IN THE MATTER OF A HEARING BEFORE THE HEARING TRIBUNAL OF THE ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS ("ACAC") into the conduct of Dr. Curtis Wall, a Regulated Member of ACAC, pursuant to the Health Professions Act, R.S.A.2000, c. P-14

DISCIPLINARY HEARING

VOLUME 1

VIA VIDEOCONFERENCE

Edmonton, Alberta

September 1, 2021

Proceedings taken via Videoconference for The Alberta College and Association of Chiropractors, Edmonton, Alberta

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September 1, 2021 Morning Session

HEARING TRIBUNAL

[redacted] Tribunal Chair

[redacted] Internal Legal Counsel

Dr. [redacted] ACAC Registered Member

Dr. [redacted] ACAC Registered Member

[redacted] Public Member

[redacted] ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

[redacted] ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen Legal Counsel

[redacted] CSR(A) Official Court Reporter

(PROCEEDINGS COMMENCED AT 9:10 AM)

THE CHAIR: Good to see everyone here. We're just checking that we've got all the parties.

Dr. Wall and counsel are here?

any objections to doing that now.

MR. [redacted] No, I think that's actually the best way to go, and, of course, Mr. Chair, after Mr. Kitchen has made his comments, I'll, of course, have some response comments.

THE CHAIR: Yes, yeah.

Submissions by Mr. Kitchen (Third Preliminary Application)

MR. KITCHEN: All right, so you have in front of you this expert report from Chris Schaefer and his cv.

As you know, the Complaints Director does not consent to this being entered, notwithstanding the admittance of the four other expert reports, one from the Complaints Director and three others from Dr. Wall.

I submit that this expert report should be admitted. It meets the test for admission, and it is very helpful. I'll walk you through that test. It's well known. There's four criteria for admitting an expert opinion. It's found in the case we've already discussed of Mohan, the citation is 1994 SCC 80.

The criteria are relevance, necessity in assisting the trier of fact, absence of an exclusionary role, and a properly qualified expert.

THE CHAIR: Mr. Kitchen, I'm sorry to interrupt you, I was trying to catch up on my writing.

Could you just go over the tests again.

MR. KITCHEN: Sure. The four criteria, and you'll find this at paragraphs 17 to 21 of the Mohan decision, which you should have a digital copy of that. The four criteria are relevance, necessity in assisting the trier of fact, the absence of an exclusionary role, and, of course, a properly qualified expert.

And I'll start -- I'll go chronologically through this. For relevance, the Schaefer report focuses on what medical masks actually are and two specific harms from these types of masks.

And by "medical", by the way, I mean the VU masks, the surgical masks, the masks that are in the ACAC Pandemic Directive. Those are the types of masks everybody's going to be talking about. We're probably going to use the term "masks" a lot, but that's what we're talking about, as far as I know. We're not talking about cloth masks, N95; we're talking about these types of masks.

So the report focuses very briefly and narrowly on these masks, what they actually are, and then two specific harms that fall from those harms, being oxygen deprivation and toxic overexposure to carbon dioxide.

Now, this content is obviously relevant to one of the central issues in this case, which is whether or not masks cause harm and whether or not, because

they -- because they cause harm, if they cause harm, whether or not they violate anybody's rights.

It's also legally relevant to whether the ACAC mask mandate Dr. Wall is challenging engages his security of a person under Section 7 of the Charter and his eventual argument that he was acting in the best interests of his patients by protecting them from the harms of surgical masks when he permitted them to not wear masks.

Moving on to necessity. The Schaefer report provides information that is outside the knowledge of the Members of the Tribunal. Common sense would support the notion that surgical masks decrease masks to oxygen, increase exposure to carbon dioxide, but only an expert can determine to what degree that that carbon dioxide overexposure is happening and that decrease in oxygen, and if that degree is actually harmful or merely a discomfort, actually determining, technically, exactly what the oxygen deprivation and the overexposure to carbon dioxide is. That knowledge is not attainable without an expert. That -- a determination on that cannot be made by people with ordinary knowledge.

This report, therefore, is required for the trier of fact, the Tribunal, to determine what is a central issue in this case, that is whether masks are, in fact,

harmful.

There is no applicable exclusionary rule engaged in this case. And I suppose my friends are going to argue that there's prejudice because the report was filed three weeks before the hearing, and so if there's any prejudice, that would be it, and I'll deal with that momentarily.

But just to deal with proper qualifications, because obviously we're dealing with an expert opinion here, so we can't have a qualified expert when we don't have something that's admissible. Mr. Schaefer presents us precisely the experience and certifications to be expertly discussing masks, surgical masks, and to competently conduct the type of testing needed to make the conclusions he does in his report about oxygen and carbon dioxide levels.

You can see from his cv there's a lot to do here with respirators, masks, testing them, instructing on them, he's got certifications in them. In fact, a lot of what he does and what he says has been doing for decades has to do with different types of masks, broadly speaking, or whatever you want to call it, breathing barriers or respirators or whatever. All these various types of devices that go on people's faces to protect them from certain things, he has an enormous amount of experience in it.

Now, I'll just deal briefly with comparing the probative value to the prejudicial effect. The Schaefer report is a rival, it's brief, it's not confusing or overly overcomplicated, which may be a reason to exclude it if it was; it's not going to take an enormous amount of time; it's a three-page report. It's not going to take an enormous amount of time for myself to take Schaefer through his report. I don't imagine it would take an enormous amount of time for the Complaints Director to cross-examine and test the value of it. It's needed to establish important and relevant facts, and that's very important for understanding probative value.

As I mentioned, there's no relevance to prejudicial effect to the Complaints Director except possibly that this report was provided to the Complaints Director three weeks prior to the hearing, and it seems he's of the position three weeks is not long enough to respond to the report. I submit that contention lacks any merit. The report's three pages long, as I mentioned, contains only five citations. Either the Complaints Director could have found a new expert to respond, or his current expert could have responded, had three weeks to respond. Three weeks is sufficient time to prepare to respond to a three-page report, whether it's in the form of a rebuttal report

that is written and provided to Dr. Wall and the Tribunal or in the form merely of dealing with it in direction examination. I submit that the probative value far outweighs any prejudicial effect on the Complaints Director.

However, if the Tribunal was to agree with the Complaints Director that there is prejudice to the degree that it challenges or competes with the probative value of this expert report, the only proper remedy is to order an adjournment, to provide the Complaints Director more time to respond. It's not to disallow the evidence. Dr. Wall has a right to a full answer in defence and should not be prevented from putting in all the relevant evidence, including expert evidence.

Now, Dr. Wall opposes a further adjournment. However, if one is to be issued, Dr. Wall requests and proposes that the adjournment only be in regards to the expert opinion evidence, and that the first two days of the hearing, today and tomorrow, proceed, at least with the attempt to get in all of the lay evidence and not waste the time of so many witness. And, in fact, if there is an adjournment of experts, then perhaps we can go into Day 3 next week to finish off all the lay witnesses.

That's very important to Dr. Wall, that there's no

further adjournment -- no further complete adjourned. If we feel there has to be an adjournment, it should be for the expert evidence only.

Lastly, I'll note, you know, my learned friend has given you Rule 8.16 of the Alberta Rules of Court that no more than once expert is permitted to give opinion evidence on any one subject on behalf of a party. Well, as we've already discussed, the Tribunal is not bound by strict rules of evidence, it's not bound by the Alberta Rules of Court. So in that sense, there's nothing binding here in any event.

But I'll say this, it should be quite obvious that this report deals with a different subject than Dr. Wall's other three experts. The other three experts are various scientists and medical doctors, immunologists, virologists, respirologists, and they are all dealing with the effectiveness or lack thereof of masks. They're deal with COVID-19; they're dealing with the SARS-CoV-2 virus. They're not dealing with whether or not masks are harmful. Certainly not in a specific sense that Chris Schaefer is doing with, and that being oxygen levels and carbon dioxide levels.

So this is a different subject, right? The effectiveness of masks is a different subject from the harms of masks. There's no way we can conflate those two. Those are different subjects; those are different

issues. Right? Does it fall under the broad issue of masks? Sure, it does. But that's a very important and different side of the coin as to whether or not it causes harm, right? Because when it comes to masks, there's a lot of different issues we've got to deal with. Do we need them, first of all? Second of all, do they help, even if we did need them? And then, of course, are they harmful?

So we have one report on a totally different issue here. That's the harms. The Complaints Director is saying that it's a fourth report on the same subject. That's just not the case. It's one report on a different subject. And so on that basis, even if the Rules of Court apply, it cannot be excluded on that basis.

THE CHAIR: Thank you, Mr. Kitchen.

MR. KITCHEN: Thank you.

THE CHAIR: Mr. [redacted]

Submissions by Mr. [redacted] (Third Preliminary Application)

MR. [redacted] Thank you, Mr. Chair. I've got a few comments.

I'm going to start with an overall comment, and that is that -- and I'll echo this in my opening statement, and you'll certainly hear about it in closing statements -- Dr. Wall would like this hearing

to be about masking and the efficacy of masking or the science that does or doesn't support it, but the Complaints Director is strongly of the view that that's not the issue before you. The issue before you is one of governance and the responsibility of professionals to adhere to the requirements of their regulatory body, which is a cornerstone of professional regulation.

I think there are a number of very significant concerns that the Complaints Director has with the introduction of this report. The first thing I will say is that Rule 8.16(1) that I've quoted from the Rules of Court, as my friend said, says that: (as read)

> Unless the Court otherwise permits, no more than one expert is permitted to give opinion evidence on any one subject on behalf of a party.

Now, my friend is quite right, and I've said this, you're not bound by the formal rules of evidence, but, as I've said to you before, the formal Rules of Evidence can provide you with important guidance, and this is a very serious and significant issue: It's an expert being called in to testify.

And I think the rationale behind that Rule 8.16 applies here. The courts don't intend for you, as a decision-maker, to be inundated with report after

report after report, and that's why this rule is there.

And I think, although you're not, again, bound by the rules, strict Rules of Evidence, and you can bend those rules, what Dr. Wall is asking you to do here breaks those Rules of Evidence. This is a situation where Dr. Wall already has three experts testifying, three expert reports, three cv's, a serious and significant amount of expert evidence. And to allow further evidence on this question, I think, invites a circle of expert after expert after expert and takes away from what your role is. And, frankly, again from the Complaints Director's perspective, this is not about masking.

I think, as my friend mentioned, getting this report three weeks before the hearing is prejudicial. It's three pages long, but there's a fair bit of information in it. It's information that the College would conceivably want to respond to.

Our expert, Dr. [redacted] is a very, very busy individual, as we all are, and I can tell you that it is challenging, if not impossible, to find time, on a three-week notice, to consult with your expert, consider preparation of a rebuttal report, prepare the expert for the hearing, and do all the things that you would normally do with an expert in preparation for a hearing. So, again, I don't think this bends the

rules; it breaks the rules.

