IN THE MATTER OF AN ARBITRATION TO REVIEW

THE DECISION OF THE ADMINISTRATOR UNDER THE HCV 1986-1990

TRANSFUSED SETTLEMENT AGREEMENT

Province of Infection: Saskatchewan

Province of Residence: British Columbia

Claim No.: 18523

Before: Vincent R.K. Orchard, Q.C., Arbitrator

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DECISION

Claim ID: 18523

I. INTRODUCTION

1. This arbitration concerns a request for review of a denial by the Administrator of a claim for compensation under the Transfused HCV Plan (the "Plan") made by the Claimant to the Administrator. The Administrator denied the claim for reasons set forth in a letter dated December 17, 2009, namely that the claim did not meet the criteria established under Article 3.01(3) of the Plan which requires a Primarily-Infected Person who used non-prescription intravenous drugs ("IV Drugs") to establish on a balance of probabilities that he was infected for the first time with HCV by a Blood transfusion in Canada during the class period.

2. The Claimant received two units of blood by way of transfusion on November 22, 1988. One unit was determined to be negative and the other unit was inconclusive as the donor had died.

3. The Claimant admitted that he had intravenously used IV Drugs but only for a very brief time in his life when he was a very young man. He deposed to having used IV Drugs in 1974 on more than one occasion but he says he never shared needles.

4. The Claimant requested review of the Administrator's decision by way of arbitration. A hearing was held on February 9, 2011 in Nanaimo, British Columbia and continued by telephone conference on August 30, 2011 to permit questioning of an expert medical witness, Dr. Gary Garber, a specialist in infectious diseases.

5. The drafters of the Plan, which has received court approval under the terms of the 1986-1990 Hepatitis C Settlement Agreement ("Settlement Agreement"), have drafted special rules for claims made by or on behalf of IV Drug users requiring a stricter burden of proof than the burden of proof required of claimants who are not or never have been IV Drug users. Under the Settlement Agreement a Court Approved Protocol for Non-Prescription Intravenous Drug Use ("CAP") confirms that stricter burden of proof.

6. As I understand it, if the Claimant had not been an IV Drug user, he would have been entitled to compensation under the Plan because of three factors:

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(i) a diagnosis of HCV;

(ii) a blood transfusion in the Class Period; and

(iii) an inconclusive Traceback.

7. Under the CAP the Administrator is required to consider the opinion of a medical specialist experienced in treating and diagnosing HCV. The Administrator is charged with the task of weighing the evidence, including medical opinion, and determining whether the Primarily-Infected Person has met the onus based on a balance of probabilities.

8. The Administrator obtained the opinion of Dr. Garber, a doctor designated to provide an opinion.

9. In a letter dated November 27, 2009, Dr. Garber wrote in part:

> There are several possible Hepatitis C infection exposure points. In 1974 during injection drug use, 1988 when one unit of blood which cannot be tested [sic] and in 1990 when he had a tattoo. Any or all of these could be potential infection points. He was a relatively slow progressor and he did not have significant liver damage when workup was done in 2007.
>
> What is the likeliest source? One untested unit of blood certainly is a potential source of infection as well the use of injection drugs in the 70s when it was not commonly known that needles as well as supplies and diluent could all be sources of hepatitis C was a potential risk. The client does give an interesting story of having had a box of needles during this time course which he then ended up throwing out with after his short course of intermittent injection drug use. There is no question that during that period this certainly was a potential risk factor.
>
> From a time perspective all the entry points were certainly greater than 15 years before the discovery of his hepatitis and clearly any of them could have been the potential trigger point and I am not able to ascertain with precision which of these time points was the likeliest infection source. I do think that his prior exposure to hepatitis B would suggest that a non blood source must be considered seriously.

10. Dr. Garber did not appear as a witness at the hearing on February 9, 2011. Since the Administrator was relying upon the opinion of Dr. Garber, in addition to other evidence, I adjourned the hearing so that the Claimant could have an opportunity to put questions to Dr.

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Garber. The Claimant took advantage of the opportunity and submitted five questions in writing for Dr. Garber. Dr. Garber also appeared for questioning by telephone conference on August 30, 2011. During the telephone conference, Dr. Garber responded to questions from Fund Counsel, a number of questions, including those submitted in writing, from the Claimant and some questions from the Arbitrator.

11. Dr. Garber is a professor and head of the division of infectious diseases at The Ottawa Hospital/University of Ottawa. He has substantial clinical experience in diagnosing and treating patients with Hepatitis C and other infectious diseases. He has testified in a number of other appeals of this nature and has been accepted as an expert. He gave his evidence in an unbiased, objective manner. I accept his qualifications to give expert opinion concerning HCV.

