D ECISION Claim # 100

Introduction

1. The Claimant, a New Brunswick resident, was born on June 29, 1956. She submitted a claim for compensation as an HCV Primarily Infected Person (HCV) in accordance with the terms and conditions of the Transfused HCV Plan (the Plan). She completed a General Claimant Information Form (TRAN 1) on October 31, 2000, in which she stated that she had been HCV infected, following a blood transfusion received in Canada between January 1, 1986 and July 1, 1990, the Class Period.

2. In his letter to the Claimant dated December 3, 2002, the Class Action Settlement Administrator rejected the claim on behalf of the 1986-1990 Hepatitis C Claims Center on the basis that the Claimant had not provided enough proof confirming that she had received a blood transfusion during the Class Period.

3. The Claimant submitted a Request for Review dated January 3, 2003, asking that a Referee review the Administrator's decision and I was appointed to hear the appeal. The hearing took place in Moncton over a six day period: May 30, 2003, January 24, 2004, August 16 and 17 and June 6 and June 7, 2006. The Administrator was represented on May 30, 2006 by Me John Callaghan and Me Maxime Faille and, subsequently, by Me Faille. As for the Claimant, she represented herself on May 30, 2003 and was subsequently represented by Me Honoré Bourque. All testimonies were given under oath. For Me Bourque's benefit, the witnesses called by the Claimant on May 30, 2003, including the Claimant herself, testified a second time at the August 16 and 17, 2005 hearing. At the end of the hearing on June 7, 2006, I indicated that I would render my decision within 60 days.

4. It was agreed that the Claimant was an HCV infected person. However, in order to benefit from the compensations set out in the Plan, the Claimant must be a "Primarily-Infected Person" as stipulated in Section 1.01:

> "Primarily-Infected Person" means a person who received a Blood transfusion in Canada during the Class Period and who is or was infected with HCV unless:

> a. it is established on the balance of probabilities by the Administrator that such person was not infected for the first time with HCV by a Blood transfusion received in Canada during the Class Period;

5. Under this definition, the Administrator had to prove on the balance of probabilities that the Claimant had not been infected for the first time by HCV following a Blood transfusion received in Canada during the Class Period.

6. Section 3 of the Plan sets out two methods to establish that the Claimant received a Blood transfusion in Canada during the Class Period: through medical files or through independent corroborating evidence provided by the Claimant and by any person who is a Family Member:

> 3.01(1) A person claiming to be a Primarily-Infected Person 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 a Blood transfusion in Canada during the Class Period;
>
> 3.01(2) Notwithstanding the provisions of Section 3.01(1)(a), if a claimant cannot comply with the provisions of Section 3.01(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 a Blood transfusion in Canada during the Class Period.

7. Under this Section, it was incumbent upon the Claimant to establish on the balance of probabilities that she had received a Blood transfusion in Canada during the Class Period.

8. Finally, mention must also be made of Section 3.04 of the Plan. This Section requires that the Administrator reject the Claim if "a Traceback Procedure" allows him to establish that one of the donors of the blood received by the Claimant before the Class Period had been HCV infected or that none of the donors of the blood received by the Claimant during the Class Period had not been HCV infected:

> 3.04(1) Notwithstanding any other provision of this Agreement, if the results of a Traceback Procedure demonstrate that one of the donors or units of Blood received by a HCV-Infected Person or Opted-Out HCV Infected Person before 1 January 1986 is or was HCV antibody positive or that none of the donors or units of Blood received by a Primarily-Infected Person or Opted-Out

> Primarily Infected Person during the Class Period is or was HCV antibody positive, subject to the provisions of Section 3.04(2), the Administrator must reject the Claim of such HCV Infected Person and all Claims pertaining to such HCV Infected Person or Opted-Out HCV Infected Person including Claims of Secondarily-Infected Persons, HCV Personal Representatives, Dependants and Family Members.

Part A: Was the Claimant HCV infected before her alleged Blood transfusion?

9. The written submission tabled before the first day of the hearing on behalf of the Administrator did not raise the possibility that the Claimant had been HCV infected before her alleged blood transfusion during the Class Period. The author of this submission merely explained the basis of the Administrator's decision according to which the Claimant had not submitted sufficient proof that she had received a blood transfusion during the Class Period. However, during the hearing, Me Faille raised three elements of proof that could possibly counter any allegation to the effect that the Claimant had been HCV infected for the first time following her alleged transfusion during the Class Period.

10. First of all, a letter dated February 18, 1997 from Dr. K. M. Peltekian, the Claimant's Treating Hepatologist, contains the following written comments:

> This 40-year old lady ... has multiple risk factors for chronic hepatitis C including blood transfusions between 1984 and 1987 during surgery for hysterectomy and occupational since she had worked in the federal and provincial correctional centers, and more recently she has been working as the sheriff s coroner. This would definitely allow exposure with contaminated blood.

11. The TRAN 2 Form contained a question asking the Claimant's Treating Physician if the Claimant had "a medical history with regards to the following hepatitis "C" risk factors. "Incarceration" was mentioned in the form as being a risk factor. Although there was no suggestion that the Claimant had been incarcerated, Dr. Peltekian's opinion, according to whom the Claimant was at higher risk of HCV infection because of her working environments, could not be disputed. Nevertheless, when cross-examined at the hearing, the Claimant denied that her former employments had put her in direct contact with the blood of inmates or of others and the Administrator submitted no other proof establishing on the balance of probabilities that such contacts had taken place or had resulted in the transmission of the virus to the Claimant.

