

IN THE MATTER OF an appeal filed
pursuant to the *Rules for Appeals* under
the *Pre-1986/Post-1990 Hepatitis C
Settlement Agreement* and its *Protocols*

CLAIM FILE: 07-01933

REASONS FOR DECISION

INTRODUCTION

[1] The Claimant has appealed decisions of the Administrator dated December 2, 2008 and April 29, 2009 in which his claim for compensation under the *Pre-1986/Post-1990 Hepatitis C Settlement Agreement* (“*Settlement Agreement*”) was denied on the basis that he had not received Blood during the Class Period.

FACTS

[2] On April 21, 2008, the Claimant filed a claim for compensation under the *Settlement Agreement*. In the claim, he stated that he was a Primarily-Infected Person who was infected with the Hepatitis C virus during the Class Period through a blood transfusion. The Treating Physician Form indicated that the Claimant was at Disease Level 5; the Claimant included with the Form a letter dated April 14, 2008 from a physician confirming his infection with Hepatitis C at Disease Level 5, as well as a related laboratory report. In the Blood Transfusion History Form, the Claimant noted that he had received a blood transfusion in September 1985 for “blood loss following a traumatic arm injury”. The Claimant indicated that he had received compensation under a provincial program in the amount of \$25,000.00 and under the *Canadian Red Cross Settlement* in the amount of \$9,850.00. He had no other risk factors for Hepatitis C.

[3] On June 23, 2008, the Administrator sent a deficiency letter to the Claimant indicating that additional information had to be filed in order to complete the application for compensation.

[4] On July 18, 2008, the Claimant re-filed the Treating Physician Form with two amendments made by the physician: in response to question 4 under Disease Level 5, the physician checked “Yes” to indicate that, in his opinion, the HCV infection had materially contributed to the Disease Level 5 medical condition, and he answered the questions in the Section G Disability Information part of the Form. The Claimant also filed the following documents: two laboratory records, dated February 15 and June 30, 2008, confirming that he was HCV positive, a medical report dated November 11, 2007 outlining the results of an abdominal scan, and a copy of the physician’s letter dated April 14, 2008 that was previously filed with the original claim Forms, as described in paragraph 2.

[5] On September 9, 2008, the Administrator sent a further deficiency letter.

[6] On October 10, 2008, the Claimant filed Forms concerning past loss of income and past loss of services in the home. At the same time, he filed documents from the provincial workers board indicating that he was entitled to a full benefit as his physical illness and psychiatric condition prevented him from returning to the workforce.

[7] By letter dated October 16, 2008, the Canadian Blood Services forwarded the final Traceback report to the Administrator, together with three documents: a Traceback Notice with a hospital response dated November 21, 2001, a Traceback Notice with a hospital response dated April 9, 2003, and a Transfusion Summary dated October 16, 2008.

[8] Each Traceback Notice was a form letter from the Canadian Blood Services addressed to the “Blood Bank Charge Technologist/Hospital Blood Bank Director” of the hospital indicating that it was conducting a traceback investigation to determine if the Claimant’s infection may be transfusion related. Each Traceback Notice stated as follows:

Please provide me with your hospital’s transfusion records indicating CBS blood group, unit number and date of transfusion on this patient, so that a Canadian Blood Services traceback investigation may proceed. [Emphasis Added]

The Hospital Response part of the form contained a choice of three possible answers: “transfused (records attached)”; “not transfused”; or “no records found for this patient”.

[9] In the Traceback Notice with the hospital response dated November 21, 2001, the form stated “Transfusion Time Frame: 1983-1991”. In the Hospital Response part of the form, the hospital clerk checked the box “not transfused” and added the handwritten words “infected dog bite”.

[10] In the Traceback Notice with the hospital response dated April 9, 2003, the form stated “Transfusion Time Frame: 1985-July, 01”. In the Hospital Response part of the form, the hospital clerk wrote “As per records within [two hospitals]” and checked the box “not transfused”.

[11] The Transfusion Summary containing the results of the Traceback stated as follows:

Timeframe investigated 1983-1991. Hospital states claimant was not transfused.

DECISION OF THE ADMINISTRATOR DATED DECEMBER 2, 2008

[12] In a decision dated December 2, 2008, the Administrator denied the claim for compensation. In its Reasons for Decision, the Administrator stated as follows:

The Settlement Agreement requires the Administrator to determine a person's eligibility for class membership.

All the material that you provided to support your claim was carefully reviewed by the Administrator. You have not provided sufficient evidence to support that you or the HCV Infected Class Member received **Blood** during the Class Period, as defined in the Settlement Agreement. [Administrator's Emphasis]

After reproducing the full definition of "Blood" in the *Settlement Agreement*, the decision continued as follows:

You indicated you were transfused at [the hospital] in September 1985. There were no medical records submitted to confirm this information. The Administrator contacted Canadian Blood Services (CBS) to request their assistance in obtaining transfusion information directly from the hospital. The final response to this request was received; the hospital searched their records from 1983 to 1991 and confirmed that you were not transfused.

