

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: 07-01011

**REASONS FOR DECISION**

**INTRODUCTION**

[1] The Claimant appealed a decision of the Administrator dated July 14, 2008, in which the 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 in Canada during the Class Period. The Administrator reconsidered its decision in view of supplementary evidence that was filed and, in a decision dated July 8, 2009, maintained the denial of the appeal. The Claimant elected to continue with the appeal.

**FACTS**

[2] On December 13, 2007, 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 3. In the Blood Transfusion History Form, the Claimant noted that he had received a blood transfusion of four units of blood on November 22, 1980 for rectal bleeding and hemorrhagic gastritis. The Claimant indicated that he had received compensation under the *Canadian Red Cross Settlement* in the amount of \$10,450.00. He had no other risk factors for Hepatitis C.

[3] In support of the claim, the Claimant delivered two documents relevant to the blood transfusion issue.

[4] The first document was a hospital record entitled “Blood Transfusion Requisition” dated November 22, 1980. At the top of the Requisition, the word “EMERG [Emergency Room]” was printed. In the column on the left hand side of the Requisition under the heading “X-Match”, the physician ordered a cross-match for four units of blood (packed cells) and checked the box for a “Routine X-Match (today)”. He did not check the box “For transfusion on floor” or the box “For transfusion in O.R.”. In the information grid on the right hand side of the Requisition, two of the units were noted as “incompatible”. In the Patient Data part of the Requisition, there were various questions. The Claimant gave the answer “No” in response to the question “Any previous blood transfusions?”

[5] The second document was a Discharge Summary from the hospital indicating that the Claimant was admitted to the hospital on November 22, 1980 and was discharged on December 6, 1980. The Discharge Summary stated, in part, as follows:

[The Claimant] presented to emergency with rectal bleeding. At the time a sigmoidoscopy revealed frank bleeding in the colon, but a rectal biopsy showed no evidence of significant inflammatory change. [...] Subsequently the patient underwent an upper G.I. series, suggesting the presence of a gastric ulcer in a post gastrectomy state. The patient underwent endoscopy and there was evidence of significant hemorrhagic gastritis. [Emphasis Added]

The final diagnosis was listed as “Hemorrhagic gastritis”.

[6] By letter dated May 13, 2008, the Canadian Blood Services forwarded the final report for the Traceback (“Traceback”) to the Administrator, together with three documents: a memorandum dated June 13, 1997 from the Supervisor of Haematology at the hospital to the Canadian Red Cross Society; a Traceback Notice dated April 16, 2002, containing a Hospital Response dated April 23, 2002; and a Transfusion Summary dated May 13, 2008.

[7] In the memorandum dated June 13, 1997, the Supervisor of Haematology advised the Canadian Red Cross Society as follows:

Please find attached, a copy of our Blood Transfusion report for the above named patient. Our Blood Bank records indicate that these units were *not* transfused to him. I also checked his medical records and there is no evidence of any transfusions occurring during his hospital stay. [Supervisor's Emphasis]

The copy of the "Blood Transfusion report" referred to in the memorandum was not included with the Traceback.

[8] The Traceback Notice dated April 16, 2002 was a form letter from the Canadian Blood Services addressed to the Blood Bank of the hospital indicating, among other things, that it was conducting a traceback investigation. In the Hospital Response dated April 23, 2002, the laboratory manager checked the box "Patient record available; not transfused". She noted that both the complete Blood Bank and patient Health Record were searched and stated "Please see copy of letter sent to you in 1997".

[9] The Transfusion Summary dated May 13, 2008 contained the results of the Traceback and stated as follows:

The hospital reported that the [Claimant] was cross matched 4 units in November 1980, but there is no evidence of Transfusion during his hospital stay.

#### **DECISION OF THE ADMINISTRATOR DATED JULY 14, 2008**

[10] In a decision dated July 14, 2008, the Administrator denied the claim for compensation on the basis that there was not "[...] sufficient evidence to support that you or the HCV Infected Class Member received Blood during the Class Period [...]".

#### **REQUEST FOR REVIEW**

[11] On August 5, 2008, the Claimant delivered a Request for Review in which he indicated, among other things, that he was in the process of obtaining hospital records to

support his claim that “[...] blood was transfused in 1980 during an emergency procedure”.

### **SUPPLEMENTARY EVIDENCE**

[12] The Claimant delivered supplementary evidence on two occasions: hospital and medical records on September 18, 2008, and two corroborating affidavits from independent witnesses on June 10, 2009.

