DECISION

BACKGROUND

1. On April 6, 2005 , the Administrator denied the Personal Representative's request for compensation under the Transfused HCV Plan on the basis that the Personal Representative failed to establish that the HCV Infected Person was infected by HCV for the first time by a blood transfusion received in Canada during the Class Period.

2. On April 26, 2005, the Personal Representative requested that the Administrator's denial of the claim be reviewed by a referee.

3. On June 8, 2006, I conducted a hearing in North Bay, Ontario.

EVIDENCE

4. The Fund was represented by Fund Counsel. The Personal Representative was represented by an agent. Four witnesses were called to testify at the hearing. The following were called on behalf of the Personal Representative: the widow of the HCV Infected Person and Dr. Andre Rivet. The Fund called Carol Miller, the Claims Coordinator for the Fund, and Dr. Gary E. Garber.

5. The parties agreed that the deceased was infected with HCV. The dispute was whether the deceased was infected with HCV as a result of a blood transfusion in 1987. The HCV Infected Person died in North Bay General Hospital on December 23, 2001. The attending physician, Dr. Andre Rivet, noted that the final cause of death was "terminal cirrhosis of the liver secondary to Hepatitis C."

6. In 1987, the HCV Infected Person had been transfused with 9 units of blood at the North Bay General Hospital: 3 units on August 26, 1987, 4 units on August 27, 1987, and 2 units on August 28, 1987. A traceback was conducted. Eight of the blood donors tested negative for HCV. One donor has not been located.

7. Carol Miller, testified that due to conflicting evidence, she contacted Dr. E.J. Heathcote, a hepatologist, about the HCV Infected Person's IV drug use. Dr. Heathcote and Dr. M. Terrault's report dated September 22, 1992 notes a purported history of IV drug use. Dr. Heathcote supplied clinic notes from September 1992 where a doctor stated that the HCV Infected Person informed him he used IV drugs when he was 15-16 years old.

8. Dr. Gary Garber was qualified as an expert witness to give opinion evidence on behalf of the Fund regarding the causes of Hepatitis B and C and the progression of both diseases. He is the Professor and Head of the Division of Infectious Diseases at the University of Ottawa/The Ottawa Hospital. Dr. Garber did not know or examine the HCV Infected Person. His testimony was based on his review of the medical records which were forwarded to him.

9. Dr. Garber testified that exposure to Hepatitis B could be a marker of exposure to Hepatitis C as both diseases have similar risk factors, such as injection drug use. He noted that on April 7, 2006, the family physician ordered blood tests for the deceased. The laboratory report noted that the Hepatitis B core antibody was positive, which Dr. Garber interpreted to mean that the deceased was exposed to Hepatitis B sometime earlier in his life.

10. Dr. Garber also testified that it could be possible that the deceased became infected with Hepatitis C in 1968 if he used intravenous drugs at that time. As the disease may take 15 years or more to be fatal, the progression of the disease could lead to death in 2001.

11. It was Dr. Garber's opinion that it would be more unlikely that if the deceased were first infected with Hepatitis C in 1987, that he would die in 2001 as a result of that exposure. However, he acknowledged that it was "within the realm of possibility" that if the deceased were first infected with HCV from his 1987 transfusion, his death could have resulted from the transfusion.

12. Dr. Garber testified that as only 1 unit of blood had not been traced, there was a low probability that one unit was infected with HCV. When he balanced this fact with the other potential exposures for the deceased which might result from intravenous drug use and the presence of Hepatitis B, he concluded that the blood transfusion in 1987 was probably not the source of the deceased's HCV infection.

13. Dr. Andre Rivet testified that he has been the deceased's physician since 1985. He claimed there was no proof that the deceased had been infected with Hepatitis B. In his view, the first core antibody test which was positive for Hepatitis B, was a false positive. He had the blood test repeated on October 1, 1992. The hepatitis B surface antigen and surface antibody and the hepatitis Be antigen and antibody were both negative.

14. Dr. Rivet acknowledged that the deceased abused alcohol. He testified, however, that he was not aware of any IV drug use on the part of the deceased. The deceased was first diagnosed with HCV infection in 1992. Dr. Rivet testified that there was nothing to suggest that the deceased had been infected with Hepatitis B or C prior to 1987. Although the deceased had elevated liver enzyme levels in the 1980s, that could be traced to alcohol abuse.