As you may already know, every claim for compensation is reviewed and approved based on our review of documentation confirming a series of different but related proven facts. As soon as a claim submission fails to meet one of several approved criteria as set out in the settlement Agreement, the claim must be denied. It is important to note that in some cases, the subsequent claim evaluation steps were not completed after determining the need to deny the claim. Should you opt to appeal our decision to deny your claim and should you succeed on appeal, any and all pending evaluation steps will have to be completed. [Emphasis Added]

REQUEST FOR REVIEW AND SUPPLEMENTARY EVIDENCE DELIVERED ON DECEMBER 12, 2008

[13] On December 12, 2008, the Claimant delivered a Request for Review, together with various letters and documents. His wife explained his reasons for appealing, in part, as follows:

We are strongly appealing this decision because it is of no fault of ours that the hospital lost his records.

[14] In support of his Request for Review, the Claimant delivered three letters from family members, a letter from his psychiatrist and five hospital records, as well as documents confirming that he was awarded compensation under the provincial plan and the *Red Cross Settlement*. He also delivered, once again, the physician's letter dated April 14, 2008, described in paragraph 2.

[15] With respect to the three family letters, the first was a letter dated December 9, 2008 from the Claimant's wife who stated, among other things, that they had been together since 1994 and she was therefore not with him when he was hospitalized. She described his severe health problems and noted the compensation that he had already received under both the provincial plan and the *Red Cross Settlement*. The second letter, from one of his sisters, was dated December 6, 2000. In her letter, she stated, among other things, that "[...] in 1985 [the Claimant] was hospitalized [...] and had a blood transfusion and now has Hepatitis C from this transfusion". She also described the terrible effect of the Claimant's illness on the family. The third letter was dated December 7, 2000 and was signed by another sister of the Claimant and his mother. In their letter, they stated as follows:

This is a letter confirming that in 1985 myself [one of the Claimant's sisters] and [the Claimant's mother] visited [him at the hospital].

He was badly injured and had to receive blood transfusions at that time. The Doctor was present and said he was lucky to pull through.

[16] The letter from the Claimant's psychiatrist was dated October 28, 2002 and stated as follows:

This is to certify that the above named is under my care for severe major depression since 1995. His depression is secondary to Hepatitis C infection that he suffered as a result of blood transfusion that he received in hospitals in Ontario. He has always been an athlete and he has never used or abused any prescription or street drugs. He has never injected himself with any needles.

[17] There were five hospital records delivered with the Request for Review.

[18] The first hospital record was an Emergency Record dated September 28, 1985. It indicated that the Claimant's "presenting complaint" was a dog bite to his right arm. In the assessment portion of the record, the nurse wrote "stitched here last Thursday – now swollen"; the physician wrote, in part, as follows:

"was here 3 days ago for dog bite wound [right] arm – was sutured – home on Cloxacillon [...] – [referral] Plastic Clinic 1/10 – needs admission for iv [intravenous] antibiotics". [Emphasis Added]

The physician also noted that the Claimant had taken Tylenol # 3 for pain, with no relief, and that the arm was very hot and swollen. In the part entitled "Investigation – Treatment", under the heading "Orders/Results", he made the notation "old chart please". He also ordered blood cultures, intravenous, Demerol and cold saline to soak the arm. In the Discharge Diagnosis part of the form, another physician wrote "Infected dog bite [right] arm". In the part entitled Disposition, it was noted that the Claimant was admitted to a hospital room at 19:35. In the space on the right hand side of the form for a consultation, the words "Plastics" was written.

[19] The second hospital record was the Doctor's Order Sheet that contained orders for September 28. The entries made several references to the intravenous antibiotics, including the need to elevate the arm to the intravenous pole, as well as to the saline treatment and the bandaging of the infected area. The entries also indicated that the Claimant was given Demerol and Graval.

[20] The third hospital record was the Doctor's Order Sheet for September 29 and 30 and October 1 to 3, 1985. The entries for September 29 and 30 and October 1, 1985 dealt respectively with the saline dressing, the dressing of the wound, and the packing and

dressings of the wound. The entry for October 2, 1985 indicated that the Claimant was given Demerol, as well as plain Tylenol for a headache. The entry on October 3, 1985 stated that the Claimant was discharged and was to return to the physician's clinic on October 9. He was to take Cloxacillin at home and a request was made to send ribbon gauze home with him for dressings.

[21] The fourth hospital record was a report from the Department of Haematology concerning the results of the Claimant's blood tests on September 28 and 30.

[22] The fifth hospital record was a Final Note prepared by a resident physician in Plastic Surgery that contained information relating to the Claimant's initial treatment in the Emergency Department for the suturing of the wound and his subsequent treatment in the hospital from September 28 to his discharge on October 3, 1985. The Final Note stated as follows:

FINAL NOTE

DIAGNOSIS: Infected dog bite on distal right forearm.

HISTORY OF PRESENT AND PAST ILLNESSES:

[The Claimant], age 32, was bitten by a dog on the distal right forearm approximately 3 days prior to admission today. Immediately following the injury he was seen in the Emergency Department where the wound was apparently cleansed and sutured and he was started on an antibiotic. The following day he noted an acute inflammatory reaction around the puncture wound. He states that he did have fevers and chills.