#### *i) Hospital and medical records*

[13] On November 21, 1980, the Claimant visited the Emergency Room at the hospital for blood in his stools. He was discharged with a diagnosis of bloody diarrhea and was to have follow-up.

[14] A hospital Emergency Room chart record indicated that the next day, on Saturday, November 22, 1980 at 1103 hours, the Claimant visited the Emergency Room at the hospital for rectal bleeding. Another Emergency Room record entitled “History and Physical Report” stated, among other things, “rectal bleeding – Thurs nite [sic] – large amt”. A specialist in gastroenterology and internal medicine (“specialist in gastroenterology”) issued and signed 12 Physician’s Orders that day in the Emergency Room for laboratory tests and other matters, including an order admitting the Claimant to the hospital in enteric isolation, an order for a “CBC [Complete Blood Count] daily and weekend x 4 days”, an order for an intravenous, and an order for blood that stated “X-I type 4 units packed cells”. A note that stated “Sent ER” was written beside the Physician’s Order for the four units of blood; in other words, the four units of blood were sent to the Emergency Room in the name of the Claimant on November 22, 1980. The specialist in gastroenterology also issued a Blood Transfusion Requisition for a routine

cross-match of four units of blood for the Claimant. The Blood Transfusion Requisition was delivered in evidence previously by the Claimant and is summarized in paragraph 4.

[15] In the “Doctor’s Orders and Treatments” part of the Emergency Room chart record, the specialist in gastroenterology wrote “Rectal blood – admit – enteric isolation”. The chart record indicated that the “time of disposition” was 1335 hours and the Claimant was admitted to a room in enteric isolation. The “Instructions on Discharge” stated “IV [intravenous] 2/3 & 1/3 [with] 30 meq KCL #18 AC”.

[16] The specialist in gastroenterology prepared two reports concerning the examination and treatment of the Claimant in the Emergency Room: an Operative Record and a Continuation Report. The Operative Report was transcribed on January 11, 1981 and indicated that, while the Claimant was in Emergency with rectal bleeding, he had a sigmoidoscopy examination that revealed “bleeding down the mucosa of the rectum”. A portion of the posterior rectum was taken for pathological assessment. The Continuation Report was dictated on November 22, 1980 and transcribed the next day. In the report, the specialist in gastroenterology stated, among other things, that the Claimant had experienced “rectal bleeding for approximately three days”. He summarized the symptoms associated with the problem and noted that the Claimant had undergone surgery for an ulcer at the age of sixteen and had no history of jaundice or liver disease. He outlined the results of his physical examination of the Claimant. In his concluding paragraph, he noted, among other things, that the sigmoidoscopy and rectal biopsy were “[...] in keeping with blood flowing down the large bowel but not specifically with the presence of an acute, inflamed bowel”; he admitted the Claimant to the hospital for “further management”. He made no reference in the Continuation Report to either the intravenous that he had ordered or to a blood transfusion.

[17] After the Claimant was transferred from the Emergency Room, hospital records, including a Nursing History, Nursing Progress Notes and the Physician's Orders, recorded information concerning his treatment.

[18] An undated "Nursing History" contained a note that "the [Claimant] has been bleeding since Thurs. [November 20, 1980]".

[19] The Nursing Progress Notes covered the period from his arrival on the ward on Saturday, November 22 to his discharge on December 6, 1980.

[20] In the first note on November 22, 1980 (erroneously recorded by the nurse as November 27), a nurse wrote that he had arrived on a stretcher from Emergency at 1500 hours under the care of the specialist in gastroenterology. The note also stated, among other things, "IV [intravenous] 2/3 & 1/3 [with] 30 KCL 800 [illegible]; isolation set up". There were also notes relating to the intravenous for the time period from 1500-1930 hours and for 2330 hours.

[21] The Nursing Notes made reference to the intravenous for November 23, 1980 at 730, 1230, 1300, 1600 and 1930 hours and on November 24, 1980 at 410, 0530 and 0700 hours; the note for the period from 1230 to 1530 hours indicated that the intravenous was discontinued on the doctor's orders. In the Physician's Orders dated November 24, 1980, the specialist in gastroenterology ordered the discontinuation of the intravenous. There was no reference in any of the Nursing Notes to a blood transfusion.

[22] The Physician's Orders indicated, among other things, that the enteric isolation was cancelled on November 26, 1980.

