

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: 07-10433

**REASONS FOR DECISION
(amended on August 4, 2010)¹**

INTRODUCTION

[1] The Claimant has appealed a decision of the Administrator dated December 11, 2009 and reconsidered on February 23, 2010 in which her application for compensation under the *Pre-1986/Post-1990 Hepatitis C Settlement Agreement* (“*Settlement Agreement*”) was denied. The Claimant, who had used non-prescription intravenous drugs, failed to satisfy the Administrator on the balance of probabilities that she was infected with HCV for the first time by a blood transfusion during the Class Period. The Claimant submitted that she had received a blood transfusion at birth as a “blue baby”.

FACTS

[2] On December 20, 2007, counsel for the Claimant delivered an application for compensation under the *Settlement Agreement*. In the General Information Form, the Claimant stated that she was a Primarily-Infected Person who was infected with the Hepatitis C virus through a blood transfusion during the Class Period. She was born

¹ On August 4, 2010, the law firm representing the Claimant raised a concern with the Administrator that two pieces of information in the Reasons for Decision could potentially identify the Claimant: her date of birth in paragraph 1 and the quote in paragraph 34 from her letter of submissions dated January 16, 2010 in which she referred to her employment. The year of her birth is relevant to the issue to be determined on appeal and I will not delete it; I have deleted the month and date of birth. I did not believe that the reference to the employment could possibly identify her, as I had deleted the reference to the province in which she works. In any event, in order to alleviate any possible concerns, I have amended the decision by deleting the reference to her employment quoted in paragraph 34 from her letter dated January 16, 2010.

in 1959. In “Section G – Other Risk Factors”, she checked the box to indicate non-prescription intravenous drug use as a risk factor for Hepatitis C and wrote as follows:

tried once new needle not shared by anyone else, one time tried, experimental approx. 1980, not sure what drug it was.

[3] The Treating Physician Form dated December 11, 2007 was completed by a specialist in internal medicine (“treating physician”) who had treated the Claimant for 11 years (since approximately 1996). He indicated, among other things, that she was at Disease Level 5. In response to question 1 in Section F – HCV Disease Verification”, he checked the box to indicate non-prescription intravenous drug use as a risk factor for the Hepatitis C virus; for some reason, he also checked the box “None”. He indicated in question 2 that the Claimant had received blood during the Class Period and wrote “@ childbirth (her own)”. In response to question 3 concerning whether there was anything in the Claimant’s medical history or clinical presentation to indicate that she had used non-prescription intravenous drugs at any time, the family physician wrote as follows:

One occasion only + had liver problems preceding her single use with a clean sterile + new needle, never used by anyone else [Emphasis by treating physician]

[4] In the Statutory Declaration Form, the Claimant declared that she had used non-prescription intravenous drugs and wrote “1 time”.

[5] Counsel delivered a letter dated July 11, 2006 from the hospital confirming that neither the hospital nor the Canadian Blood Services had any records from 1959, the year of the Claimant’s birth. He also delivered other documents including a laboratory report dated December 19, 2006 confirming a positive Hepatitis C PCR test, a laboratory report from 2005 and a liver biopsy from 2007.

[6] In two deficiency letters dated June 23, 2008, the Administrator wrote to counsel concerning the lack of records and provided information concerning the *Proof of Receipt of Blood Protocol* and documents required to support the application for compensation.

[7] By letter dated June 3, 2008, the Canadian Blood Services forwarded the final report for the Traceback to the Administrator. The Transfusion Summary stated that a Traceback could not be conducted as the hospital did not have donor records for 1959.

[8] Counsel delivered further evidence in support of the application on September 9 and October 23, 2008, January 2, 2009 and March 23, 2009.

i) Letter and medical articles from a specialist in paediatrics delivered on September 9 and October 23, 2008

[9] On September 9, 2008, counsel delivered a sworn letter from a specialist in paediatrics. The letter was dated September 3, 2008 and stated as follows:

Please be advised that I have known [the Claimant] through the Palliser Health Region over the past 5 years.

[The Claimant's] diagnosis includes chronic active hepatitis secondary Hepatitis C. She's under the medical supervision of [the treating physician] and [...] family physician in [...].

In retrospect, [the Claimant's] history includes blood transfusion and/or exchange transfusion during her immediate newborn period for ? Jaundice from ? ABO/Rh incompatibility in [...]. It is conceivable that she required the above medical procedure to prevent kernicterus.

The standard of practice from 1948 – 1998 has been one of exchange transfusion for blood group incompatibility to prevent kernicterus including prophylactic Rhogam therapy between 28 – 40 weeks gestation with known Rh incompatibility over the past 3 decades. Since 1998 to date, intravenous immunoglobulin (IVIG) has been used to prevent iso immunization in conjunction with phototherapy and/or exchange transfusion.

[10] On October 14, 2008, the Administrator sent another deficiency letter.

[11] On October 23, 2008, counsel delivered four medical articles that were sent by the specialist in paediatrics to support the medical statements made in his letter reproduced in paragraph 9. The articles concerned the practice of exchange transfusion with reconstituted blood in newborns, blood component therapy, hyperbilirubinemia and kernicterus, and intravenous immune globulin reducing the need for exchange transfusions.

ii) Letter from the Claimant and other evidence delivered on January 2, 2009

[12] On January 2, 2009, counsel delivered a letter from the Claimant, together with numerous attachments including five letters in support of the application.

[13] In her letter dated December 29, 2008, the Claimant stated, among other things, that she was given a blood transfusion at birth; she, a brother and sister have blood type A+. She has attempted unsuccessfully to find a doctor or nurses who assisted at her birth or someone who is not a family member who could confirm her transfusion. Her parents have both passed away. Although I have not summarized all of the contents of the Claimant's letter, I have read it carefully.

[14] A laboratory test dated October 28, 2008 confirmed that the Claimant has blood type "A Rh positive".

[15] An undated letter from a registered nurse described the current and past practices used in births where a baby has an Rh factor. She stated, among other things, that blood replacement was commonplace before the introduction of RhoGam.

[16] In a sworn letter dated November 25, 2008, an aunt of the Claimant recounted information that she was told by the parents of the Claimant. After the Claimant's birth,

they were told that she was a “blue baby”, “would need a blood transfusion immediately” and would remain in the hospital for several weeks. The Claimant’s grandparents were also told of her condition. The aunt has always believed that the Claimant had a transfusion at birth.

[17] In a sworn letter dated November 30, 2008, another aunt of the Claimant stated that the Claimant was diagnosed as a “blue baby”, “needed blood transfusions” and remained in the hospital for many weeks. The source of the aunt’s information is unclear, but it appears to have come from her parents (the grandparents of the Claimant).

[18] In a sworn letter dated December 12, 2008, the younger sister of the Claimant stated, among other things, that she remembered their parents “talking about” the Claimant receiving a blood transfusion at birth as she was a “blue baby”.

[19] A letter dated December 10, 2008 from a physician confirmed that the sister of the Claimant (who wrote the letter described in the preceding paragraph) has blood group “A Rh positive”.