There is no significant past medical or surgical surgery [sic] history. He is on no medications other than the Cloxacillin which he was started on in the Emergency Department. He has no known allergies.

PHYSICAL EXAMINATION:

The general physical examination was unremarkable. Examination of the distal right forearm revealed an acute and inflammatory reaction with swelling, erythema and marked tenderness around the suture puncture wound. There is no lymphangitis or lymphadenitis.

COURSE AND MANAGEMENT IN HOSPITAL:

He was admitted to hospital with arm elevation. While in hospital his temperature only rose to 38 degrees C on 1 occasion. Serial cultures were done which grew heavy *pasteurella multocida* and heavy *bacteroides* which were sensitive to the Ancef which he was started on while in hospital. There were no complications and the infection gradually subsided on this regime.

He was discharged home 03/10/85 with a return appointment to be seen in the Clinic Tuesday, October 09, 1985. By the time of his discharge the infection had settled. [Emphasis Added]

[23] None of the hospital records made any reference to a blood transfusion.

SUPPLEMENTARY EVIDENCE DELIVERED BETWEEN JANUARY 30 AND MARCH 30, 2009

[24] On January 30, 2009, the Claimant's wife delivered a letter to the Administrator and included the following documents: a Blood Transfusion Form that made reference to previous occasions when the Claimant was hospitalized, letters from his psychiatrist and physician, and a letter from a friend who had visited him in the hospital in 1985. With respect to the further Blood Transfusion History Form, she nevertheless emphasized the Claimant's position that the transfusion had occurred in September 1985. She also stated that, despite trying "[...] over and over again to get records from his original emergency treatment [...]", only the records from his subsequent admission were given to them.

[25] In the Blood Transfusion History Form delivered on January 30, 2009, the Claimant added three other occasions when he was hospitalized:

Fall of 1978 to 1979 – rectal operation
Summer of 1977 to 1978 – for 300 stitches to close an arm laceration
Summer of 1975 – for a chest operation
[Emphasis Added]

[26] A letter dated January 27, 2009 from the Claimant's psychiatrist stated as follows:

I am writing to you regarding [the Claimant]. He has been under my care since November 6, 1997 from beginning he used to have a lot of anger towards medical system. He used to talk to me in his monthly sessions how he got bit by a

dog and he had severe bleeding. He required 300 stitches and got blood transfusion.

Later on, he learnt [sic] he developed hepatitis C which is now chronic and level 5. All these discussions took place years before compensation for victims was announced. I have been treating [the Claimant] for 12 years and I am of the opinion that he did receive the blood transfusion causing hepatitis C.

Further he is a man of morals and honest he is suffering and he has no reason to not state the facts. I would recommend you to expedite his compensation so we can give him some peace of mind and validity. [Emphasis Added]

[27] A letter dated January 21, 2009 from a family physician stated as follows:

[The Claimant] had a severe laceration of his [right] arm (1985) and most likely received a blood transfusion due to the amount of blood loss from the injury.

[28] In an unsworn letter dated “Jan/09”, a friend wrote that he had visited the Claimant in the hospital in 1985 and remembered him receiving blood. The friend stated as follows in his letter:

I am writing this letter on behalf of my friend [the Claimant]. I have known [the Claimant] since 1980. I would like you to know that I remember visiting [the Claimant at the hospital] in September 85/ at this time he was admitted because of a severe arm wound. I remember him receiving blood and many stitches, to close the wound. [The Claimant] had to return a few days later because it became badly infected. The Doctor told us that he was lucky he came back because he could have lost his arm.

It is very difficult to see my friend [the Claimant] suffering this chronic liver decease. I only hope that this letter will help you in your decision to compensate him while he still has some time left.

[29] On February 6, 2009, the friend swore his letter before a Commissioner of Oaths. Three days later, the sworn document was delivered to the Administrator.

[30] By letter dated February 10, 2009, the Fund Counsel forwarded the supplementary evidence to the Administrator and requested a reconsideration of the decision to deny the claim for compensation.

[31] In a letter dated March 3, 2009, the Administrator advised the Fund Counsel that, by virtue of the provisions of the *Proof of Receipt of Blood Protocol*, it would require either the hospital records for the initial emergency room visit in September of 1985 or proof that the records were no longer available before considering the evidence in the sworn document from the Claimant's friend.

[32] By letter dated March 25, 2009, the hospital confirmed that it could not locate any record of the Claimant's September 1985 Emergency Department visit that took place prior to his return visit and hospitalization on September 28, 1985.

DECISION OF ADMINISTRATOR ON REVIEW DATED APRIL 29, 2009

[33] In a letter dated April 29, 2009 to the Claimant, the Administrator stated as follows:

The administrator carefully reviewed your claim in light of the additional material that you provided. Regrettably, the evidence is not sufficient to meet the eligibility criteria in the Settlement Agreement. Therefore, your claim for compensation remains rejected.

We have attached a summary of the Administrator's review of your supplemental evidence and/or submissions.

The decision on review dated April 29, 2009 stated as follows:

Supplementary Submissions

Introduction

1. [The] claim was rejected based on No Proof of Blood in the Class Period. [The Claimant] has submitted a Request for Review asking for review of the rejection of her [sic] claim. As per the Rules of Appeal, Fund Counsel has forwarded the Claimant's supplementary evidence on March 30, 2009 to the Administrator for our review and response.