12. Secondly, the files of the Hôpital Hôtel-Dieu of Edmunston showed that the Claimant had received on May 20, 1979 a transfusion of one unit of a product called Koate to treat a gingival problem following an odontectomy. The only medical proof with regard to Koate was submitted at the August 17, 2005 hearing by Dr. Connolly Norman, the retired Chief of Hematology and Transfusional Medicine at the Saint John Regional Hospital, the same hospital where the Claimant alleged to have received a blood transfusion during the Class Period. According to Dr. Norman's testimony:

a. The definition of blood stipulated in the Plan does not include Koate but Koate is still a blood product often given to haemophiliacs in order to trigger coagulation.

b. Koate is a reconstitution of blood coming from multiple donors and for that reason, creates a greater risk of transmission of various viruses including HVC than would a blood product coming from a single donor; amongst haemophiliacs, it has been shown that the rate of infection caused by different viruses through Koate transfusions has been as high as 70 to 80 %.

c. As a consequence, Koate was submitted to a special process in order to try to prevent such transmissions but in 1979, the year that Koate was transfused to the Claimant, such measures were less effective than they were as of the middle of the eighties; yet, Dr. Norman admitted that he had limited knowledge of the efficiency of such existing measures in 1979.

d. The Koate transfusion in 1979 constituted a risk factor in the medical history of the Claimant, but "it was not necessarily the cause" of her infection; during his cross-examination, Dr. Norman recognized that he had no knowledge of a case where HCV had been transmitted through a Koate transfusion.

13. In my opinion, Dr. Norman's testimony did not establish, on the balance of probabilities, that Koate received by the Claimant in 1979 was HCV infected, nor that measures taken in 1979 to prevent HCV transmission through a Koate transfusion were not effective enough to protect the Claimant against such transmission, nor that the Claimant had been HCV infected as a result of her transfusion of this product in 1979, before the date of her alleged blood transfusion.

14. The Administrator submitted another element of proof which, according to him, made him suspect that the Claimant had not been HCV infected for the first time following her alleged transfusion during the Class Period. In this case, he proposed two medical opinions pertaining to the normal progression of hepatitis C.

15. A letter dated October 12, 1999 from Dr. M.B. El-Safadi, the Claimant's Treating Gastroenterologist, states the following:

> She had a liver biopsy in August and they said that she was at disease level three (inflammation) and at disease level four (fibrosis), which constitutes a cirrhosis
> …
>
> **IMPRESSION**: Hepatitis C that seems to be aggressive, does not respond to Interferon. She is currently at the cirrhosis stage. Still, I find that it is a little bit unusual [sic] that her hepatitis C has progressed within a 10-year period, if it is alleged that she did contract this virus in 1988.

16. While he recognized that he was not a clinical doctor, Dr. Norman also opined that it would be "unusual" to observe that there was a time period of only ten or twelve years between the HCV infection date and the cirrhosis stage. In his opinion, a twenty-year time period would be "more likely, assuming that there was an infection in 1979". During his cross-examination, Dr. Norman agreed that a time period of only twelve years between the HCV infection date and the cirrhosis stage was possible.

17. In my view, such medical opinions raise too many doubts to be claimed as proof, on the balance of probabilities.

18. According to Dr. Malatjalian's report, the pathologist who performed the liver biopsy on which Dr. El-Safadi based his opinion, the result obtained was only "suggestive of a possibility of cirrhosis". We must also note that Dr. El-Safadi found that the progression of the Claimant's disease was only "a little bit unusual". Finally, his report mentioned a time period of about 10 years, while the time period between the date of the alleged blood transfusion received by the Claimant in September 1987 and not in September 1988, and the date of Dr. El-Safadi's report noting the cirrhosis stage in October 1999, was of 12 years.

19. As for Dr. Norman, he seemed to want to imply that the progression of the disease would have been more compatible with an infection in 1979 but only if it was presumed that there had been an infection in 1979. If Dr. Norman meant that a cirrhosis stage in 1999 confirmed, without *any other proof,* that the Claimant had been infected in 1979, he did not say it. And although he said that a time period of twelve years between the date of the HCV infection and a cirrhosis stage would be "unusual', he agreed that such a progression was possible. If he meant that such a progression was improbable, he did not say that either.

Part B: Did the Claimant receive a blood transfusion during the Class Period?

20. The Claimant did not submit the kind of documentary evidence stipulated in Section 3.01(1) a) of the Plan, i.e., "medical, clinical, laboratory, hospital, Canadian Red Cross Society, Canadian Blood Services or Héma-Québec files showing that the Claimant had received a blood transfusion in Canada during the Class Period". To prove her allegation that she had received a blood transfusion during the Class Period, the Claimant invoked Section 3.01 (2) of the Plan and relied on her own testimony and that of four other witnesses: her mother, her sister, her friend, W. K., and her work colleague, F.C. They testified, all five of them, that the Claimant had received a blood transfusion at the Saint John Regional Hospital on September 8, 1987. The Claimant also called a witness according to whom a blood transfusion could have been required for the Claimant during the same hospitalization.