[20] A laboratory report dated November 27, 2008 confirmed that the brother of the Claimant has blood type “A Rh positive”.

iii) Medical records from the treating physician delivered on March 23, 2009

[21] On March 23, 2009, counsel delivered the medical records of the Claimant from the treating physician. There were approximately 350 pages of medical records from mid-1996 to 2008. I have read all of the records.

[22] In a letter dated December 8, 2000 to a family physician, the treating physician made reference, among other things, to the Claimant's drug use history. The letter was "Dictated, but not read to avoid delay" and stated as follows:

[The Claimant] was reviewed on the 28th of November regarding her pruritus. Her labs indicate significant hepatic inflammation, she has significant neutropenia, thrombopenia, blood sugars have been poorly controlled over the past three months with high hemoglobin A1C however with increased therapy, better diet, her blood sugars are coming down and are now running between 5 and 7. Since stopping the birth control pill she is certainly less pruritic, however we had a long discussion today as to what else could be irritating her liver. There is no evidence of active sarcoid and I don't think we can blame that. She does have a past history of IVDU as well as other illicit agents including nasal cocaine, etc. and I think viral hepatitis has to be excluded. I have sent her on for further investigation at this point in time and will reassess her in a few weeks time. [Emphasis Added]

[23] In a reporting letter to the treating physician dated May 29, 2002, a specialist in hepatology stated as follows concerning his examination of the Claimant:

Thanks very much for asking me to see [the Claimant] concerning her diagnosis of hepatitis C. Furthermore, thanks very much for sending along the introductory letter and pertinent laboratory work-up. It was greatly appreciated.

[The Claimant] is a 42-year-old female who has a history of hepatitis C with the diagnosis dating back to November of 2000. [...]

Hepatitis risk factors include injection drug use in 1981 for one time and she also had a blood transfusion at birth, although she does not know the exact reason why she required that. She has had no tattoos but her ex-husband was hepatitis C positive and he was a former injection drug user. She drinks alcohol very seldomly. [...]

In summary, [the Claimant] is a 42-year-old female who has quite significant underlying liver disease, likely indicating she has been hepatitis C infected for many years. [Emphasis Added]

PRELIMINARY DECISION OF THE ADMINISTRATOR

[24] In a decision dated January 27, 2009, the Administrator advised the Claimant that the application for compensation would be rejected due to her use of non-prescription intravenous drugs, unless she provided further evidence to establish her eligibility on the

balance of probabilities. The Administrator included a Further Evidence of First Infection Form for the Claimant to return within thirty days.

FURTHER EVIDENCE OF FIRST INFECTION

[25] On February 4, 2009, the Claimant signed the Further Evidence of First Infection Form indicating her intention to provide further evidence that she was infected with HCV for the first time by a blood transfusion.

[26] On February 17 and March 25, 2009, counsel delivered further evidence of first infection to the Administrator. The evidence included an affidavit sworn by the Claimant, as well a letter from the treating physician and another copy of the letter of the specialist in hepatology reproduced in paragraph 23. There was also a medical history form.

i) Affidavit of the Claimant

[27] The Claimant swore the following affidavit dated February 5, 2009;

1. THAT my name is [...] and I reside in [...].
2. THAT my date of birth is [...].
3. THAT I first diagnosed [sic] with Hepatitis C on or about January 25, 2001. I first received blood when I was born on October 4, 1959.
4. THAT I first tried intravenous drugs in 1984² and it was the one and only time I tried intravenous drugs.
5. THAT the needle I used was sterile and not used prior to my use.
6. THAT I never shared that needle with any other intravenous drug user.
7. THAT I have never donated blood at any time.
8. THAT I have never been convicted of a criminal offence.

² In a letter dated April 9, 2010, counsel for the Claimant stated the Claimant's position that the year "1984" in the affidavit was a typographical error and referred to her letter dated January 16, 2010, reproduced in paragraph 34, indicating non-prescription intravenous drug use on one occasion in 1981. In the General Information Form, the Claimant specified her injection drug use as "approximately 1980". A specialist in hepatology stated in a letter dated May 29, 2002, reproduced in paragraph 23, that her injection drug use was in 1981.

ii) Letter from the treating physician dated February 10, 2009

[28] In a letter dated February 10, 2009, the treating physician provided an opinion concerning the source of the Claimant's Hepatitis C infection, stating as follows:

In regards to [the Claimant] and her hepatitis infection, it is my opinion that her infection arose at the time of her birth back in 1959. To the best of my ability to ascertain, she is the product of a RH incompatibility pregnancy; she is the second child of an RH-negative mother, and when she was born, her family was informed that she had "bad blood" and that she had to have a transfusion to survive. Following that she was well for many years, and it was not until she was followed for her other medical problems that her liver problems were identified many years later in life.

Though she has a history of very short-term intravenous drug use, she used clean needles, never shared needles, never shared syringes, never shared solutions, and it is not conceivable that there is any means whatsoever by which she may have contacted [sic] hepatitis C through her drug use. Similarly there is no history of nasal cocaine use, and she has never been in any major accidents or had any blood sharing activities otherwise than her probable blood transfusion as a neonate. It is therefore my opinion that in the absence of any confirmed and probable causes of hepatitis C infection, and given that her liver status is far more advanced than what would be expected for someone who was recently infected, meaning within the last twenty years, and that her liver disease presents as someone who has had liver disease for forty [sic] years or more, that it is most likely that she was truly infected at the moment of childbirth in the act of a life saving transfusion at that time.

If you have any questions in regards to this please do not hesitate to contact me.
[Emphasis Added]

OPINION OF MEDICAL SPECIALIST

[29] In a letter dated November 17, 2009, the medical specialist provided an opinion to the Administrator concerning the manner in which the Claimant likely contracted Hepatitis C. He stated as follows:

I have reviewed the file of the above named claimant as requested. Briefly this is a 50-year old woman who was found to be hepatitis C antigen antibody positive in 2000. Approximately one year later, liver biopsy showed that she had quite advanced liver disease with significant inflammation with a grade 4:4 and 3:4 fibrosis. When the biopsy was repeated in 2007 the inflammation had remained the same and her fibrosis scale was now 4:4 and significant changes in the liver architecture completely compatible with cirrhosis. Fortunately her blood work indicates that the synthetic function of her liver is intact and the clotting factors

albumin and bilirubin appear basically within normal limits. Her liver function tests have remained elevated at approximately 3 times the normal limits.

Other past issue includes pulmonary sarcoidosis diagnosed what appears to be in the 90s and she had several courses of Prednisone for her symptoms and I do not have full details of this however my understanding is that the Prednisone was for approximately 10 days in duration. As well, she had non insulin dependent diabetes, obesity and hypertension.