12. Dr. Garber noted that the Claimant is Hepatitis B Surface Antibody Positive indicating a prior infection through infected blood or other bodily fluid. Such infection is commonly associated with IV Drugs, although where and when the Claimant contracted Hepatitis B is unknown. However, the blood supply in Canada was screened for Hepatitis B in the 80's. Just as Dr. Garber cannot ascertain with precision the three potential trigger points of the Claimant's Hepatitis C, he could not with precision ascertain the potential trigger point for the Hep B. Dr. Garber explained that exposure to Hep B from an infected needle is the highest level of likelihood as opposed to contamination from sexual contact where it is apparently known that the risk is much lower despite years of potential exposure. Dr. Garber said that there is 100% risk of infection from a contaminated needle but that is far from true for sexual contact. Upon further questioning Dr. Garber indicated that he could not say for sure where the Hep B came from but it was unlikely to be from the transfusion in 1988.

13. The Claimant made a number of points in oral argument and in writing why he believes it is likely he was infected with HCV from the transfusion in 1988 as opposed to the other trigger points discussed by Dr. Garber. I will not repeat all of the Claimant's arguments but I have considered those points. One of those points was that the Claimant had a rare type of Hepatitis C known as genotype 3 which he suggested points to a later infection date rather than 1974 when he used IV Drugs. In Dr. Garber's opinion, genotype 3 is not a rare genotype and 15% to 20% of Hep C patients present with genotype 3.

14. Dr. Garber did mention the Claimant's past custodial sentence as a general risk factor but he was not identifying it in this case as a specific risk factor. The Claimant testified

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that his custodial sentence did not involve being institutionalized but rather involved an outdoor work experience, more like an outward bound program. He has long since been pardoned for his offence and I believe that the Claimant has lead a productive and useful life since that time.

15. The Claimant also argued that since his Hep C disease was not identified until 2007, it is more likely he was infected in the late 80's rather than in the early 70's. If he had been infected in the early 70's he suggests the disease most likely would have been further advanced. Dr. Garber's testimony did not accord with that proposition. He explained that the acceleration of the disease does not often occur until the patient is in his or her 50's despite an exposure many, many years before. He said that while logic might suggest that the longer one has been infected with the disease the sooner it will show, that is not really the case in his clinical experience.

16. Dr. Garber was asked why the disease might not show up on a blood test if the patient had been infected for over 30 years. Dr. Garber explained that routine blood tests in the past did not involve liver function tests. The Claimant could have had blood tests but not been given liver function tests. The Claimant did not specifically testify whether he had blood tests prior to 2007. In 2007 the Claimant was given liver function tests which showed increased liver enzymes. Fortunately for the Claimant it appears he has now cleared the virus and has a 98% chance of being free of Hep C.

17. Dr. Garber's oral testimony confirmed his written opinion that he could not state, on a balance of probabilities, which potential trigger point, the IV Drug use in 1974, the transfusion in 1988 or the tattoo in 1990 caused the Hep C infection. He confirmed that both the 1974 IV Drug use and the 1988 transfusion are reasonable trigger points from a chronological point of view. He maintained his neutrality that neither the 1974 IV Drug use nor the 1988 transfusion is more likely.

II. THE PLAN AND THE CAP

18. Article 3.01 of the Plan sets out the required proof for compensation. Article 3.01 reads in part as follows:

> **3.01 Claim by Primarily-Infected Person**
>
> (1) A person claiming to be a Primarily-Infected Person must deliver to the Administrator an application form prescribed by the Administrator together with:

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(a) medical, clinical, laboratory, hospital... records demonstrating that the claimant received a Blood transfusion in Canada during the Class Period;

(b) An HCV Antibody Test Report, PCR Test, 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,** (ii) to the best of his or her knowledge, information and belief, that he or she was not infected with Hepatitis Non-A Non-B or HCV prior to 1 January 1986, (iii) as to where the claimant first received a Blood transfusion in Canada during the Class Period, and (iv) as to the place of residence of the claimant, both when he or she first received a Blood transfusion in Canada during the Class Period, and at the time of delivery of the application hereunder. [Emphasis added]

...

(3) Notwithstanding the provisions of Section 3.01(1)(c), if a claimant cannot comply with the provisions of Section 3.01(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 a Blood transfusion in Canada during the Class Period. [Emphasis added]

19. As noted above the Claimant was a recipient of a blood transfusion in Canada during the Class Period. A Traceback was conducted to determine if any of the Blood received from a donor was determined to be HCV and anti-body positive. The results of the Traceback were inconclusive as one of the donors was deceased.

20. As the Claimant had an admitted history, albeit brief, of IV Drug use, the Claimant, has a burden of providing further evidence to the Administrator in support of his claim in accordance with the Plan and the CAP.