21. For his part, the Administrator argued that the Claimant had not discharged the burden of proof in accordance with Section 3.01{2} because, in spite of her testimony, other elements of proof eliminate all probabilities that such a transfusion had taken place.

22. Here are the various steps of my presentation of the questions and data at issue in this part of the decision. In the first instance, I will explain why, in my opinion, the testimony of the members of the family is acceptable. Secondly, I will describe the Claimant's testimony as well as that of her four witnesses. Thirdly, I will describe the proof on the matter as to whether the alleged transfusion was required. Fourthly, I will describe the elements of proof that, according to the Administrator, eliminate all probability that the alleged transfusion was required.

Was the testimony provided by the Family Members of the Claimant admissible?

23. The Administrator questioned the validity of the Claimant’s testimony and that of her witnesses but did not dispute the admissibility of the testimony of the Claimant’s mother and sister as members of her family. Nevertheless, the admissibility of this type of testimony was recently questioned by Judge Winkler’s comments in File number 1000114, dated November 8,

2004, in which he granted a request to dispute decision # 138 rendered by Referee Reva Devins. Judge Winkler wrote:

> The referee was bound by the provisions of the Plan to reject the evidence of the mother of the Claimant. As a Family Member as defined by the Plan, the evidence of the mother could not be used as corroborating evidence to establish the claim. However, I find that the referee's reliance upon the mother's evidence to reject the evidence of the former boyfriend to constitute an error in principle. If the evidence is inadmissible to establish a claim, it must similarly be inadmissible as a basis for rejection.

24. With all due respect to him, I think that the words chosen by the Honorable Judge could cause some confusion. Section 3.01(2) of the Plan does not create any impediment to the admissibility of the Claimant's testimony or of that of his Family Members to the effect that the Claimant received a Blood transfusion during the Class Period. It only requires that such testimony "be accompanied by independent corroborating evidence of the personal recollection of the claimant or of any person who is a Family Member of the claimant". It would evidently be impossible to corroborate such testimony without it being admitted as evidence. It would equally be impossible to explain how Section 3.01(2) distinguishes between the admissibility of the Claimant's testimony and that of the Family Members, when it couldn't be alleged that the Claimant's testimony is not admissible at the hearing held to determine his right to receive compensation under the Plan.

25. In my opinion, the correct interpretation of Section 3.01(2) is the one that Referee Jacques Nols invoked in his confirmed decision # 151 of June 25, 2004:

> I interpret the restriction imposed by the '*independent of the personal recollection…of any person who is a Family Member'* of Section 3.01(2) as meaning that if only the family members testify, this in itself does not constitute sufficient and acceptable evidence. On the other hand, if such independent evidence exists, this evidence will be added to the testimony of the family members, thereby adding to the weight of these testimonies. [emphasis added]

Claimant's Testimony

26. At the May 30, 2003 hearing, the Claimant testified that she had been admitted to the Saint John's Regional Hospital on September 1, 1987 for surgery, which took place the following day. She attested that she was still in the hospital on September 8, 1987, near Labor Day, when, around 2:30 or 3:00 o'clock in the afternoon, a nurse came into her room and gave her a transfusion of one unit of blood. She stated that the nurse, whose name she doesn't remember,

told her that she needed blood to get stronger. The Claimant testified that she remembered the needle, a bag containing red liquid and the transfusion of blood in her arm. She couldn't say anymore what was written on the bag. She stated that her mother, her sister, W.K. and F.C. all came to see her in her hospital room that afternoon and that they all saw that she was receiving a blood transfusion. As for F.C., her work colleague, she said that he came to have her sign her work timesheet.

27. In the TRAN 1 form, the Claimant was asked how many transfusions she had received during her lifetime and she answered "1". At the May 30, 2003 hearing, she confirmed that it was the transfusion she had received on September 8, 1987, at the Saint John Regional Hospital. She denied having received blood transfusions during the other two surgical procedures she had undergone at the Hôpital Hôtel-Dieu of Edmunston before 1987. Me Faille asked her then why she had answered another question with a question mark in the TRAN 1 Form about the number of blood transfusions she had received before 1986. The Claimant explained that she did not know how to answer the question regarding the Koate transfusion she had received in 1979 at the Hôpital Hôtel-Dieu of Edmunston. But she added that she had mentioned the Koate transfusion to Dr. El-Safadi, which, according to her, explained her positive response, indicated by a check mark, at the TRAN 2 question as to whether the Claimant had received blood transfusions outside the January 1 to July 1990 period.

28. I recognize that these explanations were consistent with the documentary testimony. According to the medical files of the Hôpital Hôtel-Dieu of Edmundston and of the Saint John Regional Hospital, the Claimant did not receive any blood transfusion at the time of these hospital admissions before September 1, 1987. Moreover, according to a note by Dr. El-Safadi, dated October 30, 2002, his knowledge with regard to the blood transfusion received by the Claimant at the Saint John Regional Hospital came from the Claimant herself and not from the hospital's medical files. It was therefore plausible that Dr. El-Safadi's knowledge of the "blood transfusions" received by the Claimant before 1986 had also come from the Claimant herself and this, in spite of the Claimant's testimony, equally plausible, that she did not know whether the Koate transfusion in 1979 was a real "blood transfusion".