[23] A record entitled "Weekly Fluid Balance" recorded the "Intake" and "Output" of fluid. In the "Intake" part of the form, there were four categories of information to be

recorded, including “Blood” and “Intravenous”. For the dates from November 22 to November 28, 1980, there were no entries for “Blood”. However, in the space underneath the word “Intravenous”, there was a notation “ $2/3$  &  $1/3$  [with] 30 KCL”. In the corresponding line, the volumes of fluid taken by intravenous were separately entered for the day and evening of both November 22 and 23, 1980.

[24] On December 3, 1980, the Claimant responded to questions in a Department of Anaesthesia Questionnaire in preparation for a surgical procedure, an endoscopy, the next day. Question 3 on the questionnaire stated as follows:

Have you ever had a blood transfusion?  
Have you ever had a reaction to a blood transfusion?

In the response to the question “Have you ever had a blood transfusion?”, a check was placed in the response column “Yes”, but was then crossed out and a check mark was placed in the response column “No”. The response to the question “Have you ever had a reaction to a blood transfusion?” was “No”. The Claimant signed the questionnaire, but the answers that were written on the questionnaire in response to certain other questions were not in his handwriting.

[25] On December 4, 1980, the “O.R. Check List” indicated, among other things, that blood was not ordered for the surgical procedure.

[26] In an Operative Report dated December 4, 1980, the specialist in gastroenterology reported on the results of the endoscopy, stating, among other things, that “the stomach showed evidence of bile reflux gastritis with some hemorrhagic areas”.

[27] On December 6, 1980, the Claimant was discharged from the hospital. The Discharge Summary was previously delivered in evidence by the Claimant and is

summarized in paragraph 5. As indicated previously, the final diagnosis was “Hemorrhagic gastritis”.

[28] Five years later, in a letter dated December 11, 1985, another specialist wrote a report to the family physician concerning the results of his examination of the Claimant.

He stated, in part, as follows:

[The Claimant] has mildly abnormal liver function tests although he does not have any clinical evidence of chronic liver disease. What he most likely has is mild chronic persistent hepatitis. These are usually viral induced and not of any clinical significance. They usually require no treatment. I will be checking him for markers for chronic liver disease including hepatitis B, hemochromatosis, etc., but I doubt these will be abnormal. [...]

[29] By letter dated January 20, 1986, the specialist reported to the family physician concerning his examination of the Claimant and stated, in part, as follows:

As you know, he is a 49 year old man who has elevated liver function tests.

His serology for hepatitis B shows that he has had a remote infection with hepatitis B. He is not infectious because the hepatitis B surface antigen is negative. He does, however, have antibodies to the hepatitis B surface antigen and the core antigen. What this means is a remote infection has left him with a chronic persisting hepatitis.

[30] On July 26, 1991, the Claimant tested positive for the Hepatitis C antibody. At the same time, he tested negative for the Hepatitis B surface antigen and the surface antibody, and “weakly positive” for the Hepatitis B core antigen.

[31] By letter dated August 6, 2008, the Claimant’s family physician wrote the following letter:

This is to inform you that [the Claimant] has been a patient of mine since 1993. He has chronic hepatitis C.

According to the hospital record, [the Claimant] presented to the emergency department with a 3-day history of rectal bleeding. The hospital record also showed a blood transfusion requisition ordered by [the specialist in gastroenterology]. Presumably the patient’s condition was most likely compromised and needed blood transfusion, as [is] usually the case with hemorrhagic gastritis. Frank red bleeding from the rectum was usually an indication of severe blood loss particularly if the bleeding was coming from the

gastric area and was ongoing for 3 days. Hence, this was done to replace severe blood loss.

*ii) Corroborating affidavits from two independent witnesses*

[32] By letter dated June 8, 2009, the son-in-law of the Claimant delivered two corroborating affidavits from independent witnesses in support of the claim: an affidavit from the Claimant's first cousin ("male affiant") and an affidavit from the cousin of the Claimant's wife ("female affiant").

[33] Before reproducing the affidavits, one matter must be addressed. The two affidavits were sworn on the same day and follow the same general format. However, it appears that an error was inadvertently made in paragraph 2 of the affidavit of the female affiant which states as follows:

2. I am a cousin of [the Claimant]. [The Claimant's] wife's grandmother and my father are brother and sister.

A reading of paragraph 2 indicates that the female affiant is not a cousin of the Claimant, as stated in the first sentence, but rather that she is a cousin of the Claimant's wife, as stated in the second sentence. This interpretation is supported by paragraph 3 of her affidavit in which she referred to a call received from her cousin, the Claimant's wife. Furthermore, paragraph 5 of the affidavit of male affiant states, among other things, as follows:

5. At the hospital, I met up with [the female affiant], [the Claimant's wife's] cousin.

In the circumstances, I am satisfied that the statement in the first sentence of paragraph 2 of the affidavit of the female affiant that she is the Claimant's cousin is an inadvertent drafting error and that she is the cousin of the Claimant's wife.

