

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 6

VIA VIDEOCONFERENCE

---

Edmonton, Alberta

November 20, 2021

1	TABLE OF CONTENTS		
2			
3	Description		Page
4			
5	November 20, 2021	Morning Session	841
6	CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen		842
7	(Qualification)		
8	Mr. Maxston Cross-examines the Witness		847
9	(Qualification)		
10	Discussion		849
11	Ruling (Qualification)		854
12	CHRIS SCHAEFER, Previously sworn, Examined by		856
13	Mr. Kitchen		
14	Mr. Maxston Cross-examines the Witness		900
15	Mr. Kitchen Re-examines the Witness		910
16			
17	November 20, 2021	Afternoon Session	914
18	DR. BAO DANG, sworn, Examined by Mr. Kitchen		915
19	Discussion		969
20	Mr. Maxston Cross-Examines the Witness		971
21	Mr. Kitchen Re-examines the Witness		979
22	Certificate of Transcript		982
23			
24			
25			
26			

EXHIBITS

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26

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

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

4

---

5 November 20, 2021 Morning Session

6

7 HEARING TRIBUNAL

8 J. Lees Tribunal Chair

9 W. Pavlic Internal Legal Counsel

10 Dr. L. Aldcorn ACAC Registered Member

11 Dr. D. Martens ACAC Registered Member

12 D. Dawson Public Member

13 A. Nelson ACAC Hearings Director

14

15 ALBERTA COLLEGE AND ASSOCIATION OF CHIROPRACTORS

16 B.E. Maxston, QC ACAC Legal Counsel

17

18 FOR DR. CURTIS WALL

19 J.S.M. Kitchen Legal Counsel

20

21 K. Schumann, CSR(A) Official Court Reporter

22

---

23 (PROCEEDINGS COMMENCED AT 9:16 AM)

24 THE CHAIR: This is continuation of the

25 Hearing Tribunal for Dr. Wall is back in session.

26 And Ms. Nelson does have your witness in the

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

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

6 THE WITNESS: Yes, good morning.

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

10 All right, so, Mr. Schaefer, the first thing we're  
11 going to do is we're going to swear you in, and  
12 Karoline, our court reporter, is going to do that, and  
13 once she does that, then we'll get into the  
14 questioning.

15 THE WITNESS: Sounds good.

16 CHRIS SCHAEFER, Sworn, Examined by Mr. Kitchen  
17 (Qualification)

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

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

1 I'll start with is what's your current occupation?

2 A My current occupation is as an Occupational Health and  
3 Safety consultant. I have been doing that now for  
4 quite a number of years. Since 2004, I've had my own  
5 company, but I've been working in Occupational Health  
6 and Safety as a consultant since 1994.

7 Q Okay, thank you. Now, you said "consulting", what are  
8 the types of things you consult on?

9 A Well, I consult on all aspects of Occupational Health  
10 and Safety training. Primarily what I do is one of my  
11 specialties is respirator fit testing and training. So  
12 respirator fit testing and training that I would  
13 consult on would be for any atmospheric hazard from  
14 anything that would require the most basic level of  
15 respiratory protection all the way up to and including  
16 respiratory protection for emergency responders like a  
17 self-contained breathing apparatus, both closed- and  
18 open-circuit systems.

19 Q And do you teach any courses on respirators or how they  
20 fit?

21 A Yes, I do. I do teach a course, a course on respirator  
22 fit testing and training, and I have been teaching that  
23 course as an advisor to the University of Alberta  
24 Faculties of Medicine and Dentistry for several years,  
25 as well as private clients.

26 Q I just want to -- on your résumé, you've got a long

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

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

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

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

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

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

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

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

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

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



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

3 A Yes, absolutely.

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

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

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

11 A M-hm, yes, I am.

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

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

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

20 A Yes, I have.

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

24 A Yes, I have.

25 Q Thank you.

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

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

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

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

17 THE CHAIR: Mr. Maxston, did you wish to  
18 comment before we --

19 MR. MAXSTON: I have I think two brief  
20 questions for Mr. Schaefer, and then my friend is aware  
21 of this, I've got a few comments about the  
22 qualification that's being tendered, so I'll just ask  
23 my questions briefly.

24 Mr. Maxston Cross-examines the Witness (Qualification)

25 Q MR. MAXSTON: Good morning, Mr. Schaefer.

26 A Good morning.

1 Q My two questions for you are this: I'm looking at the  
2 bottom of page 2 of your cv, and it talks about, you  
3 say, "Associations: Member of Alberta College of  
4 Paramedics"; are you still a regulated member of the  
5 Alberta College of Paramedics?