And there are three experts that the Complaints Director has, with a measure of reluctance will not be raising objections to them testifying. They can certainly weigh in on any kind of harm issues relating to masking. There's no independent need for this. And the prejudicial value to the Complaints Director is significant. This is a serious set of circumstances that the Complaints Director would need to respond to, and there simply isn't the time or ability to do that properly.

Now, I want to say one thing in that regard, my client opposes an adjournment. Mr. Schaefer's report could have been provided back in April or May, when Mr. Kitchen quite properly, and I commend him, sent the original three expert reports. We got those well in advance, and Mr. Kitchen I think made significant efforts in that regard.

We're not getting that here, and it's -- I'm not blaming anyone. I'm sure Mr. Schaefer is busy, but three weeks is awfully short, and it puts the Complaints Director at a serious disadvantage. And an adjournment, frankly, scratching expert evidence now, trying to find another time for Dr. [redacted] to testify I think is going to, frankly, be a loss, a real loss to this Tribunal, and we ought to proceed with the hearing

as scheduled.

So, Mr. Chair, those are my comments. I'm happy to answer any questions, and Mr. Kitchen may have some response comments as well in fairness to him.

Reply Submissions by Mr. Kitchen (Third Preliminary Application)

MR. KITCHEN: I do have some response comments just briefly.

First, the -- I hear again the comment that this isn't about masking as far as the Complaints Director is concerned; yet, he has put in an expert report himself on masking. We just went through an application where the Complaints Director sought to put in more documents about masking from AHS. Clearly the case is about masking. The Complaints Director is speaking out of both sides of his mouth when it's convenient to do so to oppose Dr. Wall's evidence or support his evidence when he wants it in.

The knife cuts both ways. If we are going to allow all this extra evidence about masking, if we're going to put in all the expert evidence about masking, then let's put it all in, let's actually get to the truth of the matter, and let's actually canvass all the issues, which is really what we're here to do.

Furthermore, Dr. Wall gets to decide what his defence is going to be. And I understand that the

Complaints Director's position is that, well, he disobeyed the rules, and that's it. But he's challenging the rules. He is impugning the ACAC mask directive as unlawful. That's his defence. So a key issue to that is not just the ineffectiveness of masks but whether or not they're harmful. If he's going to claim Charter rights and [redacted] rights violations, as he is, if he's going to challenge the lawfulness of the ACAC mask mandate, which he is, then this evidence is highly relevant to those legal legitimate legal claims.

That's my response.

THE CHAIR: Thank you.

MR. [redacted] Mr. Chair, this is a little unusual, but there's one thing that Mr. Kitchen brought up that I do want to speak to very briefly, if you'll just allow me 1 minute.

THE CHAIR: Okay.

Reply Submissions by Mr. [redacted] (Third Preliminary Application)

MR. [redacted] The comment was to the effect of the Complaints Director can't have it both ways, he's talking out of both sides of his mouth, he's putting in these documents about masking; I'll speak to this in my opening submissions, but the Complaints Director's view is this is a very focused hearing, and it's focused an a question of governability and what it

means to be a professional.

Dr. Wall has chosen to bring masking in and the efficacy of masking. The Complaints Director had no choice but to respond in some manner to that and called one expert in opposition to the three that were called. The Complaints Director didn't have any options there, because, of course, if we hadn't called an expert, what we would hear from Dr. Wall and Mr. Kitchen is that their expert evidence was unopposed, but we do not think this is about masking, and we're not having it both ways. We simply had to have an expert come in and have to talk about masking, because that's the case that Dr. Wall is mounting.

Thank you for allowing me that further comment.

THE CHAIR: I'm sure will get into that more when we get into the opening submissions.

Okay, let's take a brief caucus here so the Hearing Tribunal can determine if we have any further questions and deliberate on the admissibility of the cv and expert report from Mr. Schaefer, so hopefully it won't take us long. Let's plan for 10 after 11, and we'll try and be back by then, but if we're not, please bear with us. Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, this Hearing Tribunal is back in session.

Ruling (Third Preliminary Application)

THE CHAIR: Members of the Tribunal with the assistance of our legal counsel have discussed the two items in question, that being the cv from Mr. Schaefer and his expert report. Our finding is that it does meet -- these two documents do meet the requirements for admissibility, and as such, we will admit them as evidence.

EXHIBIT G-4 - 2-page curriculum vitae of Chris Schaefer

EXHIBIT G-5 - 89-page document titled "Chris Schaefer Expert Witness Report"

THE CHAIR: We do recognize that there is potentially a problem for the Complaints Director and counsel in terms of getting an expert of their own to rebut this information or this evidence.

If that is an issue, then we would ask that we do our best to work around it, given the dates that we have booked. We very much would agree with counsel that we would like to avoid any further adjournments, but, at the same time, we do not want to interfere with counsel's ability to prepare the case they want to present, so we will certainly listen to any requests from counsel if timing is a concern and further time is required.

MR. [redacted] Mr. Chair, thank you for your

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DISCIPLINARY HEARING

VOLUME 6

VIA VIDEOCONFERENCE

Edmonton, Alberta

November 20, 2021

TABLE OF CONTENTS

EXHIBITS

Description	Page
EXHIBIT H-8 - Excerpt from the Canadian Thoracic Society guidelines (Document not Provided to be Marked)	964

Proceedings taken via Videoconference for The Alberta College and Association of Chiropractors, Edmonton, Alberta

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November 20, 2021 Morning Session

HEARING TRIBUNAL

[redacted] Tribunal Chair
[redacted] Internal Legal Counsel
Dr. [redacted] ACAC Registered Member
Dr. [redacted] ACAC Registered Member
[redacted] Public Member
[redacted] ACAC Hearings Director

ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

[redacted] ACAC Legal Counsel

FOR DR. CURTIS WALL

J.S.M. Kitchen Legal Counsel

[redacted] CSR(A) Official Court Reporter

(PROCEEDINGS COMMENCED AT 9:16 AM)

THE CHAIR: This is continuation of the Hearing Tribunal for Dr. Wall is back in session.

And Ms. [redacted] does have your witness in the

waiting room and is prepared to bring him into the meeting, Mr. Kitchen, so I'll turn the floor over to you.

MR. KITCHEN: Good morning, Mr. Schaefer, can you hear us?

THE WITNESS: Yes, good morning.

MR. KITCHEN: Excellent. Are you able at all to tip your camera down about -- yeah, perfect, there you go, excellent.

All right, so, Mr. Schaefer, the first thing we're going to do is we're going to swear you in, and [redacted] our court reporter, is going to do that, and once she does that, then we'll get into the questioning.

THE WITNESS: Sounds good.

CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen

(Qualification)

MR. KITCHEN: So, Mr. Chair, I'm going to start with some qualification questions. As you'll know from my end the other day, there was consent between the parties on the qualification of the next witness but not on this one, so I'm going to run through some questions and then propose a qualification to you, and then, of course, Mr. [redacted] will have some opportunity to make some comments.

Q MR. KITCHEN: Mr. Schaefer, the first thing

I'll start with is what's your current occupation?
A My current occupation is as an Occupational Health and Safety consultant. I have been doing that now for quite a number of years. Since 2004, I've had my own company, but I've been working in Occupational Health and Safety as a consultant since 1994.
Q Okay, thank you. Now, you said "consulting", what are the types of things you consult on?
A Well, I consult on all aspects of Occupational Health and Safety training. Primarily what I do is one of my specialties is respirator fit testing and training. So respirator fit testing and training that I would consult on would be for any atmospheric hazard from anything that would require the most basic level of respiratory protection all the way up to and including respiratory protection for emergency responders like a self-contained breathing apparatus, both closed- and open-circuit systems.
Q And do you teach any courses on respirators or how they fit?
A Yes, I do. I do teach a course, a course on respirator fit testing and training, and I have been teaching that course as an advisor to the University of Alberta Faculties of Medicine and Dentistry for several years, as well as private clients.
Q I just want to -- on your résumé, you've got a long

list of certifications, I don't want to bring you through all of them, but I'll just ask you about a couple of them. One is a CSA respirator training and fit testing instructor. Can you tell me about that certification?

A Sure. CSA, if you're not already aware, is equipment certification, and they do have their own standards for equipment certification. So CSA stands for the Canadian Standards Association, and if you have ever worked in an industrial environment, from a very basic perspective, you would know that CSA does the approvals for basic safety equipment like steel-toed boots, hard hats, and safety glasses, among many others, but those would be probably basic ones that you would be aware of, and CSA is the certification body for the standards set for the safety of that equipment and others as well.

So as the course for CSA goes, it's a course that is within the standards of the use of that equipment through the Canadian Standards Association.

Q Thank you. I see also hazmat instructor. Now, I think I know what hazmat is, but could you please tell me what that's all about?

A Hazmat is hazards materials and training. So for people that go into high-risk situations like biohazardous environments, they need specialized

training and specialized equipment, because there is a lot of chemicals, vapours, and gases and even particulates that are very small, and those can penetrate through basically any part of your body.

So with hazmat training, it's all about, the basics are, is you've got to have full containment, you've got to have full encapsulation of workers or responders, and they have to be provided for any potential exposure through either inhalation or skin absorption of contaminants that could negatively affect their health.

Q Thank you. And just one more, right under that, you have "H2S alive instructor". Can you tell me what the H2S alive thing is?

A Yes, absolutely. H2S is the chemical formula for hydrogen sulphide gas. Hydrogen sulphide gas is a common detriment to oil and gas workers for -- primarily in Western Canada. We see our highest levels of hydrogen sulphide gas in Western Canada oil fields, so that is a course that is required for anybody that works in oil and gas situations that they have that course so that they know how to protect themselves and also respond to help others in the event of unintended or accidental hydrogen sulphide release or exposure.

Q All right, thank you. So if I understand this, I don't think I do, the 'S' stands for sulphide. I'm curious,

in your line of work, have you dealt with issues around carbon dioxide?

A Yes, absolutely.

Q Have you dealt with issues around oxygen in the air?

A Always, always. Yeah, you know, having a safe amount of oxygen in air is pretty essential to personal safety, so that's definitely a big part of my whole career.

Q And are you familiar with the Occupational Health and Safety legislation?

A M-hm, yes, I am.

Q Thank you. Is that something you commonly work with?

A You know, it depends on the course that I'm offering and the training that I'm offering, but, yeah, absolutely. Atmospheric hazards are a big, huge component of Occupational Health and Safety.

Q Have you done any testing on the cloth or nonmedical masks that have been commonly used to try and prevent the spread of COVID?

A Yes, I have.

Q Have you done any testing on the medical or procedural or surgical masks that have been commonly used to try and prevent the spread of COVID?

A Yes, I have.

Q Thank you.