[34] In an affidavit sworn on June 5, 2009, the male affiant stated as follows:

1. I make this Affidavit in support of [the Claimant's] claim and for no improper or irrelevant purpose.
2. I am the biological first cousin of [the Claimant]. Our respective fathers were brothers.
3. I received a call from [the Claimant's] wife, [...], on or about Saturday, November 22, 1980 advising that my cousin had been rushed to [the hospital] as a result of abdominal pain and excessive blood loss on his bed sheets.
4. Later that day or within the next few days of [the Claimant's] hospitalization, I visited [the Claimant] in the late afternoon and/or early evening at [the hospital]. I remember I went to visit him as soon as I could.
5. At the hospital I met up with [the female affiant] in the lobby and we took the elevator together to see [the Claimant].
6. At the hospital I was told he was in isolation and when I arrived on the floor I was given a gown and a mask by the nurse, which I put on to visit with him. Both [the female affiant] and I visited [the Claimant] together.
7. When I entered room he was by himself and had a protective plastic bag around his bed and I was alarmed to see him in a very weak state. He was being given an intravenous with some clear fluids as well as there was a single bag of blood hung on a rack next to him with a tube running to his arm.
8. When I asked about the blood he told me that he lost a lot of blood through his rectum and had bleed [sic] for three (3) days and that is why he was receiving the blood. He told me that he had already come to the hospital before being hospitalized but was sent home only to return in worse condition.
9. I left and visited him again several times over the course of the next week.

[35] In an affidavit sworn on June 5, 2009, the female affiant stated as follows:

1. I make this Affidavit in support of [the Claimant's] claim and for no improper or irrelevant purpose.
2. I am a cousin of [the Claimant]. [The Claimant's] wife's grandmother and my father are brother and sister.
3. I received a call from my cousin, [the Claimant's] wife, [...], on or about Saturday, November 22, 1980 advising that her husband [...] had been rushed to [the hospital] as a result of abdominal pain and excessive blood loss on his bed sheets.

4. In the first week of [the Claimant's] hospitalization, I visited [him] practically every day as I lived only about ten (10) minutes from the hospital [...].
5. On one of my visits within the first few days of [the Claimant] being hospitalized, I ran into [male affiant] in the lobby and we took the elevator together to see [the Claimant].
6. [The Claimant] was still in isolation at the time and we were given a gown and a mask by the nurse which I put on to visit with him.
7. [The male affiant] and I entered [the Claimant's] room and found him alone and inside a protective plastic sheet that went around his bed. He was being given an intravenous with some clear fluids and there was a single bag of blood hanging on a rack next to him with a tube running to his arm.
8. [The male affiant] asked [the Claimant] about the blood and [the Claimant] told him that because he lost a lot of blood through his rectum he needed it as he had been bleeding for three (3) days prior to being hospitalized. He told us that he had already come to the hospital before but was sent home only to return in worse condition.
9. I left with [the male affiant] and returned many times to visit with [the Claimant] during his approximate two (2) weeks of hospitalization.

[36] By letter dated August 15, 2008, the Fund Counsel forwarded the supplementary evidence to the Administrator under Rule 13 of the *Rules for Appeals* and requested a reconsideration of the decision.

### **RECONSIDERED DECISION OF ADMINISTRATOR DATED JULY 8, 2009**

[37] By letter dated July 8, 2009, the Administrator advised the Claimant that it had reviewed the decision and had determined that the evidence was not sufficient to meet the eligibility requirements in the *Settlement Agreement*. In the reconsidered Decision dated July 8, 2009, the Administrator stated as follows:

#### **Introduction**

1. [The Claimant] submitted a claim for Compensation under the Pre 1986/Post 1990 Hepatitis C Settlement Plan. The claim was rejected based on No Proof of Blood in the Class Period. [The Claimant] submitted a Request for Review on August 5, 2008, asking for review of the rejection of the claim. As per the Rules of Appeal, Fund Counsel has forwarded the Claimant's supplementary evidence and submissions on

June 10, 2009, to the Administrator for our review and response. For ease of reference these pages have been paginated starting from page 66 through to page 98 (continued from the original appeal package). Pages 67 and 68 are affidavits prepared by [the Claimant's] cousins and pages 69 to 98 are copies of Hospital records from the [hospital].