6 A No, I am not, but that is a -- that is a course that I  
7 had -- that is a -- sorry, that is a membership that I  
8 had a couple years ago. I had completed the Alberta  
9 College of Paramedic program as far as the emergency  
10 medical responder is concerned, and I did have that  
11 membership, yes.

12 Q Forgive me for not quite understanding this then, were  
13 you a regulated member of the Alberta College of  
14 Paramedics, so you could practice as a paramedic, or  
15 had --

16 A Yes --

17 Q -- just taken the --

18 A -- yes, I was --

19 Q -- courses --

20 A -- yes, I was. I was an actual member of the Alberta  
21 College of Paramedics, registered through the course  
22 that I had taken, so I had specific registration by  
23 completing exams with the Alberta College of Paramedics  
24 to practice as a medic within Alberta.

25 Q Sure, and I --

26 A So I was definitely registered.

1 Q And how long were you a regulated member of the Alberta  
2 College of Paramedics?

3 A One year.

4 Q And do you recall your designation, or were you an  
5 advanced care paramedic, primary care paramedic, EMT,  
6 EM -- you know, do you recall the designation that you  
7 were in?

8 A Of course. EMR, emergency medical responder.

9 Q And you can correct me if I'm wrong, but I think "EMR"  
10 is -- I think there's three designations; the first is  
11 advanced care paramedic, then there's primary care  
12 paramedic, and then there's the designation you were  
13 in, which is EMR; is that correct, to your  
14 understanding?

15 A That's absolutely correct, yes.

16 Q And, I'm sorry, you said you were an EMR for one year  
17 with the College?

18 A Yes.

19 Q Okay.

20 MR. MAXSTON: Those are all my questions,  
21 Mr. Chair, for the witness. I wonder if I might  
22 provide some responses to the qualification that  
23 Mr. Kitchen has tendered.

24 THE CHAIR: Okay.

25 Discussion

26 MR. MAXSTON: My friend will rightly point

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

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

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

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

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

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

20 The effectiveness of masks is a different  
21 subject from the harms of masks.

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

1 those lines.

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

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

12 THE CHAIR: Yeah.

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

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

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

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

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

17 MR. KITCHEN: Thank you.

18 (ADJOURNMENT)

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

24 MR. MAXSTON: I think, Mr. Chair --

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



1 orders?

2 MR. MAXSTON: I think it's because primarily  
3 of what is in the Pandemic Directive that the College  
4 has, which refers to the requirement for chiropractors  
5 to wear surgical or procedure masks as being the  
6 minimum acceptable standard.

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

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

22 (ADJOURNMENT)

23 Ruling (Qualification)

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

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

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

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

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

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

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

6 THE CHAIR: Duly noted, Mr. Kitchen.

7 MR. KITCHEN: Thank you.

8 CHRIS SCHAEFER, Previously sworn, Examined by  
9 Mr. Kitchen

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

12 A Yes, I can.

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

16 A That is correct, yes.

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

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

1 to educational institutions and private industry.

2 Q Has that work changed any since the onset of COVID?

3 A Absolutely, it's changed a lot. It's changed a lot  
4 primarily because there's so much -- there's no real --  
5 there's no real requirement for many of the masks that  
6 are mandated for COVID, that they would be fit tested,  
7 there's no requirement to that.

8 So before the COVID thing, everything -- any type  
9 of mask whatsoever had to be fit tested on the wearer.  
10 They had to have approval fit test for safety. But  
11 since COVID, since this virus, there has been no  
12 requirement for the majority types of these devices to  
13 require a fit test to the user, which is really, really  
14 odd.

15 Q And why is that odd?

16 A It's odd, because in order to determine whether or not  
17 the wearer is suitable for wearing a mask, there are  
18 some screening processes that have be completed first.

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

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

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

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

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

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

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

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

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

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

1 personally?

2 A I've never met him. I don't know what he looks like,  
3 and I really don't know much about him at all.

4 Q Do you have any personal interest or personal stake in  
5 the outcome of this case?

6 A Absolutely not. I've just been hired to give my expert  
7 opinion, and that's what I'm here for.

8 Q You don't have any financial interest or stake in the  
9 outcome of this case then?

10 A No, because I'm getting paid by the hour, and so it  
11 doesn't matter to me what the outcome is.

12 Q And just to confirm, do you understand your duty to  
13 provide this Tribunal with your expert knowledge and  
14 opinions in an objective and neutral manner?