MR. KITCHEN: Well, Mr. Chair, I'm going to

read out for you -- those are all my questions on qualification -- I'm going to read out what I'd like to have Mr. Schaefer qualified as. I'd like to have Mr. Schaefer qualified as an expert in the area of Occupational Health and Safety, in particular, all types of respirator masks, including the medical and nonmedical masks used to attempt to prevent the transmission of COVID-19. And, of course, I --

THE CHAIR: Can you just read that one more time, please?

MR. KITCHEN: Sure. I'd like to have Mr. Chris Schaefer qualified as an expert in the area of Occupational Health and Safety, in particular, all types of respirator masks, including the medical and nonmedical masks used to attempt to prevent the transmission of COVID-19.

THE CHAIR: Mr. [redacted] did you wish to comment before we --

MR. [redacted] I have I think two brief questions for Mr. Schaefer, and then my friend is aware of this, I've got a few comments about the qualification that's being tendered, so I'll just ask my questions briefly.

Mr. [redacted] Cross-examines the Witness (Qualification)

Q MR. [redacted] Good morning, Mr. Schaefer.

A Good morning.

Q My two questions for you are this: I'm looking at the bottom of page 2 of your cv, and it talks about, you say, "Associations: Member of Alberta College of Paramedics"; are you still a regulated member of the Alberta College of Paramedics?
A No, I am not, but that is a -- that is a course that I had -- that is a -- sorry, that is a membership that I had a couple years ago. I had completed the Alberta College of Paramedic program as far as the emergency medical responder is concerned, and I did have that membership, yes.
Q Forgive me for not quite understanding this then, were you a regulated member of the Alberta College of Paramedics, so you could practice as a paramedic, or had --
A Yes --
Q -- just taken the --
A -- yes, I was --
Q -- courses --
A -- yes, I was. I was an actual member of the Alberta College of Paramedics, registered through the course that I had taken, so I had specific registration by completing exams with the Alberta College of Paramedics to practice as a medic within Alberta.
Q Sure, and I --
A So I was definitely registered.

Q And how long were you a regulated member of the Alberta College of Paramedics?
A One year.
Q And do you recall your designation, or were you an advanced care paramedic, primary care paramedic, EMT, EM -- you know, do you recall the designation that you were in?
A Of course. EMR, emergency medical responder.
Q And you can correct me if I'm wrong, but I think "EMR" is -- I think there's three designations; the first is advanced care paramedic, then there's primary care paramedic, and then there's the designation you were in, which is EMR; is that correct, to your understanding?
A That's absolutely correct, yes.
Q And, I'm sorry, you said you were an EMR for one year with the College?
A Yes.
Q Okay.
MR. [redacted] Those are all my questions, Mr. Chair, for the witness. I wonder if I might provide some responses to the qualification that Mr. Kitchen has tendered.
THE CHAIR: Okay.
Discussion
MR. [redacted] My friend will rightly point

out to you that I could make these same comments during my closing statement, and I made them during the opening statement, but I just want to reiterate the Complaints Director's position this is not a question of the efficacy of masking in this hearing, it's about compliance with regulatory responsibilities. We'll review that in greater detail. You can, of course, accept evidence in whatever manner you see fit. The Complaints Director maintains his position that this type of evidence should be given little weight in terms of the charges that are in front of you.

I do want to mention that the College anticipated that Mr. Schaefer's testimony would be confined or largely confined to the question of surgical or procedure masks that are set out in the Pandemic Directive, and, of course, the College does not have any ability to regulate or control the types of masks that members of the public wear. So I think the qualification that's been tendered is perhaps a little bit broad in terms of it referring to all types of respirator masks, so I have a little concern in that regard -- have a concern in that regard.

And I'll just, for reference sake, I just want to remind the Tribunal of some comments that were made by Mr. Kitchen during the qualification -- pardon me, the preliminary application that occurred in terms of

whether Mr. Schaefer could be called at all as an expert witness, and you'll recall we objected to that, and you made a ruling that you would allow Mr. Schaefer.

And just very briefly, this is on page 55 of the transcripts, this is my friend commenting on what Mr. Schaefer will be called to testify about: (as read)

> It should be quite obvious that this report [meaning Mr. Schaefer's] deals with a different subject than Dr. Wall's other three experts. The other three experts are various scientists and medical doctors ... They are all dealing with COVID-19; they're dealing with the SARS-CoV-2 virus. They're not dealing with whether or not masks are harmful. Certainly not in a specific sense that Chris Schaefer is doing, that being oxygen levels and carbon dioxide ... The effectiveness of masks is a different subject from the harms of masks.

And a few pages later, you made a ruling that Mr. Schaefer can testify. So my client's clear expectation is that Mr. Schaefer's testimony will be confined to, again, the harms of masks, not the science related to COVID or transmissibility or anything along

those lines.

So Mr. Kitchen has been scribbling, and I'm sure may want to made some response comments to what I said, but again I think it's important to remember the basis on which this witness was offered initially when we had our preliminary application on that, and I think it's very important for Mr. Schaefer's comments to be confined to the question of the harm of masks and nothing more. Thank you, Mr. Chair.

MR. KITCHEN: Mr. Chair, if I could, just a couple comments in response.

THE CHAIR: Yeah.

MR. KITCHEN: First, the reason I say all types of respirator masks is because, well, that's just the reality; that's what Mr. Schaefer has dealt with in his line of work. And I'm a little surprised to hear that the Complaints Director didn't anticipate evidence about nonmedical masks in addition to medical, as, of course, you'll see in the first paragraph of Mr. Schaefer's report, it talks about the different kinds of masks, and so it's a little surprising.

But the reason that I've asked inclusion of cloth masks is -- or nonmedical masks is because that's a reality of what we're dealing with, and that's what Mr. Schaefer has dealt with, and those aren't dramatically different, they're very similar, and so I

don't think that scope is too broad, I don't think it's inappropriately broad, I don't think it's irrelevantly broad. So I would ask that he not be limited to talk about medical masks but also be permitted to talk about nonmedical or cloth masks.

And, of course, I have no issue with my friend's comments about being limited to talk about the harms of masks and not the efficacy. We won't have any questions about that, so it's just the harms of masks, but when I say "masks", I mean medical and nonmedical. Those are all my submissions in response.

THE CHAIR: Thank you. I think we'll take a short break while the Hearing Tribunal caucuses to give you an answer to your request, Mr. Kitchen. So if we could be moved to a break-out room. Hopefully this won't take very long. Thank you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: Okay, we're back in session, and the Hearing Tribunal discussed your request, Mr. Kitchen, and we have one question for Mr. [redacted] and we wanted a clarification on why Mr. Schaefer should be limited to medical masks.

MR. [redacted] I think, Mr. Chair --

THE CHAIR: Is it because of what's in the transcript? Is it because of what's in the CMOH

orders?

MR. [redacted] I think it's because primarily of what is in the Pandemic Directive that the College has, which refers to the requirement for chiropractors to wear surgical or procedure masks as being the minimum acceptable standard.

I think I said in my comments about this question, and I'll invite Mr. [redacted] to comment if he wants to, but we anticipated that the primary focus of Mr. Schaefer's testimony would be on those matters, because the College cannot -- I see Mr. [redacted] nodding his head -- the College cannot regulate what members of the public do, it can only regulate what chiropractors do. I'm not sure if that answers your question, but that was the concern. We didn't want this net to be cast too broadly.

THE CHAIR: Okay, I think we're just going to take that under advisement, Mr. [redacted] We'll go back into our cubbyhole, and we should have an answer here shortly, thank you. Just please bear with us, and we'll go to our break-out room.

(ADJOURNMENT)

Ruling (Qualification)

THE CHAIR: The hearing is back in session. The Hearing Tribunal has discussed the issues raised. We just want to clarify that the testimony

will be regarding the harm and not the efficacy associated with these masks, and we've also ruled that the testimony will relate to the medical masks not the nonmedical masks.

Having said that, we're aware that there are some issues here, and if Mr. [redacted] feels that the line of questioning goes beyond the scope that we've discussed, then he certainly has the option to raise objections.

MR. KITCHEN: I wonder, and I invite comments on this, and I can be corrected if I'm off the mark on this, is it possible for me to receive written reasons for that decision, because that will likely be something that will end up being appealed, so -- and maybe that comes at the very, very end when we get written decisions -- written reasons on the whole decision, but that's something I would -- I'd ask for written reasons on it.

THE CHAIR: At the risk of taking us back to a break-out room, my thought would be that we can address it in the decision, once the decision is made, make a note to that effect. I don't think we want to interrupt this hearing to be doing that. I don't want to start writing parts of decisions, so --

MR. KITCHEN: No, no, I'm not asking you for it right now, I apologize. No, what I meant is I'm just asking whether it's, you know, tomorrow or a week

from now or a month from now or at the very end, that's -- I'm not asking for it right now. I'm just, in general, I'm making it known that, you know, likely that will be a source of appeal, so I think it best that there be reasons for that.

THE CHAIR: Duly noted, Mr. Kitchen.

MR. KITCHEN: Thank you.

CHRIS SCHAEFER, Previously sworn, Examined by Mr. Kitchen

Q MR. KITCHEN: All right, well, with that, Mr. Schaefer, you can hear me?

A Yes, I can.

Q Excellent, we'll jump right in. And I think you've already answered this, but just to clarify, you live and work in Alberta; is that correct?

A That is correct, yes.

Q Can you tell me what was the, generally speaking, what was the type of work you did prior to the onset of COVID?

A I had been doing safety training for my own company, but I had been doing safety training for a lot longer than that, but -- so safety courses in a variety of disciplines, as well as fit testing and training. So -- but fit testing and training has definitely been a significant portion of the work that I've done in clients that range from the military, to health care,

to educational institutions and private industry.
Q Has that work changed any since the onset of COVID?
A Absolutely, it's changed a lot. It's changed a lot primarily because there's so much -- there's no real -- there's no real requirement for many of the masks that are mandated for COVID, that they would be fit tested, there's no requirement to that.

So before the COVID thing, everything -- any type of mask whatsoever had to be fit tested on the wearer. They had to have approval fit test for safety. But since COVID, since this virus, there has been no requirement for the majority types of these devices to require a fit test to the user, which is really, really odd.
Q And why is that odd?
A It's odd, because in order to determine whether or not the wearer is suitable for wearing a mask, there are some screening processes that have be completed first.

So, for instance, if you have difficulty breathing without a mask, wearing a mask is going to make it much harder for you to breathe. It will increase breathing resistance for everybody. So if you're healthy, you breathe effortlessly right now, you will experience increased breathing effort by covering your mouth and nose, and so there's a screening process. Not everybody is capable of wearing a mask. Nobody -- like

there's a screening process that has to be completed.

So for people that have pre-existing medical conditions or identify pre-existing medical conditions within screening to wear a mask, they have to go to their doctor and get further testing done to determine their suitability or ability to be able to wear a mask and stay healthy. So that's one thing. The screening process, there's no screening to determine the suitability of masking for the general population and employment in general, right? So any workers, there's no screening anymore; it's just wear one or else, and that's never happened before.