15. Dr. Rivet pointed out that when the deceased abstained from alcohol, his liver function studies were normal, as borne out by liver function tests in 1983 and 1985. Dr. Rivet accepted that the IV drug use that had been referred to by the deceased related to intravenous drugs received in a hospital setting for other medical issues.

ANALYSIS

16. The Settlement Agreement provides that if a Personal Representative cannot comply with the provisions of section 3.01(3) because the HCV Infected Person used non-prescription intravenous drugs, then he or she must deliver to the Administrator other evidence establishing on a balance of probabilities that the deceased was infected for the first time with HCV by a blood transfusion in Canada during the Class Period.

17. The Administrator relied on medical documents, including a letter from Dr. Heathcote, a hepatologist, dated September 1992, stating that the deceased had a history of IV drug use. Dr. Heathcote supplied a copy of her clinic notes from that same date in which a doctor stated that the HCV Infected Person informed him that he had used "IV drugs age 15-16."

18. The Administrator concluded that the Court Approved Protocol ("CAP") for non-prescription intravenous drug use was applicable in the circumstances. The CAP requires the Administrator to weigh the totality of evidence obtained from the additional investigations required by the CAP and determine whether, on a balance of probabilities, the HCV Infected Person meets the criteria for eligibility.

19. In response to the Administrator's request for additional information, the Personal Representative forwarded complete medical records for the HCV Infected Person and an affidavit dated July 14, 2004 from the deceased's widow. The Administrator was not persuaded that, on a balance of probabilities, the HCV Infected Person met the eligibility criteria.

20. This is a difficult case. The Personal Representative must prove on a balance of probabilities that the deceased was first infected by Hepatitis C as a result of a blood transfusion in Canada during the Class period.

21. Although some evidence was presented of possible IV drug use by the deceased, it was contradictory and confusing. On February 25, 2003, Dr. G. Franko, a specialist in internal medicine, wrote a report documenting that the deceased had vehemently denied having taken illicit intravenous drugs, his wife, who had known him since he was sixteen, had never seen him taking IV drugs, and Dr. Rivet, his family physician of 18 years, stated he was not aware of the deceased having ever used IV drugs. Dr. Franko noted that the deceased's liver function tests were normal according to studies dated March 16, 1983 and August 24, 1985, after periods of abstinence from alcohol. This would indicate the absence of any hepatic disease at that time. According to Dr. Franko, the severely abnormal liver function and positive hepatitis C tests occurred after 1987. He

stated that this supports a conclusion that prior to 1987, the deceased did not have any significant liver pathology. Dr. Franko stated in his report that if the deceased had a persistent hepatitis from his teenage years, he would have expected his liver function studies in 1983 and 1985 to be abnormal. Dr. Franko concluded that it would seem that the deceased's Hepatitis C infection was from a blood transfusion in 1987 and possibly not due to illicit IV drug use in his very distant past.

22. The evidence of Dr. Garber, the expert witness for the fund, was compelling and informative. Although Dr. Garber testified that the disease progression for the deceased was more consistent with Hepatitis C infection from 1968, he was not prepared to testify that the claimant could not have contracted Hepatitis C as a result of the 1987 blood transfusion.

23. I do not accept that there is evidence that the deceased was infected with Hepatitis B. It appears that the first blood test for Hepatitis B may have been a false positive. At best, the tests for Hepatitis B were inconclusive. Therefore, one cannot assume that the deceased was exposed to similar risk factors as those associated with Hepatitis C.

24. Dr. Rivet was unequivocal in his testimony that the deceased's cause of death was Hepatitis C, which was accelerated by alcohol abuse. He diagnosed the HCV Infected Person as at a disease level 6 on May 26, 2000.

25. I have weighed the totality of the evidence before me. Although I attach significant weight to Dr. Garber's expert testimony, Dr. Garber admitted that it was "within the realm of possibility" that the HCV Infected Person's death could have occurred as a result of the 1987 blood transfusion. I was persuaded by Dr. Rivet's testimony and Dr. Franko's report that the most likely source of the HCV Infection which caused the death of the HCV Infected Person was a blood transfusion in 1987. I find that the Personal Representative has established on a balance of probabilities that the HCV Infected Person was infected by HCV for the first time by a blood transfusion in Canada during the Class Period.

CONCLUSION

26. The Personal Representative is successful in her claim for compensation under the Transfused HCV Plan. I overturn the Administrator's denial of the Personal Representative's request for compensation under the Transfused HCV Plan.

Judith Killoran
Referee

August 31, 2006
Date