Facts

2. Page 19 – On Form 5, claimant wrote that he was transfused in September 1985 at [the hospital] because of a Traumatic Arm Injury. There were no medical records submitted to support this statement.

3. Page 104-105 – Canadian Blood Services (CBS) Final Traceback report received October 24, 2008. CBS confirmed the time frame of investigation was 1983-1991 and indicated the Hospital stated the patient was not transfused.
4. Page 106 – The Blood Bank Staff at the hospital completed a form for CBS dated Nov. 21, 2001 and advised that [the Claimant] was **Not transfused** (emphasis ours).

Summary of Supplementary Evidence

5. Page 120-124 – When [the Claimant] submitted his Request for Review he [sic] medical records from his Hospital admission in September 1985 for treatment of an infected Dog bite [sic]. Summary if [sic] these pages individually is as follows:
 - Page 120 – Emergency Room Record – Doctor wrote on the form that he was seen 3 days ago for dog bite wound [sic] to Right arm and it was sutured. Doctor indicated he was then sent home on Cloxacillin PO (orally). Mr. Rousselle was admitted for treatment of the infected Dog bite with IV antibiotics.
 - Page 121 – Doctor’s order sheet where the Doctor wrote routine orders for admission. This included lab tests, IV antibiotics and pain medication.
 - Page 122 – Laboratory results sheet where lab results are transcribed. All results within the normal limits.
 - Page 123 – Final Note (Discharge Summary). The first paragraph of the note reads as follows: “[*The Claimant*], age 33, was bitten by a dog on the distal right forearm approximately 3 days prior to admission today. Immediately following the injury he was seen in the Emergency Department where the wound was apparently cleansed and sutured and he was started on an antibiotic. The following day he noted an acute inflammatory reaction around the puncture wound.”
6. In February 2009 The [sic] Administrator received further evidence via Fund Counsel. The evidence consisted of an Affidavit prepared by [...], a friend of [the Claimant]. [The friend] affirmed “*I remember visiting [the Claimant] at [the] Hospital in September 85/ at the time he was admitted because of a severe arm wound. I remember him receiving blood and many stitches, to close the wound.*” [He] then affirmed “[*the Claimant*] had to return a few days later because it became badly infected. The doctor told us that he was lucky he came back because he could have lost his arm.”
7. On March 31, 2009, the Administrator received a copy of a letter addressed to [the Claimant] from [the] Hospital, dated March 25, 2009. The Hospital advised they were unable to locate any medical records of the Emergency visit that took place prior to the date September 28, 1985.

Administrator's Decision

8. Where there are no hospital records or where those available do not confirm receipt of Blood, claimants must submit corroborating evidence independent of the personal recollection of the claimant or any person who is a Family Member of the claimant as per the Court Approved Protocol "Proof of Receipt of Blood Protocol".
9. The claimant has indicated he believes he was transfused in September 1985 when initially treated for a dog bite to his arm.
10. Canadian Blood Services has provided documents completed by the Hospital Blood Bank staff that indicated they searched their records from 1983 to 1991 and there was no record of [the Claimant] receiving a transfusion.
11. The *Final Note* on page 123 of the claim file comments on the stitches and the antibiotic treatment however there is no comment on the need for a transfusion.
12. The affidavit prepared by the claimant's friend has been carefully reviewed and compared with the records that have been submitted.
 - [The friend] indicated he visited [the Claimant] when he was in the Emergency room for the first treatment of the Dog bite to his arm. He indicated he remembered him receiving blood and many stitches.
 - [The friend] also commented on what the Doctor said regarding [the Claimant] returning because the wound became infected. **There was no indication that [the friend] was present during the second Emergency room visit.

Conclusion

12. The Administrator has an obligation to assess each claim and determine whether the required proof for compensation exists. In this case the Hospital has clearly stated they searched records from 1983-1991 and there is no evidence that [the Claimant] received Blood. The evidence submitted in the affidavit from [the friend] is to the best of his recollection however it contains information that is inconsistent with the medical records. Additionally, [the friend] stated he visited [the Claimant] when being initially treated for the Dog bite however the Affidavit contains comments from the second Emergency room visit. The Administrator has no discretion to allow compensation where the required proof does not exist. After careful consideration of the supplementary evidence submitted, the Administrator concludes the evidence does not support that on a Balance of Probabilities the claimant received a Blood transfusion in the class period. The decision to reject this claim for compensation remains unchanged.

[34] On May 4, 2009, the Claimant elected to continue with his appeal.

SUPPLEMENTARY EVIDENCE DELIVERED IN MAY AND JUNE 2009

[35] On May 6, 2009, the Claimant's friend swore a further letter before a Commissioner of Oaths concerning his recollections from 1985. The further sworn letter was delivered to the Administrator on May 11, 2009 and stated as follows:

This letter is in regards to the appeal denial letter that my friend [the Claimant] received last week.

It seems that my first letter back in Jan/09 didn't clarify myself enough on his behalf.