29. When the Claimant testified a second time on August 16, 2005, she recognized that she could not provide the specific details relevant to her blood transfusion at the Saint John Regional Hospital

on September 8, 1987, namely the following: which arm was used for the transfusion, the number of nurses who set up the blood transfusion device, whether they came back during the blood transfusion or not, whether there was a second bag or only the one blood bag, the size of the blood bag except to make an approximate estimation that it was 8 by 4 inches and was rectangular in shape, whether the nurses made any comments when they removed the bag, the duration of the transfusion except to make an approximate estimation of an hour and a half, the size or configuration of her hospital room, her door, her window or her bed. She also recognized that she did not know the reason why a doctor would have decided that she needed blood. She did not receive a doctor's visit to tell her that she needed the blood or to ask her if she agreed to receive a blood transfusion. She had no recollection of having complained of weaknesses or of a worsening of her condition.

30. Yet, the Claimant remembered the presence of visitors in her room that afternoon. Her mother and her younger sister who was 13 or 14 years old first arrived around 2 o'clock in the afternoon as they did every day of her hospitalization. Then, W. K. arrived, meeting her mother and sister for the first time. The Claimant described W. K. as being a friend since the beginning of the eighties when they were both going to the same school. The last one to arrive, F. C., was also introduced to her mother and sister, although perhaps not for the first time. The Claimant stated that she had known F. C. between 1984 and 1989 when they both worked together for the New Brunswick Department of Justice as deputy sheriffs and sheriff's coroners. She stressed that they only had a work relationship and that they had not seen each other between 1989 and 2003 when she contacted him to ask him to testify in this matter.

31. The Claimant remembered that W. K. and F. C. arrived after the blood transfusion device had been set up, and that F. C. had made a joke about the blood resembling wine. According to the Claimant, F. C. also comforted her sister who cried when she saw the blood being transfused to the Claimant. The Claimant confirmed that she signed the sheets of paper brought by F. C. and that he left fifteen or twenty minutes later.

F. C.'s Testimony

32. In his affidavit of December 31, 2003, F. C. submitted the following facts:

THAT on Tuesday September 8, 1987 while l was employed as a Deputy Sheriff for the Province of New Brunswick I did the following.

THAT I arrived at the Saint John Regional Hospital and went to the room of then Deputy Sheriff [the Claimant] arriving there at 2:30 p.m.
THAT upon entering her room I saw that she was receiving a blood transfusion at that time.

THAT I even tried to make a little joke of her transfusion by saying that she would be feeling better if that red stuff was wine rather than blood.

The reason I can swear to the time and date is that I have my Deputy Sheriff records, log book and my time sheet from that period.

That the reason I was there at that time was I was sent out to the hospital to get her if possible to sign her overtime and expense sheet so that she would paid for them for the month of August 1987.

The "Running Sheet" and a page from F. C.'s personal log for September 8, 1987 can be found in this affidavit's appendix. The "Running Sheet" confirmed that he had gone to the Saint John Regional Hospital at 2:30 p.m. on September 8, 1987 in order to obtain the Claimant's signature on her time and expense sheets. His personal log is the same but without the details on the time of the visit or on the documents signed by the Claimant.

33. F. C. participated in the hearing on May 30, 2003 by telephone and attested the following additional facts. The Claimant's mother and sister were present in the hospital room and he talked to them. He saw an intravenous device and a red plastic bag connected to the Claimant's arm but he wasn't sure anymore to which arm it was connected. Because of his work as Sheriff's Coroner, he knew very well what he was talking about when he said he saw that the Claimant was receiving a blood transfusion. After his little joke on the blood and wine, the Claimant replied that it hurt when she was laughing and he did not stay long.

34. During his appearance at the August 16, 2005 hearing, F. C. was again cross-examined by Me Faille and he confirmed the following. He worked for the New Brunswick Department of Justice for 25 years. In addition to the Claimant's mother, whom he had already met, and the Claimant's

sister, he remembered a third visitor in the room but he did not know her. He was able to roughly describe the room but he had forgotten if the room contained one or two beds. From his former work as Sheriff's Coroner, he thought that the blood bag was quite typical but he did not measure it and he did not notice if a second bag was attached to the intravenous device. He brought with him to the hearing all the other "Running Sheets" and his complete personal log for the month of September 1987, which he presented and let Me Faille examine. He explained that up until 1992, he was required to keep the first copies and to submit copies to his boss but that he kept all the originals of the two types of documents in his own personal possession in order to protect "my butt". He recognized that the September 8, 1987 documents made no reference whatsoever to the fact that the Claimant had received, that same day, a blood transfusion at the Saint John Regional Hospital but he firmly excluded all possibility that he had been wrong in stating that this transfusion had taken place.

W. K.'s Testimony

35. In an affidavit dated November 16, 2000, W. K. testified as follows: "I, W. K., witnessed [the Claimant] receiving blood following her hysterectomy surgery in the beginning of September 1987 at the Saint John Regional Hospital in Saint John, New Brunswick".

36. At the May 30, 2003 hearing, W. K. testified to the following facts. The day after Labor Day 1987, she and her sister drove from Moncton to Saint John to visit the Claimant then admitted to the Saint John Regional Hospital. They arrived at the hospital around 2 or 2:30 p.m. and both went to the Claimant's room. W. K. saw that the claimant was connected up to a red bag. The Claimant's mother and sister were already in the room and then a man came in. The Claimant's sister was crying. W. K. stayed in the Claimant's room about twenty minutes. She remembered that the Claimant was receiving blood because during the return trip to Moncton, she and her sister discussed the fact that their brother, a Jehovah Witness, would refuse a blood transfusion.