The other thing is is that in order for any type of mask to protect the wearer, that mask has to make an airtight seal around the face. Without an airtight seal, there's no way that it can provide any respiratory protection. So a fit test determines that it is making an air-tight seal to your face so that it can verify that the contaminant is being filtered; it is having to flow through the filter into the wearer's mouth and then lungs.

But if you don't have an airtight seal, then the air that you inhale is -- a lot of it's going to follow the path of least resistance, which is through the openings, any openings, available openings, because it's harder to pull air through a filter than it is

just to breathe surrounding air. So if there's leaks, that's where you're going to be pulling the contaminant in from.

Q And so you talked about air coming in, and it coming in through what I'm going to call the path of least resistance, is that also true for air going out?

A Well, you know, there is some air coming in, but when you look at the volumes of breathing of inhalation and exhalation, it's going to cause an insufficient air supply. You're going to get a buildup of your own exhaled carbon dioxide in the cover, and if you're going to get -- see, in an actual respirator --

Let me explain in an actual respirator, actual respirators have an exhalation valve built into them, so that every time you exhale, your carbon dioxide gets pushed out the exhalation valve so you don't rebreathe it. If you just put a closed cover on your face, then it will capture some part of dioxide, and as you inhale, it will force you to rebreathe some air but also carbon dioxide that can be significant amounts above and beyond what is considered safe according to Occupational Health and Safety air quality standards.

Q Thank you. All right, well, you've already answered some questions, but just to go back to sort of a preliminary issue, let me ask you a couple different questions. Mr. Schaefer, do you know Dr. Curtis Wall

personally?
A I've never met him. I don't know what he looks like, and I really don't know much about him at all.
Q Do you have any personal interest or personal stake in the outcome of this case?
A Absolutely not. I've just been hired to give my expert opinion, and that's what I'm here for.
Q You don't have any financial interest or stake in the outcome of this case then?
A No, because I'm getting paid by the hour, and so it doesn't matter to me what the outcome is.
Q And just to confirm, do you understand your duty to provide this Tribunal with your expert knowledge and opinions in an objective and neutral manner?
A Absolutely.
Q Thank you. Now, just to give a bit of a road map, we've already got into the meat of it a little bit, but I'm going to be asking you about, you know, what masks really actually are, and then I'm going to ask you about carbon dioxide, about oxygen, a little bit about testing, and then, lastly, I'll ask you, from an Occupational Health and Safety perspective, a little bit about the harms or hazards involved.

So to start off, now -- and my friend may want to object to this, because we've got issues with different types of masks, but in the very first paragraph of your

report, you say -- we're talking about the masks that are being mandated to attempt to prevent the stop of COVID, you say: (as read)

These masks are the medical, nonmedical, and procedural masks.

Now, can you please explain for us what those terms and what those types of masks mean to you?

A Sure, absolutely. So a medical mask in a health care setting is referred to an N95. It's something that is -- what health care uses is a closed cover primarily, it is N95, which means that it's a filter, a filtration that's not resistant to oil, that's what the 'N' is. 95 refers to the best-case scenario protection that you could get with that device if it's properly fitted and used and disposed of and replaced as specified, as required, as the manufacturer requires. And that's what the medical is.

The nonmedical is any device that is really you put it on your mouth and nose. So you could take a plastic bag put it over your head; I mean, that's not a nonmedical mask, but, you know what, a nonmedical mask is anything that covers your mouth and nose. So if you want to put a bandana on your mouth and nose, you want to -- you want to -- anything literally that covers mouth and nose is classified as a nonmedical mask.

And a procedural mask is something that is -- is

something that they will typically use, and I won't say what they use it for because it's kind of -- you know, they use it for different things in health care settings, but it's a looser fitting -- it's a slightly looser fitting style, but it's still -- it's still enclosed enough that it typically -- it's like the blue mask, right? So a procedural mask is kind of -- it's a looser fitting than the N95, N95 is a tighter fitting and, depending on nonmedical, it can be anything from cloth to virtually anything anybody wants to do to cover their mouth and nose, because there's really no -- there's no rules on nonmedical masks; it's really just anything you put on your mouth and nose could be considered a nonmedical mask that covers your face.

And procedural mask, like I said, it's really just a -- it's a device. These are all -- they're all like the -- N95 and procedural would be considered temporary use only, to be replaced regularly, as needed when there's moisture buildup inside, and disposed of immediately. So the procedural and the medical in health care settings, both have to be used -- they're really only designed for short duration use and then to be immediately disposed of. They were never designed for hour upon hour use. It was never designed that way, and it's still not designed that way. So it's been used that way, but it's not designed that way.

So there are some dangers to that, but as far as procedural masks go, just -- it's a looser fitting mask that they use in the health care settings and disposable, just like N95. N95s are tighter fitting; procedurals are looser fitting.

Q Thank you, that's helpful. Would you say that when we use the word "surgical mask", in your experience, is that typically a reference to that category of procedural or blue masks?

A Yeah, you know, surgical masks, you know, in surgery, physicians and other health care practitioners, they may use N95, or they may use procedural. It's -- it depends on -- depends on what's going on, but both may be used.

Q So you're aware that what the Alberta College of Chiropractors has mandated that chiropractors must wear -- this mandate is found in the COVID-19 Pandemic Practice Directive, you're aware that the masks -- the type of masks that the Alberta College of Chiropractors is requiring chiropractors to wear are those procedural or blue masks?

A Yes, I am aware.

Q Okay. And you're aware that the CMOH orders that mandate masking for the general public mandates the nonmedical masks?

A Yes, I am aware.

Q All right, in the second paragraph of your report, you state that: (as read)

> Masks are required to have engineered breathing openings.

Can you explain what "engineered breathing openings" are, and why masks are required to have them?

A Okay, so if you are going to cover your mouth and nose with any device, it's important that you do not restrict your oxygen coming in, the air coming in, and your carbon dioxide and expelled toxic air leaving, and that is why we exhale outside of our bodies in the first place.

If we take a look at a mask, a mask has to have engineered openings. So, for instance, if you take a look at, say, here is a common Halloween-style mask, it's got engineered openings for nostrils for breathing, as well as mouth for breathing. It's important to be able to have easy, free breathing. When you restrict your breathing, then you get that accumulations of exhaled carbon dioxide that are then rebreathed because there's no exhalation valve to purge it, so you rebreathe your own exhaled waste toxic carbon dioxide, which is not going to be good for anybody, and for people over a longer period of time and if there's any pre-existing medical conditions could be a very serious situation.

Now, if you look at an actual respirator, like this, you can see that it is covered, there are two filters attached in the design. In the middle, there's an exhalation valve. That's to purge exhaled heat, moisture, and carbon dioxide, okay, for a reason, because we don't want to rebreathe it. So air comes in here, air can only enter through inhalation, air can only leave through exhalation.

And when I say "engineered openings" -- I say engineered opening and exhalation, but also engineered opening and inhalation. So if I unscrew the filter, you can see, if I just turn it like this, you can see it's a big hole, there's a big hole there. The reason the hole is there is so that air can flow in very easily and freely so that, you know, it can enter your lungs as unobstructed as possible, because anything that you put on your mouth or nose, it makes it harder to breathe. Depending upon the person, the length of exposure, the type of work or activity they're engaged in, and any pre-existing medical conditions could all change their ability to be able to wear that device at all.

Q I notice you used the word "device", just to clarify, you would say that these procedural or blue masks we're talking about, you would call that a device?

A Well, let me explain something, it's very difficult for

me to refer to any of the mandated masks for COVID as actual masks. It's really difficult. I struggle with it. It's hard, because they don't meet the actual definition of a mask from anything as simple as a Halloween mask, to a goalie mask, to a scuba mask, any kind of actual mask that's engineered, it's engineered for easy breathing.

If you look in a goalie mask, it looks full faced, it looks pretty encapsulated, but it does have breathing vents, so the air can flow in and out easily. Every type of mask, it's important that air flows in easily and air flows out easily.

Now, a goalie mask isn't going to offer anybody respiratory protection or a scuba mask, but they are devices that are engineered for breathing, but if you just close your -- take a piece of material or a paper and cover your mouth and nose with it, it will restrict breathing, it will restrict your ability to inhale, and it will restrict your ability to exhale.

Q So I know in your report, you use the term "breathing barriers" to describe these types of so-called masks that are mandated for COVID. Can you just explain to me why you use that term?

A Well, I coined that term actually, and the reason I use it is because I think it most accurately describes the situation -- what actually happens when you wear one of

these. If you've ever worn one, and, for most people, they probably have, they probably notice immediately that it does become increasingly difficult to breathe with one on. There's a reason that you're blocking your breathing. So when I call them breathing barriers, it's based upon the practicality that they block breathing, they block the normal flow of breathing.

Now, all respirators, even proper respirators, like the one I showed you, with the two filters and exhalation valve in the middle will increase breathing difficulty a little bit because you are going to pull air through the filter, so it's going to be a slight increase in inhalation effort but very minimal, and because it's designed for breathing, it's very minimal.

Let me remind you what I said earlier, anybody that wears any respirator before COVID needed -- or mask, for that matter -- needed any type of filtering mask needed to be fit tested. And before they could be fit tested, they had to be screened for their ability to wear it safely.

And without that screening, it's like Russian roulette, who's going to have to wear one and shouldn't be wearing one. Somebody with COPD, somebody with heart conditions, lung conditions of any type, high blood pressure, these are all people that need to be,

before COVID, needed to be examined by a physician to determine their ability to safely wear a respirator that's actually engineered for breathing, much less a closed cover over your mouth and nose that caps -- that makes it exponentially harder to breathe and captures carbon dioxide in significant amounts.

So that's why I call it a breathing barrier.

Q Thank you. Do you find it strange that we seem to be doing -- based on what you've said, we seem to be doing things very differently post-COVID than pre-COVID when it comes to things like fit testing? Do you find that strange?

A I think it's incredibly strange that there would be mandates for closed-cover barriers that aren't engineered -- aren't engineered for easy breathing, and I find it very strange that there is no requirement for a fit test for a filtering mask or respirator. That should be paramount; that should be primary.

Q Now, I know you've touched on this, but just to clarify, you say in the fourth paragraph in your report that wearing these what we're going to call breathing barriers are hazardous to the wearer.

A M-hm.

Q Why exactly are they hazardous?

A Well, think about it like this, if you take something, like if you take a piece of cloth or a piece of paper

towel or whatever it is, hold it closely to your mouth and nose, it becomes more difficult to breathe, right?

So we know that it's harder to breathe, which increases respiration effort. For people with pre-existing conditions, it's not going to be good. But even for people without pre-existing conditions, increased breathing effort, you increase the capture of carbon dioxide, and then you are re-inhaling that carbon dioxide, it's going to cause a variety of negative health effects, even if the person has no pre-existing medical conditions.