I would just like you to know that I was with [the Claimant] at the hospital] when he received a blood transfusion and many, many stitches to close the wound on his arm he got from a severe dog bite. This was back in Sept/85. A few days later we had to take him back to the hospital because arm [sic] became infected. I was there with him when the doctor said it was lucky he came back because he may have lost his arm. At this time they admitted [him] for a few days. His arm still gives him pain to this day and he has sever [sic] scarring from the many stitches he received.

As [the Claimant's] health is now deteriorating so much I can only hope this letter will help to let you reconsider you decision on compensating [him] for what was time he has left.

[36] In a very heartfelt and touching letter dated May 22, 2009, the Claimant's wife summarized the efforts made to support the claim for compensation, including the attempts to obtain records from the first Emergency Department visit in 1985 and the many documents and letters delivered. She also included a letter dated May 12, 2009 from a chiropractor concerning the Claimant's pain, disability and treatment.

[37] On June 10, 2009, the Claimant delivered an unsworn letter dated May 28, 2009 from a friend who had known the Claimant since 1984. In the letter, the second friend stated, among other things, as follows:

I am aware of the events that occurred in September 1985 and the extent of the injuries [the Claimant] suffered from those events. [The Claimant's] injuries surely required a blood transfusion in the emergency department of [the hospital] when he was admitted.

He also expressed the opinion that the Claimant had contracted his disease as a “[...] direct result of the treatment he received at [the hospital] in 1985, specifically the blood transfusion.”

ISSUE

[38] The issue to be determined on appeal is whether the decisions of the Administrator denying the claim were reasonable on the basis of the evidence. It is also necessary to consider the effect, if any, of the supplementary evidence delivered in May and June 2009, after the Administrator had issued its decision on review.

ANALYSIS

i) Section 2.01 of the Settlement Agreement and the Proof of Receipt of Blood Protocol

[39] In the Reasons for Decision on the appeal in Claim File 07-00464, I analysed the provisions in section 2.01 of the *Settlement Agreement* and the applicable sections of the *Proof of Receipt of Blood Protocol* concerning the requirements that must be met by a person claiming to be a Primarily-Infected Class Member in order to be eligible for compensation and stated, in part, as follows:

ii) Eligibility Requirements under Section 2.01

[32] Under the terms of the judicially approved *Settlement Agreement*, a person claiming to be a Primarily-Infected Class Member, such as the Claimant, must satisfy the eligibility requirements in section 2.01 in order to make a successful claim for compensation. In the circumstances of the present claim, the relevant provisions are subsections 2.01(1) and (2) which state as follows:

2.01 Eligibility – Primarily-Infected Class Member

(1) A person claiming to be a Primarily-Infected Class Member must deliver to the Administrator an application form prescribed by the Administrator together with:

- a) medical, clinical, laboratory, hospital, The Canadian Red Cross Society, Canadian Blood Services or Hema-Quebec

records demonstrating that the claimant received Blood in Canada during the Class Period; [...]

(2) Notwithstanding the provisions of Section 2.01(1)(a), if a claimant cannot comply with the provisions of Section 2.01(1)(a), the claimant must deliver to the Administrator corroborating evidence independent of the personal recollection of the claimant or any person who is a Family Member of the claimant establishing on a balance of probabilities that he or she received Blood in Canada during the Class Period. [Emphasis Added]

Subsections 2.01(1) and (2) require that a claimant must have “received Blood in Canada” in order to be eligible for compensation under the *Settlement Agreement*.

[33] The term “Blood” is defined in section 1.01 of the *Settlement Agreement* [...].

iii) Did Claimant’s records demonstrate receipt of Blood under paragraph 2.01(1)(a)?

[34] Under paragraph 2.01(1)(a) of the *Settlement Agreement*, a person claiming to be a Primarily-Infected Class Member, such as the Claimant, must deliver records from at least one of the prescribed categories to demonstrate that she received Blood in Canada during the Class Period.

[..]

iv) Did Claimant deliver independent corroborating evidence under subsection 2.01(2) in conformity with applicable provisions of Proof of Receipt of Blood Protocol?

[37] In circumstances such as the present where a person claiming to be a Primarily-Infected Class Member cannot deliver records under paragraph 2.01(1)(a) of the *Settlement Agreement* to confirm the receipt of Blood, subsection 2.01(2) permits a claimant to deliver independent corroborating evidence to establish on a balance of probabilities the receipt of Blood. Subsection 2.01(2) must be read in conjunction with the *Proof of Receipt of Blood Protocol* which contains provisions governing the evidence that may be delivered by a claimant. Since the Claimant did not receive notification as part of a Blood Recipient Notification Program, the applicable provisions of the *Proof of Receipt of Blood Protocol* are sections 5 and 6 which state as follows:

No Hospital Records or Hospital Records Do Not Confirm Receipt of Blood and The Primarily-Infected Class Member Did Not Receive Notification As Part Of A Blood Recipient Notification Program

5. Subject to paragraphs 2 and 7 and the following constraints, the Administrator may accept any evidence it deems reliable as proof on the balance of probabilities of receipt of Blood in Canada during the Class Period in satisfaction of section 2.01(2) of the *Settlement Agreement*:

a. evidence of the Primarily-Infected Class Member or a Family Member of the Primarily-Infected Class Member may not be considered. The claimant must deliver to the Administrator corroborating evidence independent of the personal recollection of

the Primarily-Infected Class Member or any person who is the Family Member of the Primarily-Infected Class Member; and

b. any evidence which is in the nature of personal recollection must be in affidavit form and must provide the following particulars:

- i. the month and year of the hospitalization(s);
- ii. the reason for the hospitalization(s); and
- iii. the basis of the affiant's personal recollection that the Primarily-Infected Class Member received Blood during the hospitalization(s).