### Facts

2. Page 22 – The claimant's Form 5 as received on December 13, 2007 indicated that [the Claimant] was transfused at [the hospital] on November 22, 1980. This form was not signed by the claimant. (later signed and submitted Pg 52)
3. Page 23 – Blood transfusion requisition dated November 22, 1980, from the [...] Hospital in which a request was made for 4 units of packed cells on a "routine crossmatch". There are unit numbers for 4 units of Blood on this form however there is no indication on this form that a transfusion was given.
4. Page 27 – Discharge Summary dictated by a Gastroenterologist and the end diagnosis was hemorrhagic gastritis. There was no mention of a Blood transfusion being given in this summary.
5. Page 54 – Canadian Blood Services (CBS) Final Traceback report was received May 16, 2008. CBS confirmed [...] Hospital has advised they searched their records and the patient was crossmatched for 4 units but there is no evidence he was transfused.
6. Page 56 – [The Hospital] further confirmed they searched their complete Blood Bank Record and the complete Patient Records checked the box beside the statement "Patient record available; Not transfused". The Laboratory Manager who completed the form also wrote – "Please see copy of letter sent to you in 1997."
7. Page 57 – Memo from [...] Supervisor Heamatology regarding search for evidence of a transfusion for [...]. The letter stated "Our Blood Bank records indicate these units were **not** transfused to him (emphasis hers). I also checked his medical records and there is no evidence of any transfusions occurring during his hospital stay."

### Summary of Supplementary Evidence

8. Page 67 – Affidavit of [...], the first cousin of the claimant. In paragraph 5 affirmed – Later that day or within the next few days of [the Claimant's] hospitalization, I visited [the Claimant] in the late afternoon/early evening". In paragraph 7, [the male affiant] affirmed that [the Claimant] was in the room by himself and had a protective plastic bag around his bed. He further stated that he remembers him being given an intravenous with clear fluids and as well a single bag of blood hung on a rack next to him with a tube running into his arm"
9. Page 68 – Affidavit of [the female affiant], a cousin of [the Claimant] [sic] affirmed that when she entered [the Claimant's] room he was alone and inside a protective plastic sheet that went around his bed. She further stated "He was being given an intravenous with some clear fluids and there was a single bag of blood hanging on a rack next to him with a tube running into his arm".
10. Pages 69 to 98 – Medical records from [the] Hospital. Pertinent pages are

as follows:

- Page 70 – Emergency Registration Form that noted [the Claimant] was brought into Emergency by his wife with a complaint of Rectal Bleeding. There are notations on this form that confirm a type and cross for 4 units of blood was sent. The doctor ordered Enteric Isolation and an Intravenous of 2/3 & 1/3 with KCL (potassium chloride). It is noted that he was admitted to an Isolation room at 1335 hours.
- Page 71 – History and Physical sheet in which the doctor wrote – Rectal bleeding, Thurs night –large amount – generalized abdominal pain – improves with BM – not outside country recently – began with diarrhea- weakened. Past history ulcer operation Age 16
- Page 72-76 – Doctor’s order sheets organized in chronological order. Pertinent orders are as follows:
  - Page 72 entry # 1 – Admit order and order for enteric isolation.
  - Page 72 entry # 2 – CBC result daily X 4 days (CBS [sic] means Complete Blood Count)
  - Page 73 entry # 3 – order dated Nov 22 – X-Type 4 units packed cells (sent ER)
  - Page 73 entry # 5 – order dated Nov 22 – IV 2/3 & 1/3 with 30 meq KCL/litre – 100 cc/hr
  - Page 75 entry # 1 – order dated November 24 – states D/C IV
  - Page 75 entry # 3 – order dated November 26 – Cancel enteric isolation
  - Page 76 entry # 5 – order dated December 6 – Home today
- Page 82 – 86 – Hematology requisitions in which the daily CBC was recorded. No mention on any of these requisitions that a blood transfusion was given.
- Page 97 – Anaesthesia Questionnaire completed on December 3, 1980 and signed by [the Claimant] – Box number 3 – Answered **No** to question – have you ever had a blood transfusion? [Administrator’s Emphasis]

### **Administrator’s Decision**

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”. [The Claimant’s] cousins do not fall within the Definition of Family member under the Settlement Agreement and their evidence may therefore be considered.