15 A Absolutely.

16 Q Thank you. Now, just to give a bit of a road map,  
17 we've already got into the meat of it a little bit, but  
18 I'm going to be asking you about, you know, what masks  
19 really actually are, and then I'm going to ask you  
20 about carbon dioxide, about oxygen, a little bit about  
21 testing, and then, lastly, I'll ask you, from an  
22 Occupational Health and Safety perspective, a little  
23 bit about the harms or hazards involved.

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

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

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

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

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

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

26 And a procedural mask is something that is -- is



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

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

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

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

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

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

22     A    Yes, I am aware.

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

26     A    Yes, I am aware.

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

3 Masks are required to have engineered  
4 breathing openings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 A M-hm.

24 Q Why exactly are they hazardous?

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

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

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

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

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



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

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

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

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

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

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

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

11 But I'll tell you based upon the testing that I've  
12 done and other research publications that I have as  
13 references, medical reports and research that I  
14 could -- I'm more than happy to submit a long list of  
15 certified medical scientific reports to show that  
16 levels of carbon dioxide in one of these devices exceed  
17 5, 10,000 parts per million within a minute, anybody  
18 wearing any one of those three.

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

1 tissues.

2 And so the normal oxygen level in air is 19.5 --  
3 20.9 percent, 20.9 percent. Where it becomes dangerous  
4 to health becomes immediately dangerous, life and  
5 health, according to our regulations is 19.5 percent or  
6 lower.

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

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

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

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

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

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

15       A    Yes, it is.

16       Q    Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Q Okay.

8 MR. LAWRENCE: I'm sorry, to interrupt,  
9 Mr. Chair, I don't see Dr. Aldcorn on the screen. I'm  
10 just wondering, did we lose somebody? Excuse me,  
11 sorry, Mr. Kitchen.

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

14 MR. LAWRENCE: She.

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

17 MR. LAWRENCE: Oh, there she is, okay.

18 DR. ALDCORN: Sorry.

19 MR. LAWRENCE: So I'm not sure if we want to  
20 just read the last couple of minutes back for  
21 Dr. Aldcorn's benefit.

22 MR. MAXSTON: Maybe we can ask Dr. Aldcorn  
23 when she went offline --

24 DR. ALDCORN: Yeah.

25 MR. MAXSTON -- intentionally or not or  
26 when she came back.

1 DR. ALDCORN: Completely unintentionally.

2 The last we were discussing was the fact that the  
3 numbers of the CO2 and O2 levels would depend on the  
4 nature of the tight-fittingness of the mask and the  
5 exercise level of the individual. And I apologize.

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

8 DR. ALDCORN: I'm so sorry.

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

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

17 THE COURT REPORTER: (by reading)

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

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



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

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

11   A   If they're properly --

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

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

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

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

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

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

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

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

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

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

26                And so there's various levels of it, but

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

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

8 A M-hm.

9 Q Can you explain why or how that happens?

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

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

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

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

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

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

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

15 A Yes, it is.

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

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

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

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

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

4 Q OSHA.

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

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

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

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

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

23 A (as read)

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

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

1 first page of the letter --

2 A Okay, I'm looking at -- I'm on page 085.

3 Q Maybe you've got a different page 085. Well, can I get  
4 you to go to just the first page of this letter, where  
5 it says "April 2nd, 2007, Mr. William Costello"; do you  
6 see that?

7 A Oh, okay, okay, yes, I see that now, yeah.

8 Q Okay. And if we go down, the first paragraph starts  
9 with "Thank you", second paragraph --

10 A Yeah.

11 Q -- starts "Within your letter", if you could just read  
12 the first sentence of the third paragraph there.

13 A Okay, so the third sentence of the second paragraph --  
14 third paragraph, okay, okay, I got you, okay. So it  
15 is -- is it the one "to ensure that employees", is that  
16 the second one?

17 Q No, it's starts with the word "Paragraph".

18 A Oh, "Paragraph", okay: (as read)

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

24 Did you want me to continue?

25 Q No. That sounds a little dramatic to me. Can you help  
26 me understand, you know, from the perspective of an

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

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

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

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

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

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

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

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

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

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



1 A Yes, I do.

2 Q Can I just get you to read the first three sentences of  
3 text inside that box?

4 A (as read)

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

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

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

24 And do you want me to read what's in the brackets as  
25 well there as reference?

26 Q No, that's good, thank you. Now, this concentration of

1 16 to 19.5, that range, is that what you've discovered  
2 when you've tested the levels of oxygen between these  
3 breathing barriers and the faces of those wearing them?