The claimant relates that she received a blood transfusion at birth. These are no medical records or transfusion records to corroborate this fact. Letters and attestations from family members relayed that she was a “blue baby” and was in the hospital for several months and there is a presumption that she did receive a blood transfusion. One physician does provide literature as to the exchange transfusions that had started to be in practice around that time for people who had Rh incompatibility. Unfortunately, we do not know if [the Claimant’s] mother was in fact Rh negative to support this. An alternative interpretation could be that she was a premature baby who perhaps initially had a patent ductus and that could explain why she had poor coloration at birth. Regardless, it does not answer the question whether she received any blood transfusion at that time or not. The [Claimant] also relates that she did use injection drugs on one occasion in early 1984 and she does not recall which drug she used and states that she never shared needles and used a sterile needle. In a December 8th 2000 note from [the treating physician] he relates that the patient has significant hepatic inflammation, poorly controlled diabetes and pruritus. He indicates that she has a past history of IVDU as well as illicit agents including nasal cocaine etc. and therefore he does a workup for viral hepatitis. In the note from [the specialist in hepatology] dated May 29th 2002 he relates that her hepatitis risk factors include injection drug use in 1981 for one time and she also had a blood transfusion at birth although she does not know the exact reason why she required that. He indicates that she had no tattoos but her ex-husband was hepatitis C positive and he was a former injection drug user.

The question is where did this individual more likely acquire her hepatitis C? If in fact she did receive a unit of blood in 1959 the incident of hepatitis C in the Canadian Blood Supply at that time was certainly much lower than in the 80s and in fact in '59 hepatitis B was a much more common transmissible agent. We will be unable to prove whether she did or did not receive the blood transfusion. It is known however that women who acquired the disease when they are young and are non-drinkers tend to be very slow progressors, many of whom never go on to any serious liver damage. I suppose it is conceivable that the acquisition of infection in 1959 could have a slow course of progression for 40 years and then start having an increase in inflammation fibrosis. This could have been triggered by her other medical conditions such as fatty liver associated with diabetes and her course of Prednisone. On the other hand, her pattern of disease is just as compatible with an exposure in the early 80s either through injection drug use, or sexual contact with her hepatitis C husband who was an injection drug user. There does appear to be some discrepancy into her non-injection drug use history. It is known today that nasal inhalation of cocaine has also transmitted hepatitis C through the sharing of equipment. As well, if her spouse/partner was hepatitis C positive even if clean needles were used if the drug, diluent or other

equipment was shared, this could equally lead to transmission of disease. The course of her disease as mentioned above is certainly compatible with infection at that time course.

On the balance of probabilities although I cannot totally dismiss a possible exposure in 1959, I think there is evidence of exposure in the 1980s and this would make non blood transfusion sources at least as likely a source of hepatitis C as a possible transfusion that she may have received in 1959.
[Emphasis Added]

REVIEW COMMITTEE RECOMMENDATION

[30] In a memorandum dated December 11, 2009, a Review Committee of the Administrator stated as follows:

[The medical specialist] report received and claim reviewed under the Non-prescription Intravenous Drug Use Protocol.

Pertinent facts

- Pg 6 – Form 1 claimant confirmed the IVDU once in 1980
- Pg 8-12 – GI Specialist who had known the claimant for 11 years noted the one time IVDU.
- Pg 26 – Form 3 – claimant declared the IVDU
- Claim met the criteria under CAP for Proof of receipt of Blood – see notes 01/27/2009 – 11:07:28 AM – dodgej0 – Transfused at birth
- Pg 113/4 – claimant affirmed in her Affidavit that she used IV drugs once in 1984 – using a sterile needle. Pg 102-103 – Transfused in 1972 at age 19 – TB inconclusive – no donor information available.
- Pg 133 – Seen in Dec 2000 by [the treating physician]. Doctor wrote past history of IVDU and other illicit agents including nasal cocaine.
- Pg 241 - [the specialist in hepatology] noted Risk factors of IVDU in 1981, transfusion at birth, ex-husband was hep C positive and he was a former injection drug user.
- Pg 123 - [the specialist in hepatology] wrote in consultation Nov 2007 that her partner has hep C as well
- Pg 117 - [the treating physician] wrote a letter dated Feb 10, 2009. In this the doctor noted her history of one time IVDU, using clean needles, never sharing needles, syringes or solutions. The doctor indicated in this letter that she had no history of nasal cocaine use. (contradicts letter of December 2000)

With Reference to IVDU CAP paragraph 7c: [the medical specialist] wrote “I suppose it is conceivable that the acquisition of infection in 1959 could have a slow course of progression for over 40 years and then start having an increase in inflammation fibrosis. This could have been triggered by her other medical conditions such as fatty liver associated with diabetes and her course of Prednisone.”

With Reference to IVDU CAP paragraph 8b: [the medical specialist] wrote “Her pattern of disease is just as compatible with an exposure in the early 1980s either through injection drug use or sexual contact with her hepatitis C husband who was an injection drug user.”

Conclusion of Administrator’s review: The complete claim has been reviewed including the opinion of the medical expert in hepatitis C. The opinion of the medical expert regarding the disease progression does not lean more towards either the transfusions or the Non-Prescription Intravenous Drug use. The claimant has risk factors of transfusions, IVDU once in the early 1980’s, intranasal cocaine and an ex-husband who was also an IVDU and had hepatitis C.

All of this information has been taken into account including the evidence of the medical expert and the claimant has not satisfied the criteria of the Court Approved Protocol as she has not provided evidence that supports on a balance of probabilities she was first infected with HCV by a Blood transfusion received in Canada during the class period. Based on this the Administrator must reject the claim.

Text for rejection letter

In your original application you and your Treating Physician advised the Administrator that you had used non-prescription intravenous drugs. You submitted an affidavit and medical records in compliance with the Court Approved Protocol. As directed by the courts, the Administrator has reviewed the entire claim including the opinion of the medical specialist. The Medical expert indicated the transfusion [sic] was at least as likely a source of the Hepatitis C as transfusion in 1959. Additional risk factors have also been noted of intranasal drug use and a previous marriage to a man who was infected with Hepatitis C and also used non-prescription intravenous drugs. Based on this the evidence on file does not support that on a balance of probabilities it is more likely that you were infected for the first time with Hepatitis C by your transfusions and your claim must therefore be rejected. [Emphasis Added]

DECISION OF ADMINISTRATOR

[31] On December 11, 2009, the Administrator denied the application for compensation, stating as follows:

Criteria for Class Membership

The Settlement Agreement provides that if a Claimant cannot comply with the provisions of Sections 2.01(1)(c) and 2.01(3), 2.02(1)(a) and 2.02(2) or 3.01(4) because the Claimant used non-prescription intravenous drugs, the Administrator must be satisfied on the balance of probabilities that:

- 1) The HCV Infected Hemophiliac or person with Thalassemia Major was infected with HCV for the first time by the receipt of Blood;
- OR

- 2) The HCV Infected Person was infected with HCV for the first time by a Blood transfusion for which an HCV antibody positive donor has been located or for which the status of the donor remains unknown;
OR
3) The Secondarily-Infected Person (Spouse or Parent) was infected with HCV for the first time by the alleged secondary infection.

Reasons for Decision

The Settlement Agreement requires the Administrator to determine a person's eligibility for class membership. The Court Approved Protocol ("CAP") for non-prescription intravenous drug use provides that the Administrator shall weigh the totality of evidence obtained from the additional investigations required by the provisions of the CAP and determine whether, on a balance of probabilities, the HCV Infected Class Member meets the eligibility criteria.