6. Subject to paragraph 5, the following are examples of the type of evidence which the Administrator may consider:

a. an affidavit of a medical practitioner or hospital employee involved in the care of the Primarily-Infected Class Member at the time of the receipt of Blood who recalls the receipt of Blood;

b. the opinion of a medical practitioner, who practices in the specialty to which the Primarily-Infected Class Member's underlying medical condition belongs or who specializes in blood banking, that at the time the receipt of Blood took place, and given the nature of the medical treatment the Primarily-Infected Class Member underwent and/or the circumstances of the Primarily-Infected Class Member at that time, it is more likely than not that the Primarily-Infected Class Member received Blood. If such an opinion is advanced by a person who does not have personal knowledge of the Primarily-Infected Class Member's underlying medical condition, the medical treatment the Primarily-Infected Class Member underwent and the circumstances of the Primarily-Infected Class Member at the time of the receipt of Blood, there should be independent evidence of the underlying medical condition, the medical treatment and the circumstances of the Primarily-Infected Class Member at the time of the receipt of Blood other than the recollection of the Primarily-Infected Class Member or any person who is a Family Member of the Primarily-Infected Class Member;

c. an affidavit of a person who witnessed the receipt of Blood;
or

d. hospital or other medical or clinical records which describe significant blood loss or refer to a receipt of Blood at the time of the alleged receipt of Blood.

[...]

ii) The Administrator's decision dated December 2, 2008

[40] As indicated in the preceding analysis, paragraph 2.01(1)(a) of the *Settlement Agreement* requires a person claiming to be a Primarily-Infected Class Member, such as the Claimant, to deliver records from at least one of the prescribed categories to demonstrate that he received Blood in Canada during the Class Period. In circumstances where such records do not demonstrate the receipt of Blood, subsection 2.01(2) requires the delivery of independent corroborating evidence to establish on a balance of probabilities the receipt of Blood during the Class Period. A Primarily-Infected Class Member who does not meet the requirements of section 2.01 is not entitled to compensation under the terms of the *Settlement Agreement*.

[41] At the time the Administrator made its decision dated December 2, 2008 to reject the claim for compensation, the Claimant had not delivered any records to demonstrate that he had received Blood in the Class Period, as required by paragraph 2.01(1)(a) of the *Settlement Agreement*. Rather, he had delivered a letter dated April 14, 2008 from a physician confirming his infection with Hepatitis C at Disease Level 5, together with a related laboratory report, described in paragraph 2, as well as other laboratory records and a report of the results of a medical scan, described in paragraph 4. None of those records demonstrated that the Claimant had received a blood transfusion. The only other evidence before the Administrator at that time was the final Traceback report and its accompanying documents from the Canadian Blood Services, described in paragraphs 8 to 11. Those documents demonstrated, on the basis of Blood Bank records at the hospital, that the Claimant had not received a blood transfusion at the hospital during the period from 1983 to 1991.

[42] Despite the absence of any records to satisfy the requirements of paragraph 2.01(1)(a) of the *Settlement Agreement*, the Claimant did not deliver any independent corroborating evidence, as required by subsection 2.01(2), to establish on a balance of probabilities that he had received Blood during the Class Period.

[43] The decision of the Administrator dated December 2, 2008 that the Claimant had not provided sufficient evidence to demonstrate the receipt of Blood during the Class Period was therefore reasonable. Indeed, the Administrator could not reasonably have arrived at any other conclusion on the basis of the evidence before it.

iii) The Administrator's decision on review dated April 29, 2009

[44] On December 12, 2008, the Claimant delivered a Request for Review, together with the supplementary evidence described in paragraphs 14 to 23. Between January 30 and March 30, 2009, he delivered further supplementary evidence, described in paragraphs 24 to 29. In light of the supplementary evidence, the Administrator decided to review its earlier decision.

[45] In its decision on review dated April 29, 2009, reproduced in paragraph 33, the Administrator reviewed the facts relied upon in support of its earlier decision, summarized the supplementary evidence contained in the hospital records and the sworn letter of the Claimant's friend, and provided its reasons for denying the claim.

[46] In its summary of the supplementary evidence, the Administrator referred to various details contained in the hospital records, including the Claimant's hospital admission in September 1985 for intravenous antibiotics to treat his infected dog bite. The Administrator also noted the specific references in both the Emergency Record and the Final Note on discharge, described respectively in paragraphs 18 and 22, to the

treatment that the Claimant had received in the Emergency Department of the hospital when his wound was sutured, three days prior to his admission for treatment of his infection. Finally, the Administrator quoted the relevant portions of the sworn letter dated “Jan/09” from the Claimant’s friend, reproduced in paragraph 28.