### **Evidence that does not support Receipt of Blood**

- On his Form 1 [the Claimant] indicated he believes he was transfused in 1980 at [the] Hospital.
- The Hematology Supervisor at the Hospital confirmed both in 1997 and in 2008 that the Blood Bank records and Patient Records were available and searched and there was no evidence the units that were crossmatched for him were transfused to him.

- On an Anaesthesia History form completed December 3, 1980 [the Claimant] stated he had never received a blood transfusion.
- Review of the medical records available from the time of his Admission indicated that he had an intravenous established upon admission on November 22, 1980 up until November 24, 1980.

**Supplementary Evidence to support transfusion**

- Affidavit of [the male affiant]
- Affidavit of [the female affiant]

**Conclusion**

The Administrator has an obligation to assess each claim and determine whether the required proof for compensation exists. The Administrator has no discretion to allow compensation where the required proof does not exist. Review of the medical records submitted from [the] Hospital support that [the Claimant] was crossmatched in preparation for possible transfusions however there is no Doctor's order that actually states to transfuse any of those four units of Blood. There does [sic] not appear to be any pages of the Doctor's orders missing from the medical records. Additionally the Hospital Blood bank has confirmed their records are available and there is no record of [the Claimant] receiving a transfusion of Blood during the time period in question. The Affidavits submitted have been reviewed and both Affiants have described seeing a transfusion. In weighing the statements made based on personal recollection of events that occurred 29 years ago, the review of the medical records and the results of Canadian Blood Services based upon the statements by the Supervisor of the Hematology Laboratory, the Administrator concludes that the evidence does not support 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.

[38] On July 17, 2009, the Claimant elected to continue with his appeal.

**SUPPLEMENTARY SUBMISSIONS MADE BY THE CLAIMANT ON APPEAL**

[39] By letter dated July 20, 2009, the Claimant made supplementary written submissions in which he noted, among other things, that the two affiants were credible and trustworthy witnesses whose evidence was submitted in compliance with the requirements of the *Proof of Receipt of Blood Protocol* and who saw him when he was isolation. With respect to the Department of Anaesthesia Questionnaire, summarized in paragraph 24, he explained that he checked the box "No" in response to the question "Have you ever had a blood transfusion?" due to the fact that he misunderstood the

question as applying to the period before his current hospitalization; he misinterpreted the question as English is not his first language, and his answer should have been “Yes”.

Given my conclusion on the appeal, it is unnecessary for me to determine whether any weight can be given to the Claimant’s statements concerning his misinterpretation of the question in the Anaesthesia Questionnaire, described in paragraph 24. Although the Administrator stated in its reconsidered Decision that the Claimant had answered “No” to the question “Have you had a blood transfusion?”, it is clear from the Questionnaire that he had initially answered “Yes” to the question before crossing it out and checking “No”. There was therefore obviously some confusion on his part about the question.

## **ISSUE**

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

## **ANALYSIS**

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

[41] 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.

[...]

[42] As indicated in the preceding quotation, subsection 2.01(2) of the *Settlement Agreement* and the *Proof of Receipt of Blood Protocol* must be read together.

Subsection 2.01(2) applies in circumstances where a claimant cannot comply with the requirement in paragraph 2.01(1)(a) to deliver records demonstrating the receipt of Blood. Paragraph 1 of the *Proof of Receipt of Blood Protocol* confirms as follows:

1. This protocol applies where there are no hospital records or where those available do not confirm receipt of Blood by the Primarily-Infected Class Member.

In such circumstances, subsection 2.01(2) requires, in mandatory terms, a person claiming to be a Primarily-Infected Class Member, such as the Claimant, to deliver corroborating evidence from an independent witness to establish on a balance of probabilities the receipt of Blood.

[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.