In your original application you and your Treating Physician advised the Administrator that you had used non-prescription intravenous drugs. You submitted an affidavit and medical records in compliance with the Court Approved Protocol. As directed by the courts, the Administrator has reviewed the entire claim including the opinion of the medical specialist. The Medical expert indicated the non blood transfusion sources was [sic] at least as likely a source of the Hepatitis C as transfusion in 1959.³ Additional risk factors have also been noted of intranasal drug use and a previous marriage to a man who was infected with Hepatitis C and also used non-prescription intravenous drugs. Based on this the evidence on file does not support that on a balance of probabilities it is more likely that you were infected for the first time with Hepatitis C by your transfusions and your claim must therefore be rejected.

The Administrator carefully reviewed all the material that you provided to support your claim. A Committee reviewed your claim and concluded that you do not meet the criteria for Class membership as noted above. [Emphasis Added]

REQUEST FOR REVIEW

[32] On January 8, 2010, the Claimant delivered a Request for Review and specified the reasons for appealing as follows:

I have had jaundiced eyes since I was a child. Family members have confirmed this.
I tried IV drugs one time with a clean, unused needle.
The probability of transfusion via sexual relations is very low.
I will provide further documentation.

³ There was an error in this sentence of the original decision that was identical to an error in the Review Committee's recommended text for the letter. The sentence in the original decision read "The Medical expert indicated the transfusion was at least as likely a source of the Hepatitis C as transfusion in 1959". Counsel raised the issue with the Administrator. On January 13, 2010, the Administrator corrected the error in wording.

SUPPLEMENTARY EVIDENCE AND SUBMISSIONS BY THE CLAIMANT

[33] By letter dated January 28, 2010, counsel for the Claimant delivered letters dated January 16 and 25, 2010 from the Claimant, as well as supplementary evidence. He outlined the position of the Claimant on appeal as follows:

[The Claimant] is appealing the decision of the Claims Administrator on the following points:

1. Intranasal drug use was a risk factor taken into consideration by the claims administrator in rejecting [the Claimant's] claim. [The Claimant] did not partake in intranasal drug use at any time in her life. [The treating physician] erred in his letter of December 8, 2000 (which was "dictated but not read" and unsigned) and in his letter of February 10, 2009, [the treating physician] clarifies that there was never any intranasal drug use by [the Claimant] and advises if there are any questions in this regard to contact him. As far as [the Claimant] is aware, the claims administrator, nor [sic] the medical expert contracted [the treating physician], nor is there any reference to the letter of February 10, 2009.
2. Another risk factor taken into consideration in the rejection of [the Claimant] claim was that [the Claimant] was in a previous marriage to a "man who was infected with Hepatitis C and also used non-prescription intravenous drugs". [The Claimant's] ex-husband was not aware that he was Hepatitis C positive until [the Claimant] was diagnosed in 2001. ([The Claimant] was tested in the later part of December, 2000 and advised by her physician in January 2001). When [the Claimant] was diagnosed it was recommended that her ex-husband get tested for the virus. [The Claimant's] position is that sexual contact has an extremely low rate of transmission and that if such transmission took place, although she is of the opinion it is highly unlikely, it is just as likely that she transmitted the virus to her ex-husband having had the virus herself as a result of her blood transfusion in 1959. As well, [the Claimant's] ex-husband did not partake in intravenous drug use while dating our client prior to the or during the marriage.

i) Letters dated January 16 and 25, 2010 from the Claimant

[34] A letter dated January 16, 2010 from the Claimant stated as follows:

I received a Rejection Letter from [the Administrator] dated December 11, 2009. In the Reasons for Decision, it was written that "the Medical expert indicated the non-prescription IV drug use was at least as likely a source of the Hepatitis C as transfusion in 1959. Additional risk factors have also been noted of intranasal drug use and a previous marriage to a man who was infected with Hepatitis C and also used non-prescription intravenous drugs." There are two errors in this decision that need to be addressed.

Firstly, there was never any intranasal drug use by myself and secondly, my ex-husband did not know he was infected with Hepatitis C until after I told him in 2001 that I was positive for the virus and he should get himself checked. Only then did he realize he was infected. During my marriage my ex-husband and I were monogamous and neither of us used any non-prescription drugs (see letter included). I have included articles that state sexual transmission between monogamous couples is extremely rare. [Footnote referring to two articles deleted] This would indicate that there was a very low risk of passing the virus on to me through sex **if** he had Hepatitis C when we were married. Since it cannot be confirmed that he was infected during the time we were married, this method of transmission plus the error in stating I had used intranasal drugs, absolutely cannot be factors in the balance of probabilities, to disallow me compensation.

I have admitted to using IV drugs once in 1981 with a girlfriend. We each used clean needles and separate solutions. This was the first and only time I used recreational drugs as it scared me enough to never try them again. As stated by [the treating physician], this incident carried a low risk of infection. Along with this statement, in the letter by [the treating physician] dated February 10, 2009, it is his opinion that I have been infected for a much longer period of time than 1981, as I presented as someone who had the virus for at least forty years. [The specialist in hepatology] in the Liver Unit at [a] Hospital, in his report to [the treating physician], also confirms that my liver disease is quite significant and “likely indicating that she has been Hepatitis C infected for many years”.

Two symptoms I have lived with on and off since my mid teenage years to the present, are fatigue and jaundiced eyes. People often develop jaundice because a damaged liver is unable to eliminate bilirubin effectively. I have also included statements from someone who has known me for over thirty years and has noticed when I have been jaundiced, years before I used non-prescription drugs (see letter included).

It is unfortunate that I was unable to find anyone outside of my family that knew I had a blood transfusion. My parents are both deceased and their close friends who would have this information are deceased as well. My aunts are very adamant that I had a transfusion and know many of the details as they remember my parents telling them when I was born. My aunt, [...] who has included a letter in the original file, is the wife of a retired RCMP officer and would never perjure herself under any circumstances.

As an employee of [...] for nearly ten years my position as [...] requires a level of confidentiality, reliability and integrity. I would not take on this journey if I truly did not believe that I contracted this disease from a blood transfusion at birth.

[35] A letter dated January 25, 2010 from the Claimant stated as follows:

In this letter to [the Administrator], [the medical specialist] states “fortunately her blood work indicates that the synthetic function of her liver is intact and the clotting factors albumin and bilirubin appear basically within normal limits”. Albumin is not considered to be an especially useful marker of synthetic liver

function; coagulation factors are much more sensitive. Copies of the blood work included show the clotting factors well outside the normal range as well as my INR and platelet count. This would indicate that I have well established cirrhosis and the synthetic function of my liver is far from intact.