So common symptoms of blocking your flow of breathing and inhaling excess carbon dioxide can be things like experiencing a headache, nausea, dizziness, lack of coordination, maybe impaired hearing, impaired -- sometimes impaired vision. It can be a -- it can be feeling faint, overheating. And it can be worse than that, it could be people that have a very difficult time breathing, feel like they can't catch their breath, and it can go down from there. So anybody that inhales more than what the -- anybody that inhales above what the indoor Occupational Health and Safety standard is for carbon dioxide is at risk.

So if you were to look at my report, you would see the standards for carbon dioxide according to the Alberta standards for safety and see that the maximum

exposure for indoor carbon dioxide is a thousand parts per million. That's not very high. That's not very high. That's over a 24 period -- 24-hour period, but it's not very high. Because the normal oxygen that we have currently in our atmosphere is around 3 to 400 parts per million. So it doesn't have to go very high to get to a thousand.

And the testing that I've done inside these breathing barriers is very high levels of carbon dioxide. Even if somebody like -- here's the thing, if you wear a breathing barrier, and you are just sitting at a desk, looking at a computer, you're going to have hazardous levels of low oxygen just from having it on, any one of those three devices on it.

And if you are doing an activity like lots of speaking, those levels will drop dramatically, because your oxygen demand will increase dramatically.

And as well as, if you look at physical activity like, say, going for a run or something, and your oxygen demands go up significantly, then putting a closed cover on your face and blocking that ability to breathe can have a very severe negative impact of your ability to properly absorb oxygen or as much oxygen as your body needs and dispel -- disperse and dispel carbon dioxide away from you so you don't re-inhale it.

Q Thank you. I know you said that a thousand parts per

million is the sort of the safe limit for carbon dioxide. How long is too long to be exposed to that much carbon dioxide or more?

A Well, according to the -- the highest level that you can legally be exposed to in Alberta, according to Alberta standards -- and they revised their standards in the spring of this year, they actually -- it was actually higher, but they lowered it, instead it's lower, so -- is a thousand parts per million. That's based on a 24-hour exposure.

But I'll tell you based upon the testing that I've done and other research publications that I have as references, medical reports and research that I could -- I'm more than happy to submit a long list of certified medical scientific reports to show that levels of carbon dioxide in one of these devices exceed 5, 10,000 parts per million within a minute, anybody wearing any one of those three.

And oxygen levels -- here's -- carbon dioxide is only one part of the equation. The other immediately life-threatening condition is low oxygen. Hypoxemia is low oxygen in the blood; hypoxia is low oxygen in tissues. So what happens is is if you are not inhaling oxygen concentration, enough of an oxygen concentration in air, you're going to suffer -- you're going to suffer oxygen deficiency in your blood and in your

tissues.

And so the normal oxygen level in air is 19.5 -- 20.9 percent, 20.9 percent. Where it becomes dangerous to health becomes immediately dangerous, life and health, according to our regulations is 19.5 percent or lower.

So using instrumentation, you could see that the oxygen drop between the breathing barrier in the person's mouth or nose is significantly below 19.5 percent. Immediately, within the first 20 seconds, you'll see oxygen drop below 19.5 percent, which is safe levels. And if they're -- if they've got a tight-fitting cover, if their cover is very tight-fitting, especially like the N95 style or some of these cloth covers that are especially tight fitting, but even with a procedural-based mask, you're going to see unsafe levels of carbon dioxide and unsafe levels of oxygen. And even with the procedural-based what they call mask, which I call breathing barrier, is levels far in excess of a thousand parts per million, multiples higher, 10,000, 20,000 parts per million.

And I have done -- I've done testing. I've done video to show it. I am competent to operate testing equipment, and my testing equipment has been, you know, properly calibrated and properly tested to ensure that it's working properly as well, so I could verify it.

The readings that I take would hold up in a court of law.

Q What's the device that you use; what's the name of it?

A Well, there's -- I -- there's a number of devices that I could use. It's not -- it's not restricted to one type of device, because any device that has those appropriate sensors with those arrangers -- with those ranges of gas detection, as well as, you know, proper use and maintenance of the device would be suitable, but the one that I used was a MultiRAE Lite most recently.

Q And is that -- is that testing device, is it designed to test levels of carbon dioxide and oxygen in the atmosphere?

A Yes, it is.

Q Okay.

A So with these devices, you can get to a (INDISCERNIBLE) quick with any number of sensor configurations, because they're designed to test multiple types of gases, but carbon dioxide and oxygen is a very common configuration, and the sensors can be -- they can be in the monitor and installed in the monitor for that purpose, yes.

Q So we know the limit for carbon dioxide is a thousand parts per million, and I heard you say that you took readings inside these masks while they're being worn,

and some of those readings were 5 or 10,000 parts per million, but could you give me an idea of what an average would be inside the mask after it's been on for a bit?

A Okay, so let's say a couple minutes of wearing either a nonmedical, a medical, or a procedural based, you're looking at, a couple minutes of wearing, 20,000 parts per million carbon dioxide, oxygen levels as low as 18 percent, 18 to 18-and-a-half percent. The lowest oxygen can go legally is 19.5 before it becomes immediately dangerous to life and health.

So in Occupational Health and Safety standards, when we talk about IDLH, which stands for immediately dangerous to life and health, we're looking at device -- we're looking at levels that might not necessarily cause you to drop dead once they're reached, but certainly they're considered levels that now become -- those exposures become harmful without protection from those exposures.

Q And so now I've heard you use the number 20,000. So are these -- well, let me ask you this: The parts per million of carbon dioxide inside the mask while it's being worn, does it fluctuate, or is it steady?

A Well, it depends on a number of things. It depends upon what's the activity level of the person that's wearing it. The hard -- the more exertion, the higher

the carbon dioxide's going to go. It also depends upon what is the -- how tight-fitting is it around mouth and nose. If it's very tight-fitting, obviously it's going to trap more carbon dioxide than if it's a looser fitting.

So there's various factors. So, yes, it can fluctuate, or it can remain steady, depending upon the fit of it and depending upon the activity level of the person that's wearing it.

Q But in your experience with the loose-fitting ones, even though there are these leaky areas where air gets in and out, the parts per million of carbon dioxide stays above a thousand inside --

A Absolutely. It's still harmful to wear. It's still hazardous to wear for sure, because when you're exposed to levels that are levels that are far in excess, even with the looser -- even if it's not loose-fitting, it's a looser, slightly looser fitting, you're still going to find levels of oxygen that are lower than what is legislatively allowed and levels of carbon dioxide that are higher than what is legislatively allowed.

Q Now, you talked about some of the effects of this overexposure to carbon dioxide. Have you, in your line of work, have you ever encountered individuals suffering from these effects?

A You know, I am not a physician; I am an Occupational

Health and Safety specialist, so I primary measure the hazard. So I test people and equipment for their occupations to ensure that they are protected from respiratory hazards, but I do not evaluate the health conditions of people that may be affected by low carbon dioxide or high levels.

Q Okay.

MR. [redacted] I'm sorry, to interrupt, Mr. Chair, I don't see Dr. [redacted] on the screen. I'm just wondering, did we lose somebody? Excuse me, sorry, Mr. Kitchen.

MR. KITCHEN: That's okay. I don't see him either. He's --

MR. [redacted] She.

MR. KITCHEN: I'm sorry, yes, she. Yeah, that's a concern.

MR. [redacted] Oh, there she is, okay.

DR. [redacted] Sorry.

MR. [redacted] So I'm not sure if we want to just read the last couple of minutes back for Dr. [redacted] benefit.

MR. [redacted] Maybe we can ask Dr. [redacted] when she went offline --

DR. [redacted] Yeah.

MR. [redacted] -- intentionally or not or when she came back.

DR. [redacted] Completely unintentionally. The last we were discussing was the fact that the numbers of the CO2 and O2 levels would depend on the nature of the tight-fittingness of the mask and the exercise level of the individual. And I apologize.

MR. KITCHEN: So that means you did miss one question --

DR. [redacted] I'm so sorry.

MR. KITCHEN: -- well, there's two ways we can handle this: One, there's going to be a transcript, of course, you'll get to read it; two, we could just give Miss -- Miss [redacted] to read it. It doesn't matter to me, so I leave it to the Tribunal.

THE CHAIR: Let's have the court reporter read it back. That way, she'll get the same thing we all got.

THE COURT REPORTER: (by reading)

Q Now, you talked about some of the effects of this overexposure to carbon dioxide. Have you, in your line of work, have you ever encountered individuals suffering from these effects?

A You know, I am not a physician. I am an Occupational Health and Safety specialist, so I primary measure the hazard. So I test people and equipment for their occupations to

ensure that they are protected from respiratory hazards, but I do not evaluate the health conditions of people that may be affected by low carbon dioxide or high levels.

Q MR. KITCHEN: Mr. Schaefer -- I take it -- yes, everybody's here, good -- Mr. Schaefer, are you confident that if somebody else did the same tests that you've done on these masks or breathing barriers, are you confident they would come up with the same results that you have?

A If they're properly --

MR. [redacted] I'm a little concerned, that's a little speculative. I don't know if you want to consider rephrasing that, because I mean that -- what studies, who is conducting them? I think that's just a little bit broad, because there may well be studies which disagree with Mr. Schaefer. I'm just a little concerned about that type of question.

MR. KITCHEN: Well, I didn't use the word "studies", but let me try this.

Q MR. KITCHEN: Are you confident, Mr. Schaefer, that if somebody did the same testing you've done with the same device that you used that they would produce the same data regarding carbon dioxide and oxygen?

A Well, if they're following the proper procedure, as I

have, and they had done everything the same that I did as far as making sure that the equipment is -- has been properly calibrated, properly bump-tested, and making sure that everything is working as it should, then I would anticipate that the difference being them holding it versus you holding it should have no effect on the readings whatsoever.

Q And just to be clear, you used the same device to test the levels of oxygen and the levels of carbon dioxide?

A Yes, because the device was equipped with two sensors, one with oxygen and one with carbon dioxide, to measure these simultaneously, so I measured them both at the same time actually.

So there's a display on the monitor, there's a display for the readings of oxygen, and there's a separate display for the readings of carbon dioxide, so you can see both in realtime.

Q I see. Now, I notice you used the word "asphyxiation" at one point in your report; can you just, for those of us who do not know what that means, can you explain to me what asphyxiation is?

A Well, asphyxiation is when your body is suffering from insufficient oxygen, so whether it's, you know, accidental, intentional, whatever it may be, your body's not getting enough oxygen, that's asphyxiation.

And so there's various levels of it, but

asphyxiation may be fatal. It may cause injury. So these are the kinds of things that this is what -- and it's all due -- asphyxiation's due exclusively in this -- in this -- I guess how I should say -- view to insufficient oxygen.