37. During her second appearance on August 16, 2005, W. K. attested to the following facts. After a one-year period during which time they did not talk to one another, W. K. called the Claimant

around Labor Day 1987 and learned that she was in hospital in Saint John. She decided to go and visit her without calling her at the hospital. She and her sister arrived at the hospital at twelve thirty and stayed for an hour or two. She couldn't say anymore which of the Claimant's arm was connected to a bag but that she had seen her connected to a red square bag. She had had and seen blood transfusions before. She couldn't remember if there was a second bag. The Claimant remained connected to the bag during the whole visit. With the man's arrival, they were five visitors in the room. When the Claimant's sister showed signs of anxiety, W. K. comforted her. Just like F. C. who had drawn a rough picture of the room, W. K. also drew one but she also couldn't remember the room's configuration too well. She again testified to the fact that having seen the Claimant's Blood transfusion raised a discussion between her and her sister as to how their brother, a Jehovah Witness, would have reacted.

Claimant's Mother's Testimony

38. At the May 30, 2003 hearing, the Claimant's mother testified that she and her other daughter had been in the Claimant's hospital room one afternoon in September 1987 when a nurse came in to place a blood bag . She wasn't sure anymore if this happened on a school holiday or if her other daughter was absent from school but she remembered that her other daughter showed signs of anxiety when she saw the nurse take out the needle. She claimed that once the blood bag had been set up, a man came in to have the Claimant sign documents and then he comforted her other daughter. She couldn't say which arm had been used to connect the transfusion needle or if there were other beds in the room.

39. Because of her age and health condition, the Claimant's mother participated in the August 17, 2005 hearing by telephone. She confirmed once again with certainty that she had seen a nurse insert a needle and connect a bag to transfuse blood to the Claimant. She also remembered that her other daughter was present in the room, as well as F. C. and W. K. She had never met W. K. before then. She said she believed that the blood bag had been connected between 2 and 2:30 p.m..

Claimant's Sister's Testimony

40. The Claimant's sister was 14 years old in September 1987. At the May 30, 2003 hearing, she testified that she simply had seen a blood bag suspended to a pole without explaining the circumstances, although these had been described in detail in the previous testimonies of the other witnesses. She also did not know if her visit occurred during a school holiday or if she was absent from school.

41. At the August 17, 2005 hearing, the Claimant's sister confirmed that she had seen a blood bag connected to the Claimant when she had visited her with her mother at the hospital, at the beginning of a school year. She also remembered the fact that being afraid of blood, she had become anxious and that a man had comforted her. She could no longer remember the other people in the room.

Was the alleged blood transfusion required?

42. At the June 5, 2005 hearing, the Claimant called as witness Mrs. Greta Doucet, a nurse in New Brunswick since 1964. Mrs. Doucet did not work at the Saint John Regional Hospital during the Claimant's hospitalization, but she examined all the September 1 to September 9, 1987 hospital files related to that hospitalization. In her March 2006 report, Mrs. Doucet identified several areas where, according to her, "the record keeping did not conform with the standards and left much to be desired". She also noted that the files "could easily have been modified". Yet, unless one relies on their apparent value, I recognize that these files tell a very ordinary story. I will summarize it as follows.

43. The Claimant was admitted to the Saint John Regional Hospital on September 1, 1987 complaining of heavy menses and abdominal pain. The decision to approve and perform an hysterectomy was taken on September 2, 1987. A doctor thought that it would be a good idea to order two units of blood before that particular surgery, noting: "possible blood loss at surgery ... time of anticipated usage: for surgery tomorrow". In order to reduce the possibility of an adverse transfusion reaction, the hospital, as is usually the case, undertook a cross-matching test between the Claimant's blood and two units of blood from the same blood group released by the hospital's blood bank. Once ready, the two blood units were labeled and numbered. However, the Claimant lost only

100 ccs of blood during the September 2, 1987 surgery and, according to her hemostasis, i.e., her hemoglobin level, she did not need a blood transfusion. Consequently, the two blood units prepared for the Claimant were returned to the blood bank on September 4, 1987 and were no longer "available". The Claimant had a recovery period which was at times painful and incommodating, but the nurses' notes for the afternoon of September 8, 1987 make no mention of a blood transfusion nor of visitors. The notes read as follows: "2 pm : a good day" ; "4 pm : resting quietly all afternoon". According to the Treating Physician's note when the Claimant was released from hospital, the post-operative period had been "uneventful". The Claimant left the hospital on September 9.

44. To counter this description of normal progress with no sudden change, and to support her allegation that a blood transfusion could have been required, Mrs. Doucet's report stated:

> Regarding the state of [the Claimant], I note on pages 179 and 180, items 50, 52, 55 and 63, that the latter was on a liquid diet on September 4 and 5, 1987. In my opinion, this shows that her health condition was frail or quite serious, this, after the second and third day of her surgery. Usually, she would be on a much more complete diet. There is always the possibility that [the Claimant] lost blood and that the nurses did not note this fact. Whatever the situation, it would seem that there were reasons to give her blood as [the Claimant] alleged.