My Internist, [the treating physician], in a letter dated December 8, 2000 to [...], mentioned that I had a past history of IVDU as well as other illicit agents including nasal cocaine, etc. He clarifies this claim (of using nasal cocaine) in further letters since this date by stating I have no history of nasal cocaine use.⁴

Again, please reconsider my appeal as I believe the balance of probabilities rests with my claim.

ii) Supplementary Evidence

[36] The supplementary evidence included a letter from the treating physician, sworn statements from two witnesses and various laboratory reports from January 2010. Copies of the letters of the treating physician dated December 8, 2000 and February 10, 2009, reproduced in paragraphs 22 and 27, were again delivered, as well as the liver biopsy referred to in paragraph 5.

[37] In a letter dated January 14, 2010, the treating physician stated that the source of the Claimant's Hepatitis C infection was a blood transfusion and the probability of infection from her former spouse was very low. He stated as follows:

It has come to my understanding that [the Claimant] remains uncompensated for her Hepatitis C infection which you are aware of, and which in my opinion, is of blood transfusion etiology.

You are in receipt of my letter dated February 10, 2009 in which I outline my rationale for my determination of my position that she was infected at birth via a blood transfusion. My understanding is that your concern is that she may have contacted [sic] HCV from her prior spouse but the probability of this is very low as follows;

⁴ A letter dated January 14, 2010 from the treating physician, reproduced in paragraph 37, was delivered as supplementary evidence. However, the letter from the treating physician dealt with the Claimant's risk of infection from her former spouse and did not "clarify" the question of the use of intranasal cocaine, as suggested by counsel for the Claimant in his letter reproduced in paragraph 33. However, in response to comments made by the Administrator in the reconsidered decision, counsel delivered a letter from the treating physician dated April 1, 2010, reproduced in paragraph 45, as further evidence on appeal. In the letter, the treating physician stated, among other things, that the Claimant had never used nasal cocaine and he was "in error".

Due to her underlying phobia of infection since childhood.

- 1) she never used illicit drugs with him
- 2) she never shared needles with him
- 3) she never shared shaving razors with him
- 4) she never shared toothbrushes with him
- 5) she never shared eating utensils, glasses, plates, etc. either
- 6) she never engaged in any high risk sexual behaviours with him nor any other persons (and as you are aware, there is no meaningful statistical risk of HCV transmission with consensual intercourse).⁵

For the above reasons, I believe the only rational, logical reason for [the Claimant's] infection is that of her neonatal blood transfusion. [Emphasis by the treating physician]

[38] In a sworn statement dated January 14, 2010, a friend of the Claimant stated as follows:

I am writing in regards to [the Claimant]. We met each other in 1975 and we have been friends ever since. Throughout this period of time, we have spent a lot of time together. I have always noticed that the whites of her eyes are yellowish. She has large eyes so it is especially noticeable. When asked about it, she says that her eyes have been like that since she was a baby and needed a blood transfusion at birth. Her parents and relatives have told her this is the reason why her eyes are yellow. Throughout all the years I have know her, her eyes have never been white and have remained yellowish.

[39] In a sworn statement dated January 15, 2010, the former spouse of the Claimant stated as follows:

My name is [...] and I was married to [the Claimant] from 1983 to 1999. We had a monogamous marriage and neither of us used any sort of non-prescription drugs during the time we were dating and then married, either with each other or with anyone else. We did not share razors or toothbrushes during our marriage. I was not aware that I had Hepatitis C until [the Claimant] told me she had it (in 2001) and I was tested and found positive for the virus. [Emphasis Added]

⁵ There is nothing in the letter to indicate when the former spouse of the Claimant was diagnosed with Hepatitis C. Several (if not all) of the points raised by the treating physician seem to have relevance only if the former spouse was infected with Hepatitis C before the Claimant and posed a potential risk of infection to her. However, in an affidavit dated January 15, 2010, reproduced in paragraph 39, the former spouse stated that he tested positive for Hepatitis C in 2001 after the Claimant. In any event, in view of my decision in this matter, it is unnecessary for me to consider this question.

RECONSIDERATION OF DECISION BY ADMINISTRATOR

[40] By letter dated February 23, 2010, the Administrator advised counsel for the Claimant that it had reviewed the claim in view of the supplementary material and had concluded that the evidence was not sufficient to meet the eligibility criteria in the *Settlement Agreement*. It provided counsel with the following summary of its review:

Supplementary Submissions

Introduction

[The Claimant]'s claim for compensation was denied on December 11, 2009. On January 11, 2010 it was noted the initial letter contained a typographical error and a second letter was mailed on January 13, 2010. The reason for Rejection of the claim was the evidence submitted did not support on a Balance of Probabilities that she was *infected with HCV for the first time* by the transfusions she received in the class period (emphasis ours). Fund Counsel has forwarded the Claimant's Submissions on February 3, 2010 for review and requesting the Administrator reconsider the decision on the claim. [The Claimant's] Legal Representative has noted their Client's "points" for the Appeal of the Administrator's Decision. [The Claimant] believes the Administrator erred in the decision to reject her claim by taking into account her risk factors of intranasal drug use and being married to a man who was HCV positive.

Summary of Supplementary Evidence

1. [The Claimant] has submitted a summary of a research paper on Individual and Couple level risk factors for hepatitis C infection among heterosexual drug users and an excerpt from an Article regarding Sexual Transmission of Hepatitis C among monogamous couples.
2. [The Claimant] submitted a sworn statement from her ex-husband [...] indicating they were married from 1983 to 1999 and they were both monogamous and did not use non-prescription drugs during the time they were dating or married. He also stated he was not aware he had hepatitis C until after she tested positive.
3. [The Claimant] submitted a letter from [...], a friend of hers since 1975. [The friend] stated [the Claimant]'s whites of her eyes were yellowish and have been that way since he has known her. He also stated he was told it was because of her blood transfusions at birth.
4. [The Claimant] submitted a letter from [the treating physician] dated January 14, 2010 in which the Doctor summarizes the reasons he believes [the Claimant] was not infected with HCV by her spouse.

5. [The Claimant] submitted a letter written by herself dated January 25, 2010 in which she indicated. [sic] [The treating physician] clarified the statement made regarding intranasal drug use. [The Claimant] additionally commented on [the medical specialist's] statement regarding her liver function. She has submitted lab results and commented on the significance of specific lab tests regarding her Hepatitis C.

Analysis and comment

6. The excerpts from the Research papers (see paragraph 1) regarding sexual transmission indicate the likelihood of sexual transmission of HCV is low, however they do not indicate there is no risk at all.
7. The sworn statement submitted by [the Claimant's former spouse] (paragraph 2) has been reviewed. [He] has affirmed that he was married to [the Claimant] from 1983 to 1999 and during that time neither of them used any sort of non-prescription drugs during the time they were dating or married. [The Claimant] has affirmed in her Application for compensation (p 113 of Appeal file) that she used intravenous drugs in 1984.
8. [The Claimant's] friend [...] stated her eyes were yellow and he was told they were like that because she had a blood transfusion at birth. Review of the medical records on file from [the Claimant] Treating Physicians do not contain any comments regarding "Yellow eyes". There is no medical evidence that this observation would be related to her hepatitis C.
9. [The treating physician's] letter dated January 14, 2010 comments on the risk of sexual transmission and because of that he believes she was not infected with HCV by her spouse.
10. [The Claimant] has commented several times that [the treating physician] has clarified the discrepancy between his letters dated December 2000 and February 2009. The claimant has not submitted any evidence from [the treating physician] to explain this discrepancy.
11. [The Claimant] has also commented on lab results and provided her opinion as to the significance of these in relation to her hepatitis C. Unfortunately [the Claimant] does not have the medical credentials to provide this interpretation and the Administrator may not consider it.