[47] In its decision, the Administrator specifically relied on three aspects of the evidence: the final Traceback report of the Canadian Blood Services, the hospital record entitled Final Note and the sworn letter of the Claimant’s friend dated “Jan/09”. The Administrator’s findings concerning the Traceback report and the sworn letter must be scrutinized.

[48] With respect to the final Traceback report of the Canadian Blood Services, summarized in paragraphs 8 to 11, the Administrator stated that the hospital Blood Bank records from 1983 to 1991 showed that “[...] there was no record of [the Claimant] receiving a transfusion”. However, the Hospital Response did not indicate that there were “no records found for this patient”; rather, it stated that the Claimant was “not transfused”. The actual wording of the Hospital Response is therefore somewhat more definitive than the manner in which the Administrator expressed it and demonstrates that, according to the Blood Bank records of the hospital for the period from 1983 to 1991, the Claimant did not receive a blood transfusion. In any event, the characterization of the evidence by the Administrator in its analysis was not prejudicial to the Claimant and, indeed, could only have benefited him.

[49] In considering the contents of the friend’s sworn letter, the Administrator stated that there was “[...] no indication that [the friend] was present during the second Emergency room visit”. In his letter, reproduced in paragraph 28, the friend outlined his

recollection of the visit to the hospital in September 1985 and stated that the Claimant received “[...] blood and many stitches to close the wound”. He continued by stating as follows:

[The Claimant] had to return a few days later because it became badly infected. The Doctor told us that he was lucky he came back because he could have lost his arm. [Emphasis Added]

A reading of the letter in its totality, and particularly the usage of the expression “the Doctor told us”, indicates that the friend was also present at the hospital on the occasion of the second visit by the Claimant. The Administrator therefore misinterpreted the contents of the letter in that regard and erred in stating that “[...] there was no indication that [the friend] was present during the second emergency room visit”.

[50] In the conclusion of its decision, the Administrator stated that there was no evidence in the records that the Claimant had received Blood. Furthermore, in assessing the independent corroborating evidence in the sworn letter from the friend, the Administrator gave two reasons for concluding that it did not satisfy the balance of probabilities standard of proof required by subsection 2.01(2) of the *Settlement Agreement*. First, the Administrator found that the evidence in the friend’s letter was “inconsistent with the medical records”. Second, the Administrator stated:

Additionally, [the friend] stated he visited [the Claimant] when being initially treated for the Dog bite however the Affidavit contains comments from the second Emergency room visit.

[51] In assessing the question of reasonableness, the decision on review must be read as a whole and in conjunction with the evidence. When the decision on review is read in that manner, I am satisfied that it was reasonably open to the Administrator to conclude,

on the basis of the evidence, that the Claimant had not met the requirements in section 2.01 of the *Settlement Agreement*.

[52] With respect to the requirement in paragraph 2.01(1)(a) of the *Settlement Agreement*, the Administrator concluded that the records delivered did not demonstrate that the Claimant had received Blood in September 1985. That conclusion was reasonably open to the Administrator on the basis of the evidence. In particular, although the actual record of the Claimant's first visit to the Emergency Department was not available, both the Emergency Record from the second visit and the Final Note on discharge described, among other things, the treatment received by the Claimant during his first visit to the Emergency Department and his subsequent hospitalization three days later. Significantly, the hospital records did not make any reference to a blood transfusion received by the Claimant during his first visit to the Emergency Department or his return visit and hospitalization three days later. Similarly, there was no reference in the hospital records to any significant blood loss suffered by the Claimant. Furthermore, the documents in the final Traceback report of the Canadian Blood Services, including the Hospital Response based on its Blood Bank records, confirmed that the Claimant did not receive a blood transfusion during the time period question. In the circumstances, it was reasonably open to the Administrator to conclude on the basis of the evidence that the records did not demonstrate the receipt of Blood by the Claimant, as required by paragraph 2.01(1)(a) of the *Settlement Agreement*.

[53] With respect to the independent corroborating evidence delivered under subsection 2.01(2), the Administrator concluded that the evidence did not establish on a balance of probabilities that the Claimant had received a blood transfusion. In the first

reason advanced to justify its conclusion, the Administrator found that the sworn letter of the friend was inconsistent with the medical records. The Administrator's finding on that point was reasonably open to it on the basis of the evidence, particularly the hospital Emergency Record and the Final Note, as well as the records from the Canadian Blood Services. In its second reason, the Administrator essentially expressed some doubt or concern about the reliability of the friend's recollection of the events in 1985. However, since the Administrator's reasoning on that point was based on its erroneous interpretation of the contents of the letter, it cannot be relied upon as a basis for supporting the conclusion and must therefore be disregarded.