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

12 THE CHAIR: Mr. Kitchen --

13 MR. KITCHEN: Yes.

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

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

23 THE CHAIR: Certainly, certainly.

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

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

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

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

1 percent.

2 Q Thank you.

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

5 THE CHAIR: Okay, well, let's reconvene at  
6 11:00 then, and we'll continue on with Mr. Kitchen and  
7 Mr. Schaefer. Thank you.

8 MR. KITCHEN: Thank you.

9 (ADJOURNMENT)

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

13 MR. KITCHEN: All right, thank you.

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

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

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

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

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

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

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

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

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

4 Q Is asthma one of those conditions?

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

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

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

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

19 Q Well --

20 MR. MAXSTON: Mr. Kitchen, I'm not going to  
21 contest your client's view on different conditions.  
22 I'm not sure if we have to go down this road, to be  
23 honest with you. I don't --

24 MR. KITCHEN: Yeah --

25 MR. MAXSTON -- want to have to get him to  
26 read from something, if that's what you need him to do.

1 MR. KITCHEN: No, I don't.

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

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

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

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

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

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

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

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

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

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



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

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

9    A    I have thought --

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

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

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

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

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

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

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

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

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

26 Q Why do you think that is?

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

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

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

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

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

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

17 A Yes, I'm aware.

18 Q On page 8 of his report, Dr. Hu, I think his first name  
19 is Jia, but Dr. Hu says -- and just to clarify, he is  
20 the expert tendered by the Alberta College of  
21 Chiropractors -- on page 8 of his report, he says: (as  
22 read)

23 There are no known harms associated with  
24 masking.

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

1 A Completely. I completely disagree with Dr. Hu's  
2 statement, because there are numerous scientific  
3 research papers and studies. I've looked through  
4 Dr. Hu's references, and I didn't see one registered  
5 scientific study in any one of his references, but I  
6 have references from registered scientific journals,  
7 medical journals. I have references from the --  
8 published by the National Library of Medicine to show  
9 quite the opposite of what Dr. Hu's references claim.

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

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

20 MR. MAXSTON: I am going to have to object  
21 to that, Mr. Chair, that runs afoul of commenting on  
22 the harm or lack thereof in terms of masking.

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

25 THE CHAIR: Can you restate it?

26 MR. KITCHEN: And this is part of the reason

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

7           MR. MAXSTON:                   I'll just again state,  
8           Mr. Chair, that I think this witness is being tendered  
9           for a very specific purpose, and that was harms, in his  
10          view, that are caused by masking, and I don't think  
11          this witness is anywhere near the -- is a very  
12          different type of witness from the other experts that  
13          have testified.

14          MR. KITCHEN:                   I don't see what entitles  
15          Dr. Hu to talk about the politicisation of the issue  
16          that doesn't also entitle Mr. Schaefer to talk about  
17          it.

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

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

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

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

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

16 MR. MAXSTON: Mr. Chair, if you're  
17 comfortable, I'll just continue on. I don't expect to  
18 be too long.

19 THE CHAIR: Yes, that's fine. Just before  
20 you start, Mr. Maxston, Mr. Schaefer, you're okay to  
21 continue with this cross-examination, or did you want a  
22 break?

23 A I'm fine. Thank you very much, Mr. Lees.

24 THE CHAIR: Okay.

25 Mr. Maxston Cross-examines the Witness

26 Q MR. MAXSTON: Mr. Schaefer, I've got some

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

6 A Sure.

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

12 A Yes, I do.

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

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

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

23 A That is correct.

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



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

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

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

12 A Yeah.

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

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

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

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

1 correct.

2 Q And you've had a chance to look at the College's  
3 Pandemic Directive, I assume?

4 A I have not memorized it, but I have had exposure to it;  
5 I have looked at it, yes.

6 Q Yeah, and it's not a memory test for you. I'm just --  
7 there's a phrase, and my friend and I talked about this  
8 when you were being qualified, there's a phrase in it  
9 that says "surgical or procedure masks are the minimum  
10 acceptable standard", and it goes on to say that  
11 chiropractors and staff must be masked. You'd agree  
12 with me that that's mandatory for chiropractors?

13 A You know, I can't agree with -- look, just because --  
14 just because it's -- just because one of these or more  
15 of these breathing barriers is mandatory for  
16 chiropractors and other professions, doesn't mean  
17 they're safe.

18 Q Oh, I'm not asking you that. I'm asking you it's  
19 mandatory for chiropractors, question mark, full stop.

20 A Aware a procedural-based is what you're saying?

21 Q Yeah, I'm just saying that the Pandemic Directive, and  
22 I pointed you to the masking situation in particular,  
23 that's mandatory for chiropractors; aside from your  
24 views on the safety or harm, that's mandatory?