Conclusion

As noted in paragraphs 6 & 9 above the evidence submitted supports the risk of infection with hepatitis C by Sexual transmission. The discrepancy in [the treating physician's] letters regarding his initial statement that she used intranasal drugs in the past has never been addressed by [him]. The Court Approved Protocol for Non-prescription intravenous drug use stated the Administrator must obtain the opinion of a medical specialist experienced in treating and diagnosing HCV as to whether the HCV infection and the disease history of the HCV

Infected Class Member is more consistent with infection at the time of the receipt of Blood or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence. Although [the medical specialist] provided his opinion as to how the claimant was first infected with HCV, the Administrator relies **only** upon his opinion regarding the HCV Disease history based on the medical evidence provided. [The medical specialist's] opinion was as follows "*I suppose it is conceivable that the acquisition of infection in 1959 could have a slow course of progression for over 40 years and then start having an increase in inflammation fibrosis. This could have been triggered by her other medical conditions such as fatty liver associated with diabetes and her course of Prednisone. On the other hand, her pattern of disease is just as compatible with an exposure in the early 80's either through injection drug use or sexual contact with her hepatitis C husband who was an injection drug user.*"

The Administrator has an obligation to assess each claim and determine whether the required proof for compensation exists. The Pre1986/Post1990 Hepatitis C Settlement Agreement Article 2.01 (3) states *Notwithstanding the provisions of Section 2.01(1)(c), if a claimant cannot comply with the provisions of Section 2.01(1)(c) because the claimant used non-prescription intravenous drugs, then he or she must deliver to the Administrator other evidence establishing on a balance of probabilities that he or she was infected for the first time with HCV by Blood in Canada during the Class Period.* Review of the Supplementary submissions and evidence of the claimant as summarized above does not change the decision of the Administrator. In support of the claimant if the Administrator were to remove the risk factor of sexual transmission from her ex-husband the evidence submitted does not support on a Balance of Probabilities that the claimant was infected for the first time with HCV by her class period transfusions and the claim remains rejected. [Emphasis Added]

[41] On March 9, 2010, the Claimant elected to continue with the appeal.

FURTHER EVIDENCE AND WRITTEN SUBMISSIONS ON APPEAL

[42] In a letter dated April 9, 2010, counsel for the Claimant stated as follows:

Further to electing to continue with her appeal, [the Claimant] has submitted a further letter from [the treating physician] wherein he explains his error contained in his statement of November 28 [sic], 2000 regarding intranasal drug use.

As well, [the Claimant] would like you to note that the affidavit she swore wherein it was stated that the date she tried intravenous drugs was the year 1984 – this was a typographical error. The first and only time she did try intravenous drugs (with a clean, unshared needle) was in 1981 and this is supported by her letter dated January 16, 2010 sent to you under cover letter dated January 28, 2010 from our office (copies enclosed for your reference). This was prior to her dating and marriage to [her former spouse].

[43] Rule 16 of the *Rules for Appeals* permits a claimant “[...] to provide brief supplementary written submissions restricted to new issues arising out of the Administrator’s revised decision”. There is no provision in the *Rules for Appeals* to permit a claimant to provide further supplementary evidence at this stage of the process. Under the *Rules for Appeals*, all supplementary evidence must be delivered to and considered by the Administrator before a reconsidered decision is made on an application for compensation.

[44] The issue concerning intranasal drug use was raised by counsel and the Claimant as one of the primary issues on appeal in their respective letters dated January 28 and 16, 2010, reproduced in paragraphs 33 and 34. There were contradictory statements made by the treating physician concerning this issue in his letters dated December 8, 2000 and February 10, 2009, respectively reproduced in paragraphs 22 and 27. One of the items of supplementary evidence delivered by counsel was a letter of the treating physician dated January 14, 2010, reproduced in paragraph 37. However, it was obvious that the letter did not address the earlier discrepancy in the evidence concerning intranasal drug use. Given the provisions in the *Rules for Appeals* and the position taken on appeal, counsel should have delivered all relevant evidence before the Administrator reconsidered its decision. Although the *Rules for Appeals* do not permit evidence to be delivered at this point, I will nevertheless receive and consider it in order to avoid a real or perceived prejudice to the Claimant.

[45] In a letter dated April 1, 2010, the treating physician stated as follows:

[The Claimant] is adamant that she has NEVER used nasal cocaine. She was in a social setting at a party where cocaine was in use. [The Claimant] went to use it and exhaled onto it, causing it to scatter to the floor. Never did she inhale it, nor did she put an inhalational instrument (rolled dollar bill) in her nose.

Thus in contrast to my statement of November 28, 2000, that she had used nasal cocaine, she has not and I was in error.

[46] Both counsel and the treating physician referred to the “statement of November 28, 2000” that the Claimant had used intranasal cocaine. The letter of the treating physician was dated December 2, 2000, but he indicated that he had “reviewed” the Claimant on November 28.

ISSUE

[47] The issue to be determined on appeal is whether the Administrator erred in denying the application for compensation.

ANALYSIS

i) Section 2.01 of the Settlement Agreement

[48] In the Reasons for Decision on the appeals in Claim File 07-00464 and 07-07727, I analysed the requirements in section 2.01 of the *Settlement Agreement* respectively in the context of the *Proof of Receipt of Blood Protocol* and the *Non-Prescription Intravenous Drug Use Protocol*. Given my conclusion in this matter, it is not necessary for me to make any reference to the *Non-Prescription Intravenous Drug Use Protocol*. In Claim File 07-00464, I stated in part, as follows:

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

[20] Under the terms of the *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. Section 2.01 states 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-Québec records demonstrating that the claimant received Blood in Canada during the Class Period;

(b) an HCV Antibody Test report, PCR Test report or similar test report pertaining to the claimant;

(c) a statutory declaration of the claimant including a declaration

(i) that he or she has never used non-prescription intravenous drugs, and

(ii) as to where the claimant first received Blood in Canada during the Class Period, and

(iii) as to the place of residence of the claimant, both when he or she first received Blood in Canada during the Class Period and at the time of delivery of the application hereunder; and

(iv) where the claimant is a Primarily-Infected Person, that to the best of his or her knowledge, information and belief, he or she was infected with HCV 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.

(3) Notwithstanding the provisions of Section 2.01(1)(c), if a claimant cannot comply with the provisions of Section 2.01(1)(c) because the claimant used non-prescription intravenous drugs, then he or she must deliver to the Administrator other evidence establishing on a balance of probabilities that he or she was infected for the first time with HCV by Blood in Canada during the Class Period.

[49] With respect to the provisions of the *Proof of Receipt of Blood Protocol*, I stated, in part, as follows:

[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) requires 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.