[54] In the circumstances, it is necessary to determine whether the second reason, which was based on an erroneous interpretation of the sworn letter, tainted the conclusion reached by the Administrator. I have carefully considered this matter and have concluded that the error did not taint or undermine in any manner the first reason that the Administrator gave in support of its conclusion under subsection 2.01(2), namely that the letter of the friend was inconsistent with the medical records. In particular, the first reason given by the Administrator, which I have already found to be reasonably supported by the evidence, was not related to, dependent on or otherwise affected in any manner by the tainted finding expressed in the second reason. Furthermore, since it was not possible to reconcile the contents of the hospital and Canadian Blood Services records with the recollection of the friend, it was open to the Administrator to place more reliance on the records in weighing the evidence in order to make its determination on the balance of probabilities standard under subsection 2.01(2).

[55] In assessing the independent corroborating evidence, it was therefore reasonably open to the Administrator to conclude, in view of the hospital and Canadian Blood Services records, that the evidence in the friend's sworn letter was not sufficient to establish on a balance of probabilities that the Claimant had received Blood in Canada during the Class Period, as required by subsection 2.01(2) of the *Settlement Agreement*. Indeed, I would have reached the same conclusion on the basis of the evidence in this matter.

[56] I should also note that, in arriving at its decision, the Administrator properly did not consider the letters from the Claimant's wife and some other members of his family that were described in paragraph 15. Section 5(a) of the *Proof of Receipt of Blood Protocol* expressly excludes the receipt of evidence from family members and their evidence was therefore not "independent corroborating evidence" within the meaning of subsection 2.01(2) of the *Settlement Agreement*. The Administrator also properly placed no reliance on the references in the two letters from the psychiatrist dated October 28, 2002 and January 27, 2009 and the letter from a family physician dated January 21, 2009, reproduced respectively in paragraphs 16, 26 and 27, to the effect that the Claimant had received a blood transfusion; those statements or opinions did not satisfy the requirements of sections 6(a) or (b) of the *Receipt of Blood Protocol*. In particular, a reading of those letters confirms that the statements relating to the Claimant's receipt of a blood transfusion were not based on personal knowledge or were not consistent with the type of independent evidence suggested in section 6(b).

iv) Effect of the supplementary evidence delivered in May and June 2009

[57] In his sworn letter dated May 6, 2009, the friend clarified the wording in his original letter in order to make it clear that he was present at the hospital on the occasion of the Claimant's second visit to the Emergency Department in 1985. As indicated previously, a proper reading of the original letter indicates that the friend was present on the occasion of the both visits at the hospital. Since I have already concluded that the Administrator erred in interpreting that letter, the second letter has no effect on the outcome of the appeal.

[58] In addition, the letter dated May 28, 2009 from another friend cannot be considered on appeal, as it was unsworn and therefore did not comply with section 5 of the *Proof of Receipt of Blood Protocol*. In any event, even if the letter had been sworn, it would not have advanced the case of the Claimant in that the friend clearly did not witness or have any personal knowledge of a blood transfusion received by the Claimant.

v) An observation

[59] Although the Claimant prepared a further Blood Transfusion History Form, described in paragraph 25, he neither delivered nor made any reference to any records concerning the three other occasions when he was treated at different hospitals. It is interesting to note that, in a period described in the further Blood Transfusion History Form as "the summer of 1977 to 1978", the Claimant stated that was treated at a hospital for "300 stitches to close an arm laceration". In a letter from his psychiatrist dated January 27, 2009, reproduced in paragraph 26, the psychiatrist stated, in part, as follows:

He used to talk to me in his monthly sessions about how he got bit by a dog and he had severe bleeding. He required 300 stitches and got blood transfusion.

It would perhaps be useful for the Claimant to ascertain whether hospital records exist for the three other occasions when he was hospitalized.

vi) Compensation under another program

[60] As indicated previously, the Claimant has applied for and received compensation under the terms of a provincial plan and the *Red Cross Settlement*. In the Reasons for Decision rendered in Claim File 07-00464, I commented on the perception of inequity that may arise when compensation is awarded under one plan or agreement and denied under another. In particular, I stated as follows in paragraph 41 of that decision:

[41] I can appreciate the frustration and distress that this decision will cause to the Claimant, particularly given that the member of the provincial review committee found him to be eligible for a benefit under that program. It must be recognized that the framework governing eligibility for compensation under the terms of the *Settlement Agreement* is completely different from the one applied by the member of the review committee in the context of the provincial agreement.

Although I fully understand that it must be confusing and upsetting when compensation is granted under the auspices of one program or agreement and yet denied under another one, the terms of the *Settlement Agreement* govern the present claim and must be applied. It is also important to recognize that the terms of the *Settlement Agreement* are the result of an agreement between the Parties which was approved by the Courts; neither the Administrator nor the Appeals Officer has any power or discretion to alter those terms.

CONCLUSION

[61] The decisions of the Administrator to deny the claim for compensation were reasonable on the basis of the evidence and the Claimant has not satisfied the fundamental eligibility requirements in either paragraph 2.01(1)(a) or subsection 2.01(2) of the *Settlement Agreement*, namely that he received Blood in Canada during the Class

Period. Regrettably, the Claimant is not entitled to receive compensation under the terms of the *Settlement Agreement*.

[62] The appeal is dismissed.

"D. McGillis"

The Honourable D. McGillis, Q.C.
Appeals Officer

DATED June 19, 2009

TO: Claimant
Fund Counsel
Administrator