45. However, during her cross-examination by Me Faille, Mrs. Doucet supported this allegation in a very poor way. First, she recognized that one does not feed a patient through blood transfusions when one can do so, just as in the Claimant's case, through "Ringer's lactate", a clear liquid also given through an I.V. line. She did not question the documents showing that the I.V. line had been removed on September 5, 1987, the day the Claimant started to eat soft foods. As for a blood transfusion to correct a blood loss, Mrs. Doucet recognized that it would have been normal procedure to check the Claimant's hemoglobin level before and after the transfusion. It follows that if the Claimant received a blood transfusion for that reason, the nurses in charge would have neglected to note three things: her loss of blood, her blood transfusion and her hemoglobin levels. In any case, I note that according to the Claimant's and F. C.'s testimonies, the alleged transfusion took place on September 8, 1987, three or four days after the dates of the "items" mentioned by Mrs. Doucet. Moreover, Dr. Norman also testified that if the Claimant left the hospital less than 24 hours after this alleged transfusion, it is because she had had "an uneventful recovery" without the need for a blood transfusion.

Are there other elements of proof which eliminate any probability that the alleged blood transfusion took place ?

46. When one mentions the elements of proof allegedly likely to eliminate any probability that the Claimant had received a blood transfusion on September 8, 1987 at the Saint John Regional Hospital, one must begin by clarifying that, except for Mr. Fortier's testimony mentioned below, all such elements of proof came from this hospital's files or from members of its staff who testified at the hearing. It is true that I received several letters as elements of proof from the Canadian Blood Services with regards to the results of the traceback procedure, as stipulated in Section 3.04. Nonetheless, inasmuch as such letters denied that the Claimant had received a blood transfusion on September 8, 1987 at the Saint John Regional Hospital, they simply conveyed again information provided by the latter. For example, in a letter dated September 29, 2002, the Society stated that during the Claimant's hospitalization in September 1987, the Saint John Regional Hospital had not cross-matched the Claimant's blood with the blood units released by its blood bank. This information proved to be inaccurate and the hospital subsequently corrected it. I make no comment on them except for the one already made at the beginning of this paragraph.

47. Thus, this comment applies to the first important element of proof, i.e., the one raised in another letter from the Society dated August 8, 2003, which stated that both blood units prepared for the Claimant were eventually transfused to other persons. Given that there is no proof that the hospital cross-matched blood for the Claimant, one could argue that the proof eliminates any probability that the Claimant had received a transfusion of one or the other of both units specifically prepared for her or of another blood unit having been cross-matched with her blood. However, there is no proof establishing that the Claimant would necessarily have had an adverse or visible reaction if she had received a blood unit that had not been cross-matched with her blood.

48. On the other hand, according to the second element of proof which is not disputed, one could expect a very adverse and visible reaction, maybe even fatal, if a patient receives a transfusion of a blood unit which does not belong to the same blood group as this patient's blood.

It was also agreed that the Claimant had had no such reaction after her alleged transfusion. Given that the Claimant's blood was of the O (+) type, one could thus argue that the proof eliminates any probability that the Claimant had received a transfusion of a blood unit from a group other than the O (+) or O (-) type , the latter being the "universal" type.

49. The third element of proof was mainly submitted by Mrs. Diane MacLeod, the blood bank supervisor at the Saint John Regional Hospital since January, 1987, i.e., during the period of the alleged transfusion. She testified twice: at the hearings of January 24, 2006 and June 6, 2006. She described the established procedures to order blood units from this bank, if such procedures had not changed significantly since 1987 and, indeed, there was no indication that they had changed since that time. According to her testimony, no blood unit would have been released from this bank without a doctor's order, a number and a label. Mrs. MacLeod submitted a copy of a blank label (normally yellow) as proof and one could read the blank lines indicating the following: the patient's name, the patient's hospital number, the hospital name, the room ("ward"), the name of the Treating Physician, the number of the blood unit, the initials of the person responsible for the cross-matching test, the date and the patient's blood group and blood unit. Once the label had been placed on the blood bag, a bank technician would fill out a document entitled "Record of Donor Units Issued" to confirm that the unit in question, identified in this document by its number, had been given to a messenger at a certain date and time for delivery to its destination. To deliver the blood bag, the messenger would have had in his hands another form which accompanied the blood bag. (The name of this form is given below.) Mrs. MacLeod testified that if a blood unit had not been transfused, it would have been returned to the bank and this fact would have been recorded in the bank files. To that effect, Mrs. MacLeod drew my attention to the leaflet in the Claimant's file which confirmed that both blood units prepared for her had been returned to the blood bank on September 4, 1987. Given that there is no documentary evidence that a blood unit had been ordered by a doctor, numbered or labeled for a Claimant's transfusion after September 4, 1987, one can argue that Mrs. MacLeod's testimony eliminates any probability that a blood unit had been ordered by a doctor, numbered or labeled for Claimant's transfusion on September 8, 1987.