[...]

[43] Sections 5 and 6 of the *Proof of Receipt of Blood Protocol*, the provisions that apply in the factual circumstances of the present claim, govern the types of evidence that may be delivered to establish on a balance of probabilities the receipt of Blood. In particular, section 5 permits the Administrator to “[...] accept any evidence it deems reliable as proof on the balance of probabilities of the receipt of Blood [...]”, subject to paragraphs 2 and 7 and the requirements in paragraphs 5(a) and (b). By virtue of section 5, the Administrator must assess the reliability of the evidence delivered as proof of the receipt of Blood.

[44] In considering the nature of the reliability assessment to be conducted by the Administrator, it is important to determine the intent and purpose of the applicable provisions.

[45] An examination of subsection 2.01 of the *Settlement Agreement* and sections 5 and 6 of the *Proof of Receipt of Blood Protocol* establishes that records were intended to be important in the evidentiary assessment of the eligibility of a claim, but were not viewed as being infallible or necessarily definitive. For that reason, the parties agreed that alternate types of evidence could be delivered in accordance with the provisions of subsection 2.01(2) of the *Settlement Agreement* and the *Proof of Receipt of Blood Protocol*. The parties therefore intended that a claim should not be rejected solely because either records do not exist or do not establish the receipt of blood. The parties also agreed to the evidentiary framework in the applicable provisions with the full knowledge and intent that it would apply, among other things, to claims involving events that pre-dated 1986. The parties therefore intended that the types of evidence prescribed in sections 5 and 6 of the *Proof of Receipt of Blood Protocol*, including corroborating affidavit evidence in the nature of personal recollection of an independent witness, would be accepted as proof of events that may have occurred before 1986 (in other words at times more than 23 years ago), subject to an assessment of its reliability. In agreeing to the evidentiary framework, the parties to the *Settlement Agreement* acknowledged that the passage of time, in and of itself, is not a sufficient reason to discredit the contents of a sworn affidavit.

[46] The purpose of subsection 2.01(2) of the *Settlement Agreement* and the applicable provisions of the *Proof of Receipt of Blood Protocol*, when read together and in their proper context, is therefore twofold: first, to ensure that claims are not rejected simply because either there are no records or the available records do not establish the receipt of Blood; and second, to permit other types of reliable evidence to be delivered to satisfy the mandatory requirement in subsection 2.01(2) that a person claiming to be a Primarily-Infected Class Member must have received Blood to be eligible for compensation. [...]

ii) *Did the Administrator err in denying the application for compensation?*

[50] In order to succeed in the application for compensation, the Claimant had to meet the requirements in section 2.01 of the *Settlement Agreement*. She was unable to deliver records from one of the categories prescribed in paragraph 2.01(1)(a) to demonstrate the receipt of blood. As a result, the provisions of subsection 2.01(2) applied to the application and required her to deliver corroborating evidence independent of her recollection or any person who is a Family Member to establish the receipt of blood on a balance of probabilities. Due to the fact that the Claimant had admitted the use of non-prescription intravenous drugs in the Statutory Declaration Form, subsection 2.01(3) also applied to the claim, requiring her to deliver evidence to establish on a balance of probabilities her infection for the first time with Hepatitis C by the receipt of blood.

[51] In the factual circumstances of the application, section 2.01 of the *Settlement Agreement* required the Administrator to determine two separate and distinct issues: first, whether the Claimant had delivered corroborating evidence to establish on a balance of probabilities her receipt of blood, as required by subsection 2.01(2); and second, whether she had delivered evidence to establish on a balance of probabilities her infection with Hepatitis C for the first time by a blood transfusion, as required by subsection 2.01(3).

[52] With respect to the first issue, a review of the decision and the reconsidered decision, reproduced respectively in paragraphs 31 and 40, indicates that the Administrator did not consider whether the Claimant had established on a balance of probabilities the receipt of blood, as required by subsection 2.01(2) of the *Settlement Agreement*. The Administrator therefore erred by not determining whether the Claimant had satisfied this fundamental requirement.

[53] The second issue to be determined is whether the Administrator erred in concluding that the Claimant had not met the requirements under subsection 2.01(3) of the *Settlement Agreement*. In analysing this issue, it is necessary to review the memorandum of the Review Committee dated December 11, 2009, the decision of the Administrator dated December 11, 2009 and the reconsidered decision dated February 23, 2010, reproduced respectively in paragraphs 30, 31 and 40.

[54] In the outline of the facts in the memorandum dated December 11, 2009, the Review Committee referred to the statements by the treating physician, made respectively in the letters dated December 8, 2000 and February 10, 2009, that the Claimant had used “illicit agents including nasal cocaine” and that she had “no history of nasal cocaine use”. The Review Committee specifically noted that there was a contradiction in the evidence of the treating physician, but concluded that intranasal cocaine use was a risk factor. The proposed “Text for rejection letter” stated that intranasal drug use by the Claimant was an “additional risk factor” for Hepatitis C. In the decision of the same date, the Administrator adopted the text proposed by the Review Committee and reproduced it in the reasons denying the application for compensation.

[55] Neither the Review Committee nor the Administrator analysed the contradiction in the evidence of the treating physician concerning the intranasal use of cocaine by the Claimant or gave any reason to justify or explain the reason for choosing one version of the evidence over the other. The Administrator was not entitled to prefer or simply choose one version of the contradictory evidence over the other in the absence of cogent reasons to justify or explain why. Furthermore, the blatant contradiction in the evidence was impossible to reconcile at that point in time without the benefit of further information

from the treating physician. In the circumstances, his contradictory statements concerning the use of intranasal cocaine by the Claimant had no evidentiary value. The Administrator therefore erred in concluding that intranasal drug use by the Claimant was an additional risk factor for the Hepatitis C infection. A reading of the decision as a whole indicates that the Administrator relied upon its erroneous finding concerning intranasal drug use in determining that the Claimant had not established on a balance of probabilities that she was more likely infected with Hepatitis C for the first time by a blood transfusion. In the circumstances, the decision of the Administrator dated December 11, 2009 was tainted by the error.

[56] The Administrator reconsidered the decision to deny the application for compensation after reviewing supplementary evidence delivered by the Claimant on appeal, including a letter dated January 14, 2010 from the treating physician reproduced in paragraph 37 concerning sexual transmission as a risk factor. The Administrator properly concluded that the letter from the treating physician did not address or explain the contradiction in his two earlier letters concerning the use of intranasal cocaine by the Claimant. In the conclusion, the Administrator found that the supplementary evidence and submissions of the Claimant did not “change the decision”. It further found that, even in the absence of sexual transmission as a risk factor, the evidence did not establish on a balance of probabilities an infection for the first time with Hepatitis C by a blood transfusion. A reading of the reconsidered decision as a whole indicates that the Administrator relied upon the findings in the decision dated December 11, 2009, save and except for sexual transmission as a risk factor, to support its conclusion denying the application. In other words, the tainted finding concerning the use of intranasal drugs as a

risk factor was considered and relied upon by the Administrator in making the reconsidered decision. As a result, the reconsidered decision was tainted by the error made by the Administrator in the decision dated December 11 2009. The reconsidered decision therefore cannot be permitted to stand.