[47] There are no set rules for conducting an assessment of the reliability or trustworthiness of evidence. In circumstances such as the present where corroborating affidavit evidence of an independent witness is delivered under subsection 2.01(2) of the *Settlement Agreement* and sections 5 and 6 of the *Proof of Receipt of Blood Protocol*, the Administrator must examine and analyse the contents of the affidavit in order to determine whether the evidence is reliable. In assessing the reliability of the affidavit evidence, the Administrator may consider any relevant factors, including the following: other evidence in the claim file, from records or other sources, to corroborate any of the statements made by the witness in the affidavit; affidavit evidence of another independent witness or any other source of evidence permitted under the terms of the *Settlement Agreement* to corroborate the evidence in the affidavit; the level of detail provided in the affidavit; the circumstances that provided the affiant with an opportunity to make any observations; the actual opportunity that the witness had to make the observations; any evidence or other reliable information in the claim file that may cast doubt on the credibility of the affiant; and the cogency of the evidence. This list is not intended to be exhaustive; it is intended simply to give the Administrator some guidance concerning factors that could be relevant, depending on the case, in assessing the reliability of the corroborating affidavit evidence in future cases.

*ii) Did the Administrator err in its reconsidered Decision dated July 8, 2009?*

[48] The hospital records in the present claim do not confirm that the Claimant received blood during his hospitalization for hemorrhagic gastritis in November 1980 or

during any other time period. The claim is therefore governed by subsection 2.01(2) of the *Settlement Agreement* and sections 5 and 6 of the *Proof of Receipt of Blood Protocol*.

[49] In the analysis in the reconsidered Decision dated July 8, 2009, the Administrator stated that the Claimant was “[...] crossmatched in preparation for possible transfusions [...]”. However, there was no Physician’s Order to transfuse any of the four units of Blood and no pages appeared to be missing from the Physician’s Orders. Furthermore, the hospital Blood Bank records did not contain any record of the Claimant receiving a transfusion. In referring to the affidavits filed by the two independent witnesses to corroborate that the Claimant had received Blood, the Administrator stated that it had reviewed the affidavits and that “[...] both affiants have described seeing a transfusion”.

The Administrator concluded as follows:

In weighing the statements made based on personal recollection of events that occurred 29 years ago, the review of medical records and the results of the Canadian Blood Services based upon the statements made by the Supervisor of the Hematology Laboratory, the Administrator concludes the evidence does not support on a Balance of Probabilities [the Claimant] received a Blood transfusion in the class period.

[50] In referring in its analysis to the two corroborating affidavits of the independent witnesses, the Administrator simply stated that the affiants had “described seeing a transfusion”. However, the affiants did not just make an assertion that they had seen a blood transfusion. To the contrary, both affiants gave detailed evidence concerning the hospitalization of the Claimant, various conversations that took place at the time and other observations that they each made when visiting the Claimant in the hospital. In stating that the two affiants “described seeing a transfusion”, the Administrator erred by failing to consider or appreciate the totality of the evidence given by each of the two witnesses under oath.

[51] Furthermore, in determining that the evidence did not establish on a balance of probabilities that the Claimant had received Blood, the Administrator stated that the “statements” made by the independent witnesses were based on personal recollections that occurred 29 years ago. In its analysis, it made no other assessment of the reliability of the evidence in the corroborating affidavits of the two independent witnesses. As stated previously, the evidentiary framework in subsection 2.01(2) of the *Settlement Agreement* and sections 5 and 6 of the *Proof of Receipt of Blood Protocol* applies to certain claims that fall within the Class Period, including those relating to events that occurred before 1986. Furthermore, sections 5 and 6 of the *Proof of Receipt of Blood Protocol* specifically permit the delivery of corroborating affidavit evidence based on the personal recollection of an independent witness in all claims to which subsection 2.01(2) of the *Settlement Agreement* applies, including those that fall within the pre-1986 part of the Class Period. As a result, it was not open to the Administrator to rely upon the fact that the corroborating affidavit evidence was based on personal recollections from events occurring 29 years ago. Otherwise, that reason could be given as a basis for undermining the reliability of corroborating affidavit evidence in all of the claims for compensation in the pre-1986 part of the Class Period to which subsections 2.01(2) of the *Settlement Agreement* and the *Proof of Receipt of Blood Protocol* apply. Instead, the Administrator was required by section 5 of the *Proof of Receipt of Blood Protocol* to conduct a proper assessment of the reliability of the corroborating affidavit evidence in order to determine its inherent trustworthiness. The Administrator therefore erred in diminishing the weight to be accorded to the corroborating affidavit evidence of the two independent witnesses by stating that it related to events that occurred 29 years ago, given that the terms of the

*Settlement Agreement* and the *Proof of Receipt of Blood Protocol* expressly authorize and provide for the delivery of such evidence.