50. The fourth element of proof related to blood transfusion procedures in place for patients at the Saint John Regional Hospital. The testimony for this element was submitted on June 7, 2006, mainly by Mrs. Kim Roberts, a nurse who also worked at the Saint John Regional Hospital during the period of the alleged transfusion but in the surgery and intensive care unit and not in the gynecology unit where the Claimant happened to be on September 8, 1987. Again, with the noted exception, there was no mention to the effect that the procedures described by Mrs. Roberts had changed since 1987. According to her testimony, a blood bag intended for a patient outside the operating room would have been brought by a messenger to the hospital unit where the patient happened to be. The messenger would have carried a form called a "dispense form" on which the number of the blood unit, the patient's name and the blood group would have been written. The messenger would have located this hospital unit's clerk who would, in turn, have located either this hospital unit's nurse or the relevant patient's nurse. The act of receiving blood from the messenger would have been recorded with the signatures of two nurses on the "dispense form". Such signatures would have meant that the relevant nurses had certified that the data on the blood bag label was consistent with the data on the "dispense form". However, in 1987, the hospital policy did not require that once the "dispense form " had been signed, it had to be kept or placed on the patient's file. Thus, this form would have been thrown away. Then, a single nurse could have ensured that the data on the blood bag label was also consistent with the data on the patient's hospital bracelet and this nurse could have made the decision to proceed with the blood transfusion. If the patient had not been already been connected to an intravenous device, it would have been necessary to do so. As the blood transfusion should have been accompanied by a sodium chloride transfusion, the latter should have taken place beforehand, i.e., before or concurrently - "piggy back" - with the blood transfusion. The nurse who had performed the blood transfusion would have recorded it on the patient's file but not necessarily immediately. This file would have been located in the same unit and on the same ward as the patient. Given that the Claimant's file does not mention that she received a blood transfusion, one can argue that Mrs. Roberts's testimony eliminates any probability that the Claimant received a blood transfusion during her hospitalization at the Saint John Regional Hospital on September 8, 1987.

51. Although the testimony relating to the third and fourth element of proof was mainly submitted by Mrs. MacLeod and Mrs. Roberts, the testimony of one was totally compatible with that of the other. Furthermore, in spite of the fact that Dr. Norman and Mr. Antonin Fortier, a doctor assistant employed by the Administrator as claims' examiner, had not worked for the Saint John Regional Hospital in 1987, their testimony was also compatible with that of Mrs. MacLeod and Mrs. Roberts. Given their importance for my analysis of the next element of proof described below, I mention here three other observations made by these witnesses. Firstly, Dr. Norman corroborated Mrs. MacLeod's testimony when she asserted that if a unit of blood was released by the blood bank and was not subsequently transfused, such a blood unit would have been returned to the blood bank and this fact would have been recorded in the bank files. Secondly, according to Dr. Norman, a blood unit having been cross-matched would have remained good for transfusion to the patient for whom it had been prepared during the next 48 hours or maybe for a longer period of time, if required. This observation was consistent with Mrs. MacLeod's testimony. She confirmed that a blood unit which had been released by the blood bank and had not subsequently been transfused would have been returned to the blood bank for a wait period not exceeding 48 hours but, she added, such a return would also have been recorded in the bank files. For his part, Mr. Fortier also stated that according to standard procedures, if a blood unit is released from a hospital blood bank and is not subsequently transfused, this unit must be returned to the blood bank and this fact should be recorded in this bank's files. Thirdly, according to Mrs. MacLeod's testimony, almost half of the population, i.e. 45 %, are of the O (+) or O (-) blood type.

52. The fifth element of proof was a verification of the blood units released on September 8, 1987 by the Saint John Regional Hospital's blood bank. According to the January 14, 2005 and February 7, 2006 reports of Mrs. Kathy Perrin, " RN, MHS, Consulting Quality and Risk Management" of the Corporation of the Atlantic Health Sciences Corporation, 27 blood or plasma units had been released on that same day for six patients. Mrs. Perrin stated that except for one single case, the nurses' notes, copies of which were attached to her second report, confirmed that each one of the 27 blood or plasma units had been transfused to the right patient. In her report of January 14, 2005, Mrs. Perrin explained why the nurses' notes did not exist any

more for one of the six patients but how she was able all the same to assert that this sixth patient, and not the Claimant, had received the blood units in question.

> On this date 27 units were issued from transfusion medicine for 6 different patients within the hospital. With this knowledge the patient's health record [that is, the health record for each of the six patients] was reviewed to confirm transfusion through review of nursing progress notes. This was verified in all but one of the patient's records as the nursing notes had been discarded. This "thinning process" of the chart has now been halted. If this patient had not received the units of blood tested and issued to him there would be a record of these two units being "non-issued" and units being cross-matched for another patient. This was verified by a review of the ledger as well as the disposition sheet. It is important to note that the two units I have referred to are grouped as A(-) blood type. [The claimant's] blood type is O{+). If [the claimant] had received these units she would have had a transfusion reaction. The permanent transfusion record was reviewed and there were no reactions in the entire building from August 30, 1987 to September 10, 1987.

53. One could obviously argue that Mrs. Perrin's reports eliminate any probability that the Claimant had mistakenly received a blood transfusion intended for another patient. Nevertheless, such reports did not take into account three observations mentioned at the end of paragraph 51. If a blood unit would have remained good for transfusion for at least the next 48 hours following its preparation and release from the blood bank , it would have been preferable to check the path followed by each unit of O (+) or O (-) blood released by the blood bank within the 48 hours or even more, before the alleged Claimant's transfusion. In fact, relying on the documents attached to Mrs. Perrin's second report, I notice that four units of the 0 (+) blood group had been released on September 7, 1987 between 4:45 and 5:56 p.m. for a male patient in the surgery and intensive care unit. However, this document did not confirm that such units had been transfused to this patient or returned to the blood bank. The document did not confirm either if the other O (+) or O (-) blood units hade been released by the blood bank on September 6 or 7, 1987 or if such units had been transfused to the right patients or returned to the blood bank and this, in spite of the fact that, according to the third observation noted above, there was almost a 50 % chance that the blood units released on September 6 or 7 had been of the O (+) or O (-) blood groups.