[57] Since the evidence in the claim file is complete, I have decided to make the decision, rather than returning the matter to the Administrator.⁶

iii) Has the Claimant met the requirements in subsection 2.01(2) of the Settlement Agreement?

[58] Subsection 2.01(2) of the *Settlement Agreement* prohibits consideration of evidence that is based on the personal recollection of a claimant or a Family Member. I have therefore not considered any of the extensive evidence and submissions that are based on the recollection of the Claimant or her Family Members.

[59] The evidence relating to the question of a blood transfusion includes a letter from a specialist in hepatology dated May 29, 2002, a letter from a specialist in paediatrics dated September 9, 2008, letters from the treating physician dated February 10, 2009 and January 14, 2010, and the opinion of the medical specialist.

[60] The letter from the specialist in paediatrics, reproduced in paragraph 9, does not indicate any awareness on his part that the Claimant had used non-prescription intravenous drugs. Furthermore, the basis for his statement that the Claimant's "history includes blood transfusion and/or exchange transfusion during her immediate newborn period" is not detailed or explained in any manner. The fact that he put question marks in front of the words "jaundice" and "ABO/Rh incompatibility" also raises questions

⁶ See, by way of analogy, the approach taken by Rothstein J. in *Apotex v. Sanofi-Synthelabo Canada Inc.*, 2008 SCC 61 at paragraph 72.

concerning the meaning of his opinion. As a result, I have concluded that his opinion is entitled to no weight. The principal evidence to be considered is therefore found in the letter of the specialist in hepatology, the opinion of the treating physician, who is a specialist in internal medicine, and the opinion of the medical specialist in infectious diseases.

[61] A review of the opinion evidence of the treating physician and the medical specialist indicates that the pivotal aspect of the evidence relates to the length of time that the Claimant likely had her infection with Hepatitis C. This evidence is crucial because there is simply no independent corroborating evidence to establish that the Claimant, who is blood type “A Rh positive”, received blood at birth or that her mother was Rh negative.

[62] In his reporting letter dated May 29, 2002 and reproduced in paragraph 23, the specialist in hepatology made a relevant comment concerning disease progression by stating that the Claimant “[...] had quite significant underlying liver disease, likely indicating that she has been hepatitis C infected for many years”.

[63] In a letter dated February 10, 2009 and reproduced in paragraph 28, the treating physician expressed the opinion that the Hepatitis C infection of the Claimant arose “at the time of her birth back in 1959”. He noted that her liver problems “[...] were identified many years later in life”. He considered her risk factors, including her “very short-term intravenous drug use”. In his opinion, it was “not conceivable” that she had contracted Hepatitis C through the drug use. He gave two reasons for concluding that the Claimant was “most likely” infected with Hepatitis C by a transfusion at childbirth: first, the absence of any “confirmed and probable causes of hepatitis C infection”; and second, the fact that “[...] her liver status is far more advanced than what would be expected for

someone who was recently infected, meaning within the last twenty years”. In particular, he stated that “[...] her liver disease presents as someone who has had liver disease for forty [sic] years or more”. In a letter dated January 14, 2010 and reproduced in paragraph 37, he reiterated his opinion that the Claimant’s Hepatitis C infection was “of blood transfusion etiology”. Interestingly, the treating physician stated in the Treating Physician Form, summarized in paragraph 3, that the Claimant’s “liver problems” preceded her “single use” of intravenous drugs. There was no medical evidence in the Claim File to support the statement, and the source of the information that led to the statement is unclear. In the circumstances, I have not relied on the statement in arriving at my decision.

[64] With respect to the progression of the disease, the medical specialist acknowledged in his opinion, dated November 17, 2009 and reproduced in paragraph 29, that women who acquired Hepatitis C as young non-drinkers “[...] tend to be very slow progressors [sic], many of whom never go on to any serious liver damage”. He stated that it was “[...] conceivable that the acquisition of infection in 1959 could have a slow course of progression for 40 years and then start having an increase in inflammation fibrosis”. Furthermore, the Claimant had conditions that could have triggered the disease, “such as fatty liver associated with diabetes and her course of Prednisone”. However, he concluded that the course of her disease was “just as compatible” with an exposure in the early 1980’s through other risk factors. In his conclusion, he stated that he could not “totally dismiss a possible exposure in 1959”.

[65] The statement of the medical specialist that the Hepatitis C could have had “a slow progression for 40 years” supported the position that was fundamental to the

opinion expressed by the treating physician. However, the medical specialist did not specifically address or disagree with the express and definitive statement of the treating physician that “[...] her liver disease presented as someone who has had liver disease for forty [sic] years or more”. He also made no comment on the statement by the treating physician that her “liver status” was “[...] far more advanced than what would be expected for someone who was recently infected, meaning within the last twenty years”. Similarly, he did not address the statement of the specialist in hepatology that the Claimant was “likely” infected with Hepatitis C for “many years”.

[66] The medical specialist had access to the Claim File, including all of the medical records of the treating physician dating from 1996 to 2008. In explaining the basis of his opinion, he had an obligation to confront, address and contradict on the basis of the evidence, if possible, the statements of the treating physician that the Claimant’s liver disease indicated an infection of forty years or more and was “far more advanced” than a person who was “recently infected, meaning within the last twenty years”. At a minimum, he had an obligation to provide a cogent explanation to indicate why the disease progression was less than the forty years or more indicated by the treating physician. He also should have addressed the statement of the specialist in hepatology that the Claimant was infected with Hepatitis C for many years.

[67] In the circumstances, I have concluded that the opinion of the medical specialist is entitled to less weight than the opinion of the treating physician on the question of disease progression. In particular, the opinion of the treating physician that the Claimant had liver disease for forty years or more was not diminished by any cogent analysis in the opinion of the medical specialist. I am therefore satisfied that the opinion of the treating

physician, when considered in the context of the totality of the evidence, establishes on a balance of probabilities the receipt of blood by the Claimant as an infant. In the circumstances, a blood transfusion could be the only cause of her infection with Hepatitis C, and the other risk factors, including the use of non-prescription intravenous drugs, have no relevance.

[68] Alternatively, I am satisfied that the principle of inclusiveness should apply in view of the divergent opinions of the specialists who have examined and considered the same evidence, particularly given the acknowledgement by the medical specialist that a disease progression of forty years was “conceivable” on the basis of the evidence. In the Reasons for Decision on further appeal to the Court in claim file 07-00464 dated October 29, 2009, Chief Justice Winkler allowed an appeal where there was conflicting evidence as to whether the Claimant had received a blood transfusion, stating as follows:

In my view, this is a case where the principle that, with respect to class membership, if an error is to be made, it should be made on the side of inclusion rather than exclusion, should be invoked.

CONCLUSION

[69] The appeal is allowed.

"D. McGillis"

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

DATED June 16, 2010

TO: Counsel for the Claimant
Fund Counsel
Administrator