Q Now, you say carbon dioxide is an asphyxiant, and it displaces oxygen.

A M-hm.

Q Can you explain why or how that happens?

A Well, carbon dioxide is used to -- carbon dioxide can displace oxygen, because it is considered an inert gas, so pure carbon dioxide is able to displace oxygen.

So, for instance, let me give you an example, carbon dioxide is often used in industrial situations to purge out hazardous atmospheres of, say, things like confined spaces and such to remove oxygen from those spaces. So we know carbon dioxide can cause displacement of oxygen. And it can do that in any closed container, it doesn't have to be a confined space like industrial, but any closed container where you've got accumulations of carbon dioxide, and it can affect how you can absorb and how you can be exposed to oxygen, how you can absorb oxygen basically.

Q Now, I know you've mentioned the 19.5 figure, but I'm just curious, what is the number that the Occupational Health and Safety code in Alberta describes as being

the point at which, if you go below it, it becomes hazardous?

A 19.5 percent. That's immediately dangerous to life and health. So you can't go below 19.5 percent for any reason.

And if you are exposed to air in Alberta, if you are exposed in air -- breathing air that has an oxygen concentration below 19.5 percent, you have to be equipped with a separate air source, like self-contained breathing apparatus, a supplied-air system, that will give you the correct oxygen requirement that you need.

Q That number of 19.5, is that fairly universal throughout jurisdictions?

A Yes, it is.

Q Okay. I know in your report, you mention the Occupational Health and Safety Administration [sic]; could you tell us what that is?

A Occupation Health and Safety Administration? What exactly is your question?

Q I'm just wondering what is the Occupational Health and Safety Administration, because that's not Occupational Health and Safety Alberta. I just want to know what that is.

A Okay, so Occupational Health and Safety Administration [sic] is the US standard of safety

requirements. So it's funny, because when you say it -- you said it full out; I'm more familiar with it in its abbreviated form, which is OSHA.

Q OSHA.

A If you would have said "OSHA", I'm like absolutely, but because I never hear it as Occupational Safety and Health Administration, that's why I kind of just hesitated for a second.

So anyhow, OSHA is the governing body for safety standards and exposures in the United States.

Q Okay, and is that -- are they similar to OHS here in Alberta?

A Yeah, many of the OSHA standards are accepted in various jurisdictions in Canada as well.

Q So in your report, you refer to a 2007 letter from OSHA. Can I just get you to turn to the first page of this letter, that's page 085 or 85 from your report, and for those who are following along, that's near the end of the report, and then the top left-hand corner is the page number, 085. Now, this letter, can I just ask you to read out the first sentence of the third paragraph there at the bottom of that page.

A (as read)

This letter constitutes OSHA's interpretation of the requirements discussed.

Q We must be on different pages. So I'm looking at the

first page of the letter --
A Okay, I'm looking at -- I'm on page 085.
Q Maybe you've got a different page 085. Well, can I get you to go to just the first page of this letter, where it says "April 2nd, 2007, Mr. William Costello"; do you see that?
A Oh, okay, okay, yes, I see that now, yeah.
Q Okay. And if we go down, the first paragraph starts with "Thank you", second paragraph --
A Yeah.
Q -- starts "Within your letter", if you could just read the first sentence of the third paragraph there.
A Okay, so the third sentence of the second paragraph -- third paragraph, okay, okay, I got you, okay. So it is -- is it the one "to ensure that employees", is that the second one?
Q No, it's starts with the word "Paragraph".
A Oh, "Paragraph", okay: (as read)

> Of paragraph (d)(2)(iii) of the respiratory protection standard considers any atmosphere with an oxygen level below 19.5 percent to be oxygen deficient and immediately dangerous to life or health.

Did you want me to continue?
Q No. That sounds a little dramatic to me. Can you help me understand, you know, from the perspective of an

Occupational Health and Safety expert, what does "immediately dangerous to life or health" actually mean?

A Well, I thought I actually explained that a little earlier, but I'll tell you what, I'll go over it again.

So "immediately dangerous to life and health" means that if you are exposed at that level or below that level especially, then you are going to be putting your health in harm's way. So that can have significantly dangerous impacts on your health. And the lower it goes, the lower it goes, like the more it differentiates, like if it's -- the lower it -- for oxygen, oxygen requirements here, the lower it goes below the minimum oxygen requirement, the 19.5 percent, the more dramatic and the more negative those effects are going to be. So it's bad.

You never are allowed to exceed -- you're never, ever allowed to breathe air less than 19.5 percent under any circumstance in Occupational Health and Safety settings. There's no -- there's no exceptions. This is the deadline. You can't go below 19.5.

If you do, if somebody is tested and they are exposed to levels of oxygen below 19.5 percent, the operation, the working operation, would have to be immediately shut down, and they would have to be evacuated from that space; even if it was 19.4, they'd

have to be immediately evacuated. There's nothing below 19.5 that's acceptable.

If somebody had to work in an atmosphere of 19.5 percent or lower, they would have to be equipped with a separate source of clean air with -- delivered via air line, supplied air-breathing apparatus. For those of you listening that might not necessarily be aware what that is, that is the same type of breathing apparatus that fire fighters wear when they go into smoking buildings, so they have a separate source of air. Why? Because they need it, because they go into oxygen-deficient atmospheres. And that's the type of equipment you need to be exposed to any oxygen concentration below 19.5 percent.

Q So when people are working with a procedural mask on, are they working in an environment that's immediately dangerous to life or health?

A The barrier, the breathing barriers create this environment. So if you are in your office or home or wherever it may be, and you are exposed to good breathing air without a breathing barrier, wearing a breathing barrier will create this hazardous environment for your body.

Q Could I get you to turn the page over on this letter, and you'll see there a box containing two paragraphs of text; do you see that?

A Yes, I do.
Q Can I just get you to read the first three sentences of text inside that box?
A (as read)

> Human beings must breathe oxygen to survive and begin to suffer adverse health effects when the oxygen level of their breathing air drops below 19.5 percent oxygen.

So for the person doing the documentation on this, I should probably say that -- I'll read it over again, just so that they can do their recording properly on it by hand. So: (as read)

> Human beings must breathe oxygen ... to survive, and begin to suffer adverse health effects when the oxygen level of their breathing air drops below (19.5 percent oxygen). Below 19.5 percent oxygen ..., air is considered oxygen deficient. At considerations of 16 to 19.5 percent, workers engaged in any form of exertion can rapidly become symptomatic as their tissues fail to obtain the oxygen necessary to function properly.

And do you want me to read what's in the brackets as well there as reference?
Q No, that's good, thank you. Now, this concentration of

16 to 19.5, that range, is that what you've discovered when you've tested the levels of oxygen between these breathing barriers and the faces of those wearing them?

A Absolutely. Every oxygen concentration, whether it's procedural they're wearing, and even at resting rate without any form of exertion, just resting rate, resting rate, we're seeing an oxygen drop of below 19.5 percent within 2 minutes of wearing it on either procedural, nonmedical, or medical masks. Within 2 minutes, and that's without, that's without speaking a lot or any other type of obvious exertion.

THE CHAIR: Mr. Kitchen --

MR. KITCHEN: Yes.

THE CHAIR: -- I'm just wondering, it's quarter to 11, we started at 9, and I don't want to interrupt the flow, but I'm wondering if people would like to take a 5- or 10-minute break just to stretch and whatever.

MR. KITCHEN: I'm fine with that. Can I just -- because I'm almost done with this area of questioning; can I just -- can I ask one question to tie that up?

THE CHAIR: Certainly, certainly.

Q MR. KITCHEN: Mr. Schaefer, I'll just get you to turn the next page over, can you just tell me who is it that wrote this letter, and what's his title?

A The person who wrote this letter is Richard E. Fairfax, F-A-I-R-F-A-X, Director, and his title is Directorate of Enforcement Programs. So he would be in charge of -- just for the record, this is somebody that's in charge of enforcement programs for all of OSHA, which is -- encompasses all of the United States, and in Canada, we have the same even, within our own individual provinces, we have the same standards for oxygen that nothing under 19.5 percent. Everything below 19.5 percent is immediately dangerous to life and health. It's universal throughout North America -- or I should say through the US and Canada.

Q One last question before we break, do you find it strange that the public has been mandated to wear, by various government bodies, devices that cause their oxygen to be below a level that's safe?

A Well, I don't know if "strange" is the right word, James. I'm not sure if "strange" is the right word. I think it's much more serious than "strange", because I know how serious it is, I know how serious the rules are regarding oxygen concentrations below 19.5 percent. In every one I've tested, every one, I've tested adults, I've tested children, everyone, within 2 minutes of wearing either a procedural, nonmedical, or the medical N95, even that's (INDISCERNIBLE) approved, within 2 minutes is having oxygen drops below 19.5

percent.

Q Thank you.

MR. KITCHEN: And that's it for me for now until we come back after our break.

THE CHAIR: Okay, well, let's reconvene at 11:00 then, and we'll continue on with Mr. Kitchen and Mr. Schaefer. Thank you.

MR. KITCHEN: Thank you.

(ADJOURNMENT)

THE CHAIR: We are back in session, and we'll have Mr. Kitchen continue with his direct exam of Mr. Schaefer.

MR. KITCHEN: All right, thank you.

Q MR. KITCHEN: Now, Mr. Schaefer, I think you touched on this, but just to clarify, in your experience, do some people tolerate wearing these breathing barriers better than others?

A Oh, absolutely, because some people have pre-existing medical conditions that make it difficult to breathe without any restriction. If you added a restriction on top of that, it could be life threatening for those people, and every bit of, you know -- depending upon -- there's levels, right? So if it's -- it depends on the level of pre-existing medical condition they have and the severity of it, but it could be life threatening, it could cause somebody a life-threatening medical

emergency to wear a breathing barrier, even a properly certified respirator, if they haven't -- if they don't have the health and they haven't been properly screened beforehand, before wearing it. It's important. It's important that we check out and people are health-assessed before we restrict our breathing. It's important.

Q Do you do screening and fit testing at workplaces for employees?

A Absolutely. Screening is a prerequisite for fit testing. I can't fit test anybody that hasn't completed screening protocol.

Q Can you tell me what are some of the things you look for when you're screening?

A Well, the screening is a document that the patient -- I shouldn't say "patient", but the client, the customer or client is going to complete in their own -- with their own privacy, so they're going to complete it completely themselves, and then I just look at the results.

The results that I'm looking for, there's a list of pre-existing medical conditions, and if they identify that they currently have any of those pre-existing medical conditions, then my obligation, as an Occupational Health and Safety fit testing professional, is that I have to refer them to their

physician for further testing and analysis to determine whether or not they have the physical fitness to be able to handle a restriction in their breathing.

Q Is asthma one of those conditions?

A Yes. Do you want me to mention some of the conditions?