21. Almost the entirety of the CAP is relevant. I summarize its relevance as follows:

(i) The CAP applies because of an admission that the Claimant used IV Drugs;

(ii) The effect of sections 2 and 3 of the CAP is to put the burden of proof on the Claimant to satisfy the Administrator, on the balance of probabilities, that he was infected by a Blood transfusion received in Canada within the Class Period;

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(iii) Under Section 4 of the CAP, the Administrator must conduct a Traceback unless certain circumstances apply. None apply in this case, therefore the Administrator conducted a Traceback;

(iv) Under paragraphs 8 – 13 of the CAP, the Administrator must perform additional investigations where the claim is not rejected under the Traceback. In this case, the Claim was not rejected under the Traceback. For example, under Section 8(b), the Administrator shall 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 Person is more consistent with infection at the time of receiving the Blood, the Class Period blood transfusion(s) ... or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence.

22. There a number of references in the CAP to the Administrator's responsibility to weigh the evidence and to consider the totality of the evidence.

III. ANALYSIS

23. The documents from the claim's file reveal the Administrator's office conducted a thorough review and investigation before denying the claim on December 17, 2009. The Administrator had relevant medical records of the Claimant, affidavit evidence from the Claimant and the opinion of Dr. Garber. The Administrator also conducted a Review by Committee, specifically the IDU (Intravenous Drug User) Committee which consisted of two managers and a claims examiner. The decision of the Committee was reached on December 16, 2009. The Committee reviewed both supportive and non-supportive factors related to the claim and made its findings in writing in a four page document. The Committee, concluded that the Claimant had not satisfied the onus of proof. It appears from the file that the Committee carried out its mandate under the Plan and the CAP appropriately.

24. Dr. Garber was provided with 110 pages of the claim's file including all relevant medical records and claims documents.

25. In a previous decision under the Transfused Settlement Agreement, in Claim No: 5714, I determine that the standard of review of the Administrator's Decision to deny the Administrator's Decision in this context is one of correctness.

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26. The drafters of the Settlement Agreement, the Plan and the CAP intended that IV Drug users would be presented with a more difficult burden in proving that a blood transfusion during the Class Period is a source of their HCV infection.

27. It is clear that the Administrator followed carefully the CAP and conducted the investigation as required. The Administrator obtained an independent medical opinion from Dr. Garber. The Administrator reviewed all available medical and clinical records. The Administrator took into account Dr. Garber's opinion that he could not ascertain with precision which of the three remote sources of infection, IV Drug use in 1974, the transfusion in 1988 or a single tattoo in 1990, is the likeliest infection source. All are possibilities.

28. Regrettably this Appeal must fail. The Claimant submits that since he was not found to be Hepatitis C positive until 2007 as part of an application for insurance, the infection may more likely have occurred closer in time to 2007, i.e. infection in 1988 is more likely than infection in 1974. The Claimant submits that had he been infected in 1974 his condition would have been diagnosed before then. There is no evidence before me to substantiate the inference. The Claimant submitted no medical evidence to confirm his point. Dr. Garber testified that while one might draw that inference based on logic, i.e. the longer one is infected, the sooner the disease will show; however, that is not really the case based on clinical experience. Apparently, the disease may be stable over a long period of one's life and then accelerate when one is in his or her fifties.

29. The difficulty for the Claimant is the wording of Article 3.01(3) and the CAP which puts the onus on the Claimant to establish on a balance of probabilities that he was infected for the first time with HCV by the 1988 blood transfusion. Unfortunately for the Claimant, the most that can be said is that the transfusion is an equal possibility as a source of infection with his previous IV Drug use. That is not enough under the Plan to tip the scale in his favour.

30. Fund Counsel made the point that neither he nor the Administrator were judging the Claimant's lifestyle. I certainly accept that the Claimant was involved with IV Drug use only for a short period of time when he was quite a young man and turned his life around since then.

31. In civil law the party who has the onus of proof, and here it is the Claimant, must tip the scale in his or her favour. In this case at best the scale is evenly balanced. Unlike baseball a tie does not go to the runner. Therefore I say, with regret, I must dismiss this Appeal. I am not able to conclude the Administrator's decision was incorrect. No error of law or fact has been

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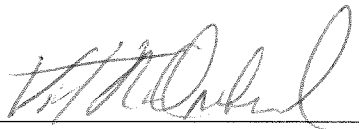
shown. No misapprehension of the evidence has been shown. I therefore uphold the Administrator's denial of the claim.

DATED at Vancouver, British Columbia, this 30th day of September, 2011.



Vincent R.K. Orchard, Q.C., Arbitrator

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