToAlbertaPremierMarch072023.pdf>
<https://dksdata.com/Court/ToAlbertaPremierFebruary282023.pdf>
<https://dksdata.com/Court/ToAlbertaPremierJanuary292023.pdf>

Communications with Patient Relations

https://dksdata.com/PatientRelations/Letter-RAH-DI_Redacted.pdf
<https://dksdata.com/PatientRelations/PatientRealtionsResponsesMay92023.pdf>
https://dksdata.com/PatientRelations/letter-Kaye_Redacted%20ops.pdf
https://dksdata.com/PatientRelations/letter-PS_Redacted.pdf
https://dksdata.com/PatientRelations/letter-RAHPhy_Redacted.pdf
https://dksdata.com/PatientRelations/letter-kaye%20phy_Redacted.pdf
<https://dksdata.com/PatientRelations/Dickson-RAH-Redacted.pdf>
<https://dksdata.com/PatientRelations/DicksonPS-Redacted.pdf>
<https://dksdata.com/PatientRelations/DicksonKAYEclinic1-Redacted.pdf>
<https://dksdata.com/PatientRelations/AlbertaCareHome5thMay2023.pdf>
https://dksdata.com/PatientRelations/CapitalCare%2014072020_Redacted.pdf
https://dksdata.com/PatientRelations/CapitalCare%2016072020_Redacted.pdf

Deena Hinshaw hiring attachments:

<https://dksdata.com/DS/ahs-org-orgchart.jpg>
<https://dksdata.com/DS/HealthMinisterinCharge.jpg>

<https://dksdata.com/DS/RollingTheDie.jpg>

https://dksdata.com/DS/IWC_Memo_Announcement_DH_June1.2023%20Final.pdf

<https://dksdata.com/DS/DeenaIWC.jpg>

<https://dksdata.com/DS/DeenaLookup1.jpg>

<https://dksdata.com/DS/DeenaLookup2.jpg>

David

David T. Dickson

Disabled Police Officer (retired - injury on duty)

C.E.O. DKS DATA (www.dksdata.com)

Consulting C.I.O.

Management/Legal Consultant

Privacy and Cybersecurity Expert.

Cell: [redacted]

Fax: [redacted]

Email: david.dickson@dksdata.com

COVID 19 Information: <https://dksdata.com/COVID19>



Microsoft
Partner

"The darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis."

Dante Alighieri

"So whoever knows the right thing to do and fails to do it, for him it is sin."

James 4:17

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)



PRIVACY NOTICE: *This e-mail message and any attachments are intended only for the named recipient(s) above and may contain information that is privileged confidential and/or exempt from disclosure under applicable law. If you have received this message in error or are not the named recipient(s) please immediately 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.*