Q Well, you can only do that if I ask you to do that. Well, let me ask you, just off the top of your head, you don't need to go through the whole list, but just give me some examples of some of these conditions just so we have an idea. We know one of them is asthma, but give us an idea.

A Allergies, high blood pressure, cardiac conditions, lung illnesses. I'm not reading; I'm just going off memory right now. Let's just see here, I can look up that form quickly here if you would like me to read them all, but, you know, those are included in that, so allergies, asthma, heart disease, high blood pressure.

Okay, I'm just going to open it up right now.

Q Well --

MR. [redacted] Mr. Kitchen, I'm not going to contest your client's view on different conditions. I'm not sure if we have to go down this road, to be honest with you. I don't --

MR. KITCHEN: Yeah --

MR. [redacted] -- want to have to get him to read from something, if that's what you need him to do.

MR. KITCHEN: No, I don't.

Q MR. KITCHEN: And, you know, since what you're reading from, Mr. Schaefer, is not actually in the record. I think that's fine, that answers my question anyways.

Now, we've talked about this immediate danger, that life and health, but does it surprise you then that most people, when they wear these breathing barriers, even for hours on end, that they don't pass out from wearing them?

A Well, it doesn't surprise me, but just because they're not physically passing out does not mean that harm is not being done.

So here's the facts that I've been able to establish from my testing: People that wear breathing barriers are subjecting themselves to an oxygen deficient IDL -- IDLH inhalation atmosphere. And in many cases, they subject themselves to an IDLH level carbon dioxide as well.

If you subject yourself to IDLH levels of low oxygen, it will negatively impact your health whether you're aware of it or not, and that's why all the governing bodies that govern the rules of health and safety legislate what the minimum oxygen concentration in air that you can be exposed to, because you might not necessarily feel harm right away, you might not

necessarily have a headache right away or dizziness, you might not necessarily feel nausea right away, any of these other minor -- more minor types of symptoms of low oxygen.

But we know that if you are exposed to a hazard in a low enough concentration or a high enough concentration, depending on what the hazard is, harm will occur, and it might be something -- it might not necessarily be something that the wearer or user is aware of, at least not immediately.

Q In your experience, has Alberta Health Services or the Alberta Public Health authorities generally, have they acknowledged the risks and harms associated with these breathing barriers that you've been talking about?

A I've reached out to Dr. Hinshaw back in June of last year with a very detailed letter on pointing out -- at that time, it was -- nothing was mandated, it was just a recommendation that people wear, in Alberta, N95, nonmedical, or procedural what they call, you know, surgical mask for protection from COVID, and I had to point out a lot of the errors that she had stated.

I have read -- the only reply that I have received from Dr. Hinshaw's office to date is a read receipt. Actually it was CC'd to 23 other doctors in charge of public health in Alberta. So I have a lot of read receipts, no official response.

To also clarify, besides not having an official response, I have never -- there's been numerous attempts to contact Dr. Hinshaw's office for a response, and it has not been granted, it's been denied.

Q Do you have any thoughts on why Alberta Health Services or the Chief Medical Officer of Health hasn't been willing to discuss these risks and harms?

A I have thought --

MR. [redacted] I don't want to be difficult here, but I think that question really is asking your witness to talk about what's in the minds of the other people. I think if you rephrase it and ask him a different question, I might not object, but I don't think he can speak to why they're not doing or doing anything.

MR. KITCHEN: Right, I was asking him his thoughts, so I'll just ask it again with those words in there.

Q MR. KITCHEN: Mr. Schaefer, and, you know, maybe you just have no idea, and that's okay, but do you, from your perspective, can you think of any reason -- or what do you think the reason is that there hasn't been any discussion on this?

A I don't know. In all honesty, Mr. Kitchen, I have no clue, but I will tell you this, is that normally,

normally, before any types of mask mandates are -- would be even recommended in Occupational Health and Safety settings, professionals like myself would be consulted long in advance of any potential mandates that would occur, and that has not happened this time, in this instance.

Q Now, as an Occupational Health and Safety expert, as an Occupational Health and Safety consultant, do you work at all with Occupational Health and Safety Alberta?

A I'm always -- I don't work specifically for Occupational Health and Safety Alberta; they have their employees, their own government employees, but do I work in union with them, like in cooperation? Absolutely. Everything that is Occupational Health and Safety-related in Alberta works in cooperation with Occupational Health and Safety representatives in Alberta.

Q And in your experience, has Occupational Health and Safety, OHS, have they acknowledged any of these risks or harms associated with these breathing barriers?

A There hasn't been any -- there hasn't been any real willingness to discuss that on behalf of OH&S, and they're more than happy to back Provincial mandates without discussion and without discussion or any other opinion that's contrary to the AHS mandate.

Q Why do you think that is?

A I don't know. I don't know, Mr. Kitchen, but it is very strange, because in a normal time, before COVID, there was so much discussion about any new policy that could be implemented long in advance before it would become a mandate. There's planning, there's discussion, there's determination.

But I think what I find that's very interesting is that this is not just an Alberta situation; this is a worldwide thing. How strange is it that something like this type of breathing barrier could be mandated, rolled out so fast without any consulting of, you know, no one, no one trusted respirator professionals, by medical staff, who aren't experts in respiratory protection, they aren't qualified to -- medical doctors alone are not qualified to comment or give advice on various aspects of respiratory protection because they're not asked -- they don't deal in respirators professionally, they have very limited knowledge about respirators and masks and their protection levels and what they can do and what they can't do. And I find it strange that this has been implemented on a worldwide basis with virtually no contest, without official contesting of it, it's very strange.

Q In fact, earlier you said, it was more than strange, you said it was serious?

A Well, strange that it hasn't been documented, but when

I said serious, I said serious in relation to oxygen -- I said serious in response to your question for me on the effects on people being exposed to less than 19.5 percent oxygen. Yes, that is beyond strange. That is alarming. That is alarming that these devices could be mandated when they clearly -- when the testing that I am trained to perform clearly shows oxygen levels dropping below 19.5 percent with all three of these versions of mandated breathing barriers, whether it's an adult or a child even at resting rate, and we know that the drop is going to be even more significant for people that are engaged in any kind of activity.

Q And do you understand that we're here today because Dr. Wall has contested these breathing barriers and that, for doing so, he is facing professional discipline?

A Yes, I'm aware.

Q On page 8 of his report, Dr. [redacted] I think his first name is [redacted] but Dr. [redacted] says -- and just to clarify, he is the expert tendered by the Alberta College of Chiropractors -- on page 8 of his report, he says: (as read)

> There are no known harms associated with masking.

Now, maybe it's obvious, but do you disagree with his statement?

A Completely. I completely disagree with Dr. [redacted] statement, because there are numerous scientific research papers and studies. I've looked through Dr. [redacted] references, and I didn't see one registered scientific study in any one of his references, but I have references from registered scientific journals, medical journals. I have references from the -- published by the National Library of Medicine to show quite the opposite of what Dr. [redacted] references claim.

Plus, in addition, my own -- obviously, my own testing, of course, but then as far as scientific references go, there's -- I can send a whole bunch of actual registered, published, scientific medical researchers that have shown quite the contrary to what Dr. [redacted] has stated.

Q A number of witnesses in this hearing, including Dr. [redacted] have said that the issue of masking as it relates to COVID is a politicised issue. Do you think it's a politicised issue?

MR. [redacted] I am going to have to object to that, Mr. Chair, that runs afoul of commenting on the harm or lack thereof in terms of masking.

MR. KITCHEN: I think that's a fair question.

THE CHAIR: Can you restate it?

MR. KITCHEN: And this is part of the reason

why I raised the fact that this has been a constant issue in the hearing, the other expert, Dr. [redacted] who Mr. Schaefer just responded to, said that masking is a politicised issue, and so have several other witnesses, so now I'm asking Mr. Schaefer if he thinks masking as it relates to COVID is a politicised issue.

MR. [redacted] I'll just again state, Mr. Chair, that I think this witness is being tendered for a very specific purpose, and that was harms, in his view, that are caused by masking, and I don't think this witness is anywhere near the -- is a very different type of witness from the other experts that have testified.

MR. KITCHEN: I don't see what entitles Dr. [redacted] to talk about the politicisation of the issue that doesn't also entitle Mr. Schaefer to talk about it.

THE CHAIR: Well, I don't want to go back and retroactively deal with Dr. [redacted] but I do think this witness was qualified as an expert in a very specific area, and I do think the question extends beyond that.

Q MR. KITCHEN: Well, just one more question then, Mr. Schaefer, from your perspective, do you think Occupational Health and Safety is the primary consideration in forming these mask mandates?

A Well, Mr. Kitchen, Occupational Health and Safety has

not been a consideration at all in these mask mandates, as demonstrated, and I would contest any safety professional with qualifications equal to mine to prove otherwise, that oxygen deficiency is created by wearing a breathing barrier. That is why our parents taught us to never put a bag over our heads. It is pretty standard, you cover your mouth and nose with a random object, it limits your ability to breathe naturally, and anything that limits your ability to breathe naturally can potentially be harmful to health. That's why we have screening, and anybody with pre-existing medical conditions that has a limit on their breathing could cause a life threatening medical emergency.

MR. KITCHEN: Thank you. Those are all my questions.

MR. [redacted] Mr. Chair, if you're comfortable, I'll just continue on. I don't expect to be too long.

THE CHAIR: Yes, that's fine. Just before you start, Mr. [redacted] Mr. Schaefer, you're okay to continue with this cross-examination, or did you want a break?

A I'm fine. Thank you very much, Mr. [redacted]

THE CHAIR: Okay.

Mr. [redacted] Cross-examines the Witness

Q MR. [redacted] Mr. Schaefer, I've got some

questions I'm going to take you to in a couple of minutes that I had thought of in advance of the hearing, but I want to touch on a few things that are fresh in my mind now that you've just talked about with Mr. Kitchen, if you don't mind.

A Sure.

Q So a few minutes ago, you talked about the fact that some people tolerate masking better than others and that that was a function of pre-existing medical conditions and the severity of those medical conditions; do you remember that exchange you had?

A Yes, I do.

Q And I think you talked about properly screening individuals as well, and it's important that people are health-tested in terms of masking and medical preconditions; do you remember that?

A Well, at least as far as identifying pre-existing medical conditions that could make them not a good candidate for wearing any type of mask or respirator.

Q Sure. And you would agree with me that it's important to go to a doctor to determine whether they have any pre-existing medical conditions?

A That is correct.

Q I want to touch on a few things that you talked about with Mr. Kitchen. You talked about, in your view, that Dr. Hinshaw didn't contact OHS, I think that's the

Provincial OHS, but I think you'd agree with me that you don't have any direct knowledge of that, do you?