[52] With respect to the corroborating affidavit evidence of the two independent witnesses, I have decided to conduct the assessment of its reliability, rather than returning the matter to the Administrator.<sup>1</sup>

[53] In the corroborating affidavits, two independent witnesses gave their personal recollections concerning a blood transfusion received by the Claimant in 1980. Both witnesses were sufficiently close to the Claimant that they were informed when he was hospitalized and visited him frequently at the hospital: the male affiant visited the Claimant several times over the course of the week following his hospitalization; the female affiant lived only 10 minutes from the hospital and visited him “practically every day” during the first week and “many times” during his two week period of hospitalization. Both witnesses had gone to visit the Claimant in the hospital after receiving a call from the wife of the Claimant on November 22, 1980. The male affiant visited the Claimant as soon as he could “later that day or within the next few days”, in the “late afternoon or early evening”. The two affiants recalled that they ran into each other in the lobby and took the elevator together to see the Claimant. According to the male affiant, he and the female affiant visited the Claimant together on the occasion of his first visit to the hospital; from the perspective of the female affiant, they saw the Claimant together on one of her visits within the first few days of the hospitalization of the Claimant. Both affiants recalled that the Claimant was in isolation and that they were each given a gown and mask by a nurse to put on. They visited the Claimant together and found him alone with protective plastic around his bed. The male affiant was “[...]”

---

<sup>1</sup> See, by way of analogy, the approach taken by Rothstein J. in *Apotex v. Sanofi-Synthelabo Canada Inc.*, 2008 SCC 61 at paragraph 72.

alarmed to see him in a very weak state”. Both affiants recalled that the Claimant was being given an intravenous with clear fluids and that “[...] there was a single bag of blood hung on a rack next to him with a tube running to his arm”. The male affiant specifically asked the Claimant about the blood. The Claimant told him that he was receiving blood because he had lost a lot of blood through his rectum and had bled for three days; he had gone to the hospital before but was sent home and then returned in worse condition. The female affiant was present during the conversation between the male affiant and the Claimant and related it in her affidavit.

[54] In assessing the reliability of the corroborating evidence given by the two independent witnesses, there are several important points to be made. First, two independent witnesses have sworn affidavits to corroborate the receipt of Blood by the Claimant. Both of these affiants had an opportunity to make their observations, as they each visited the Claimant in the hospital frequently. Although there are some differences in the affidavits concerning the timing of the visit when they saw the blood transfusion, the two witnesses corroborate each other’s evidence in all other material respects, particularly concerning what they saw and heard while visiting with the Claimant in the isolation room. In particular, they have both sworn that they saw a “single bag of blood hung on a rack next to him with a tube running into his arm” and that the male affiant had a conversation with him about the blood. The female affiant corroborated the evidence of the male affiant concerning the conversation that he had with the Claimant in her presence. Second, the two affidavits provide a significant amount of detail concerning the visit to the hospital, their meeting in the lobby, their observations while in the isolation room with the Claimant and the conversation between the male affiant and the Claimant. The level of detail provided in the two affidavits demonstrates that the visit with the

Claimant, who was seriously ill in an isolation room in the hospital, was a significant event for the two affiants, something unexpected and out of the ordinary that has not faded into the recesses of memory with time. The fact that the male affiant stated that he was “alarmed” to see the Claimant in his weakened state supports the inference that this was a shocking event for him and something that he would remember. Third, several of the important facts related in the two affidavits are confirmed in hospital records: the Claimant was in isolation, was receiving fluids by intravenous, had rectal bleeding, had experienced bleeding for three days, had visited the Emergency Room the day before his admission, was sent home and had returned the next day due to his bleeding. The only material fact in the two affidavits that was not confirmed in the hospital records, other than the conversation between the male affiant and the Claimant, was the blood transfusion itself. Finally, there is no apparent reason to doubt the credibility of these two witnesses, each of whom has come forward to swear under oath, in a detailed affidavit, that the Claimant received a blood transfusion on the occasion in question. For these reasons, I have concluded that the corroborating affidavits of the two independent witnesses contain reliable evidence of the receipt of Blood by the Claimant.

[55] I have carefully considered all of the evidence in this matter, including the reliable corroborating affidavit evidence of the two independent witnesses, and have concluded that the evidence, when considered in its totality, establishes on a balance of probabilities that the Claimant received Blood in Canada during the Class Period, within the meaning of subsection 2.01(2) of the *Settlement Agreement*.

**CONCLUSION**

[56] The appeal is allowed.

"D. McGillis"

---

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

DATED August 12, 2009

TO: Claimant  
Fund Counsel  
Administrator