25 A That appears to be correct.

26 Q So, Mr. Schaefer, I'm going to turn you to now a couple

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

6 A That is correct.

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

10 A That's correct.

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

15 MR. KITCHEN: Hold on, hold on --

16 A Well -- well --

17 MR. KITCHEN: -- that question --

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

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

24 MR. MAXSTON: I'm trying to just make a  
25 comment that this witness isn't providing that  
26 evidence.

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

5 MR. MAXSTON: Well, I just wanted to be  
6 clear that this witness is not providing evidence about  
7 any potential benefits to persons in the presence of  
8 the wearer of a mask.

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

10 MR. MAXSTON I'll move on, I'll move one,  
11 yeah. Mr. Kitchen, if you have a problem with this,  
12 you'll let me know.

13 Q MR. MAXSTON: You're not here to provide any  
14 evidence about the transmission of COVID for preventive  
15 measures for COVID?

16 A That's correct.

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

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

22 Q Yeah, that would be correct.

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

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

1 attached to your expert report, is it?

2 A That testing that I've done is not -- let me just take  
3 a look here.

4 MR. KITCHEN: Perhaps you could be a little  
5 more specific, Mr. Maxston --

6 MR. MAXSTON Yeah (INDISCERNIBLE) --

7 MR. KITCHEN: -- there's no exhibit that has  
8 a list of the readings. Is that what you're getting --

9 MR. MAXSTON: Yeah, that's kind of what I'm  
10 getting at.

11 Q MR. MAXSTON: And, Mr. Schaefer, this isn't  
12 a gotcha question, but I'm just looking at the second  
13 page of your report, and you talk about using the  
14 MultiRAE Lite, and you observed that upon commencement,  
15 and you have some comments then. I'm just saying  
16 there's no data or test results from those tests you  
17 performed which are part of your expert report,  
18 correct?

19 A I don't have it in the report, specific readings, but I  
20 have -- I've done lots of documentation on it and  
21 reports on it, so --

22 Q Yeah, I'm just -- I wasn't trying to take you down the  
23 road of what you did; I just wanted to be clear they're  
24 not attached.

25 A Yeah, the specific testing, I've done a lot of testing,  
26 so for me to have all of the different test subjects

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

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

10 A Absolutely.

11 Q -- College of Paramedics?

12 A Yes, I did.

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

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

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

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

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

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

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

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

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

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

26 So a closed cover is not something that I would

1 wear, no, but I would wear an actual mask.

2 Q So I just want to be clear, again, when we look at the  
3 Pandemic Directive for the College of Chiropractors, it  
4 says that the requirement is a surgical or a procedure  
5 mask; you would comply with that kind of directive from  
6 your regulatory body if that was applicable?

7 A I know that those aren't masks. Those are breathing  
8 barriers. I'm not going to jeopardize my health and  
9 safety through low oxygen and accumulations of carbon  
10 dioxide for any occupation, because that's my health,  
11 and my health is important to me. It's more important  
12 than anything else.

13 Q So you would choose to not comply with it?

14 A I would wear -- I would wear something that far exceeds  
15 the recommended protection, which is an actual  
16 certified respirator that actually is designed for easy  
17 and safe breathing, I would wear that, and it would far  
18 exceed any potential respiratory benefit that a  
19 breathing barrier could provide.

20 Q Those are all my questions --

21 A (INDISCERNIBLE)

22 Q Sorry, did you want to finish? I cut you off.

23 A Oh, sorry, I just wanted to say that -- so what I would  
24 wear would be far and above what has been currently  
25 mandated.

26 MR. MAXSTON: Those are all my questions,



1 Mr. Schaefer, thank you.

2 A Thank you very much, Mr. Maxston.

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

5 MR. KITCHEN: Just a couple.

6 Mr. Kitchen Re-examines the Witness

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

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

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

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

21 MR. KITCHEN: Thank you.

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

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

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

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

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

20 A Thank you very much, Mr. Lees.

21 THE CHAIR: It's 20 to 12, and we could  
22 start at 12:45. Mr. Maxston?

23 MR. MAXSTON: Yes, I wondered, do you have  
24 any questions? You didn't have any questions, I'm  
25 assuming, of Mr. Schaefer --

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

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

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

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

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

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

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

1 MR. KITCHEN: Okay, thank you.

2 \_\_\_\_\_

3 PROCEEDINGS ADJOURNED UNTIL 12:45 PM

4 \_\_\_\_\_

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26