A I didn't say that Dr. Hinshaw didn't contact OH&S. What I had said was that Dr. Hinshaw has not been -- air testing on these masks has not been done, so they haven't -- the safety of people wearing them has not been properly determined, because there has been absolutely no air testing on oxygen deficiencies or carbon dioxide accumulations on these masks by --

Q Well, I don't want to belabour -- oh, sorry, so sorry, were you finished?

A Yeah.

Q I don't want to belabour this, but I think, Mr. Schaefer, it's fair to say though you haven't been involved in the development of the CMOH orders, have you?

A That is fair to say; I have not been involved in the development of those orders.

Q You made a comment I think it was a couple times during your testimony then, Mr. Kitchen had sort of a wrap-up question for you, and you were talking about the fact that it was strange that devices are mandated, that breathing devices are mandated. Would you agree with me that it is clear they are mandatory though?

A I would agree with you that it is clear that these breathing barriers are currently mandated, that's

correct.
Q And you've had a chance to look at the College's Pandemic Directive, I assume?
A I have not memorized it, but I have had exposure to it; I have looked at it, yes.
Q Yeah, and it's not a memory test for you. I'm just -- there's a phrase, and my friend and I talked about this when you were being qualified, there's a phrase in it that says "surgical or procedure masks are the minimum acceptable standard", and it goes on to say that chiropractors and staff must be masked. You'd agree with me that that's mandatory for chiropractors?
A You know, I can't agree with -- look, just because -- just because it's -- just because one of these or more of these breathing barriers is mandatory for chiropractors and other professions, doesn't mean they're safe.
Q Oh, I'm not asking you that. I'm asking you it's mandatory for chiropractors, question mark, full stop.
A Aware a procedural-based is what you're saying?
Q Yeah, I'm just saying that the Pandemic Directive, and I pointed you to the masking situation in particular, that's mandatory for chiropractors; aside from your views on the safety or harm, that's mandatory?
A That appears to be correct.
Q So, Mr. Schaefer, I'm going to turn you to now a couple

of, I guess, more generic questions, and I just wanted to be clear, and you kind of touched on this with Mr. Kitchen and I think with me a minute or 2 ago, you haven't been involved in the Government's response to COVID-19; that's correct?

A That is correct.

Q And you've been qualified today to provide your opinion about the harms that masking can cause for the wearer, and that's correct?

A That's correct.

Q And you're not here, of course, to provide any evidence about the benefits that might accrue from masking for people in the presence of the person being masked; is that correct?

MR. KITCHEN: Hold on, hold on --

A Well -- well --

MR. KITCHEN: -- that question --

THE CHAIR: Just (INDISCERNIBLE), Mr. Schaefer. Sorry, go ahead, James.

MR. KITCHEN: That question is premised on efficacy of masks, which my friend, my learned friend, went out of his way to make sure we were not going to talk about, and now he's trying to talk about it.

MR. [redacted] I'm trying to just make a comment that this witness isn't providing that evidence.

MR. KITCHEN: Well, that's been established time and over again, so I don't understand why we're just filling the record with repeats of what we've already established.

MR. [redacted] Well, I just wanted to be clear that this witness is not providing evidence about any potential benefits to persons in the presence of the wearer of a mask.

MR. KITCHEN: Well, I think we're --

MR. [redacted] I'll move on, I'll move one, yeah. Mr. Kitchen, if you have a problem with this, you'll let me know.

Q MR. [redacted] You're not here to provide any evidence about the transmission of COVID for preventive measures for COVID?

A That's correct.

Q Would it be fair to say that your views about mandatory masking are inconsistent with most government Public Health agencies, in Canada I should say?

A In Canada, as far as the mandates that have come down provincially and nationally?

Q Yeah, that would be correct.

A Yeah, I would say that we definitely have a difference of opinion.

Q You talked with my friend, Mr. Kitchen, about the testing that you've done. None of that testing is

attached to your expert report, is it?
A That testing that I've done is not -- let me just take a look here.
MR. KITCHEN: Perhaps you could be a little more specific, Mr. [redacted] --
MR. [redacted] Yeah (INDISCERNIBLE) --
MR. KITCHEN: -- there's no exhibit that has a list of the readings. Is that what you're getting --
MR. [redacted] Yeah, that's kind of what I'm getting at.
Q MR. [redacted] And, Mr. Schaefer, this isn't a gotcha question, but I'm just looking at the second page of your report, and you talk about using the MultiRAE Lite, and you observed that upon commencement, and you have some comments then. I'm just saying there's no data or test results from those tests you performed which are part of your expert report, correct?
A I don't have it in the report, specific readings, but I have -- I've done lots of documentation on it and reports on it, so --
Q Yeah, I'm just -- I wasn't trying to take you down the road of what you did; I just wanted to be clear they're not attached.
A Yeah, the specific testing, I've done a lot of testing, so for me to have all of the different test subjects

and all of the different readings would be quite extensive as far as those testing results would be, so they're not attached, no.

Q Okay. I want to ask you some questions about your registration with the Alberta College of Paramedics, and I think you've told me that you were at EMS for one year, you were a regulated member of that college for one year. Did you have to meet any entry requirements to get your EMS registration with the ACP --

A Absolutely.

Q -- College of Paramedics?

A Yes, I did.

Q And that's a mandatory requirement to become an EMS with the College of paramedics?

A It's a mandatory requirement to be registered with the Alberta College of Paramedics to work in an occupational setting as a medic in Alberta.

Q And even though you were only a -- I shouldn't say "only" -- but it was a one-year period you were a regulated member, there were mandatory requirements you had to follow during that year like con ed or paying a licence fee; would you agree with that?

A Yes, in fact, the only requirements they registered with Alberta College of Paramedics, because I completed all of their requirements, the only requirement, moving forward from year to year, was to pay the fee to stay

registered. And that registration is required to work as a medic in Alberta, and I had no intention of working as a medic in Alberta as I was already fully employed as an Occupational Health and Safety specialist, so that's why I ended it.

Q Sure. And just to be clear, is it your understanding that if you don't follow those requirements, you can't be a member of the College?

A Yeah, you have to follow -- you have to work -- you have to practice your skills within a protocol as determined by Alberta College of Paramedics, yes, in an occupational setting.

Q Sure. I'm going to ask you a fairly specific question here, but would you comply with the paramedic equivalent of the College's pandemic requirement about mandatory masking if you were in the field?

A I would comply with wearing a mask, but I would not wear a breathing barrier. I have not worn a breathing barrier, and I won't. So, remember, there's a big difference between what's currently been mandated and what an engineered mask is.

A mask is safe to wear. A mask is engineered inhalation openings. A mask has an engineered exhalation opening. That's safe. It's established as safe. It's proven as safe over many decades.

So a closed cover is not something that I would

wear, no, but I would wear an actual mask.
Q So I just want to be clear, again, when we look at the Pandemic Directive for the College of Chiropractors, it says that the requirement is a surgical or a procedure mask; you would comply with that kind of directive from your regulatory body if that was applicable?
A I know that those aren't masks. Those are breathing barriers. I'm not going to jeopardize my health and safety through low oxygen and accumulations of carbon dioxide for any occupation, because that's my health, and my health is important to me. It's more important than anything else.
Q So you would choose to not comply with it?
A I would wear -- I would wear something that far exceeds the recommended protection, which is an actual certified respirator that actually is designed for easy and safe breathing, I would wear that, and it would far exceed any potential respiratory benefit that a breathing barrier could provide.
Q Those are all my questions --
A (INDISCERNIBLE)
Q Sorry, did you want to finish? I cut you off.
A Oh, sorry, I just wanted to say that -- so what I would wear would be far and above what has been currently mandated.
MR. [redacted] Those are all my questions,

Mr. Schaefer, thank you.

A Thank you very much, Mr. [redacted]

THE CHAIR: Mr. Kitchen, did you have anything on redirect?

MR. KITCHEN: Just a couple.

Mr. Kitchen Re-examines the Witness

Q MR. KITCHEN: Mr. Schaefer, you attest to the truth of what you said about the results of the testing you did?

A Well, I am under oath in this courtroom, so I believe I've already done that.

Q You just finished a discussion with my learned friend about whether or not you would wear a breathing barrier if your regulatory body told you you had to in order to practice, and if you didn't have access to the respirator, if all you had access to was the breathing barrier that they said you had to wear, would you wear it to keep your licence?

A No, I would not wear it to keep my licence because my health is more important than my job.

MR. KITCHEN: Thank you.

Q MR. KITCHEN: Wait, hold on, forgive me. Mr. [redacted] asked you about screening and pre-conditions. Just to clarify, you would say that masks -- well, would you say that masks are harmful to people who have no pre-existing conditions at all?

A Look, a mask is engineered for breathing. People without pre-existing conditions should be able to wear an actual engineered mask with engineered inhalation and exhalation valves no problem, provided -- you know, depend -- again, it depends like on previous -- if there's no pre-existing conditions, they're considered fit, then an actual mask is safe to wear for that person.

But if you're talking -- I'm not talking about a breathing barrier here. A breathing barrier with no inhalation valves, no exhalation valve, that's not safe for anybody.

MR. KITCHEN: Thank you. Those are actually all my redirect questions.

THE CHAIR: Thank you very much, Mr. Schaefer. I believe that concludes your testimony this morning, and we thank you for your attendance and for your testimony, and you're free to leave the hearing.

A Thank you very much, Mr. [redacted]

THE CHAIR: It's 20 to 12, and we could start at 12:45. Mr. [redacted]

MR. [redacted] Yes, I wondered, do you have any questions? You didn't have any questions, I'm assuming, of Mr. Schaefer --

THE CHAIR: Oh, I'm sorry, I jumped the

gun there. Did the Members of the Tribunal want to caucus and discuss that? I think I'll have to take a lashing for that, probably ten lashes, but yeah.

So I suggest then that we break for lunch, and we reconvene at 12:45 with Mr. Kitchen's witness and go from there.

MR. [redacted] Just so I'm clear, Mr. Chair, my apologies, will you want Mr. Kitchen -- maybe this is a question Mr. Kitchen is going to ask, do you want him to have Mr. Schaefer available then at 12:45 if you have any further questions? And I'm just asking, I don't know exactly where we're heading at 12:45.

THE CHAIR: Okay, I'll touch base with the Tribunal Members when we break here, and if there are some follow-up issues from the Hearing Tribunal with respect to Mr. Schaefer, I'll get in touch with Mr. Kitchen, and we'll arrange to get him back.

MR. KITCHEN: Yeah, if you could just please let me know within 10, 15 minutes, just that way, I can release him or I can keep him around.

THE CHAIR: Yeah, thank you for bringing that up. That's my fault, I got ahead of myself. When we break now, we'll go into a break-out room first, the Panel Members and our legal counsel, and we'll just find out if there are any follow-up questions, and then I will let you know, Mr. Kitchen.

MR. KITCHEN: Okay, thank you.

PROCEEDINGS ADJOURNED UNTIL 12:45 PM