54. The sixth and last element of proof was also meant to eliminate any probability that the Claimant had mistakenly received a blood transfusion intended for another patient. This was related to Dr. Norman's, Mrs. MacLeod's and Mrs. Roberts' testimonies who all asserted that such an error would have been noticed by the doctors or nurses of the patient for whom the transfusion was intended. They also insisted on the fact that the computer system in place since

1982 to record prescriptions at the hospital, including blood transfusion prescriptions, would not have allowed anyone to modify the data already entered with the view of erasing any traces of error. In addition, I notice that nurses' notes were not integrated to this computer system. Furthermore, I notice that according to Mrs. MacLeod's testimony, the nurses were not yet worrying, in 1987, about the possibility of virus infection through blood transfusions.

Analysis and conclusion

55. In my opinion, the proof leaves no doubt on one matter: if the Claimant received a blood transfusion on September 8, 1987 during her hospitalization at the St John Regional Hospital, she received it by mistake. I reject without hesitation Mrs. Doucet's allegation according to whom such a transfusion would have been medically required. Neither the hospital records as a whole, nor the Claimant's testimony itself support this claim. Relying on her Treating Physician's and on Dr. Norman's opinions, I note that if the Claimant left the hospital less than 24 hours after the alleged transfusion, it is because she had completely recovered without the slightest need of a blood transfusion.

56. Nevertheless, if the Claimant had received this alleged transfusion by mistake, this error, being effectively an error, could also have explained why we do not find any record of it in the hospital files. There is no proof establishing that such an error should have inevitably been recorded in the Claimant's file. It is possible that the nurse who made this error realizes it before writing down her notes and, seeing that there was no danger for the Claimant because she did not yet worry, in 1987, about the possibility of virus infection through blood transfusions, decided not to record it. It is possible that this nurse would have given the Claimant an O (+) or O (-) blood unit released by the blood bank on September 6 or 7, 1987 for another patient. I recognize that the proof does in no way explain how a nurse would have been able to make such an error, but the proof does not confirm either that the O (+) or O (-) blood units released by the blood bank on September 6 or 7, 1987 had been transfused to the right patients or returned to the blood bank. It is possible that even if the blood unit transfused to the Claimant had not been cross-matched with the Claimant's blood, this blood transfusion to the Claimant did not cause a transfusion reaction, because such a reaction was not certain or not visible. It is possible that the doctors and nurses responsible for the care of the patient for whom this O (+) blood unit had

been intended realized the error but noted it only in *their patient's file.* It is possible that they could have corrected this error through a transfusion of an O {+) or O (-) blood unit prepared and released for their patient on September 6 or 7, 1987 but not yet transfused to this patient or returned to the blood bank before the afternoon of September 8. Or it is possible that they never realized that their patient had not received a unit intended for them, especially if this patient had received many others. Let us resume the example of the four O {+) blood units released on September 7 for the patient in the surgery and intensive care unit. I note that the number of blood or plasma units released for this patient between the afternoon of September 7, 1987 and the early morning of September 9, 1987 totaled 28 and that he received twelve (12) O {+) blood units and 8 plasma units, i.e., 20 units in total, between 3:40 p.m. on September 8 and 12:20 p.m. on September 9.

57. Evidently, the Claimant could not base her claim on this series of possibilities only. But, indeed, the Claimant knew nothing of all such possibilities when she filed her claim. She based her claim on her own testimony and that of her four witnesses. In my opinion, she did not have to explain why the hospital files had not recorded a blood transfusion. Her burden of proof, by virtue of Section 3.01 (2), was to submit a corroborating and independent proof establishing on the balance of probabilities that she had received a blood transfusion and that it had happened in spite of the fact that the hospital files had not recorded it.

58. In my opinion, F.C.'s testimony allowed the Claimant to discharge the burden of proof. F. C. was so credible that he transformed the series of possibilities evoked above in probabilities that the Claimant had effectively received a transfusion at the St John Regional Hospital, on September 8, 1987. I found it impossible to reject F. C.'s testimony for several reasons: his relation with the Claimant is not a close one, his recollections were supported by contemporaneous documents, his work as the Sheriff's Coroner has taught him what a blood transfusion was, his work as Sheriff has taught him the significance of testifying under oath and finally, his testimony on the main issue at hand was very clear and very firm. Because his testimony was an independent one, it confirmed that of the Claimant and the Family Members, thus giving weight to the latter. Although the W.K.'s testimony was less solid in its accessory

details than that of F.C., it also deserves to be recognized on the main issue. Thus, it constitutes a second corroborating and independent proof.

59. In the result, I conclude that the Claimant discharged the burden of proof in accordance with Section 3.01(2), that the Administrator's decision must be rescinded and that the Claimant is a "Primarily Infected Person", as stipulated under the Plan.

Original signed by — August 14, 2006

David Garth Leitch, Referee. — Date