Claim No. 11567

DECISION

A. Introduction

[1] The Claimant, now a Saskatchewan resident and 49 years of age, applied for compensation as a Primarily-Infected Person pursuant to the Transfused HCV Plan ("the Plan"), which is Schedule B to the 1986 -1990 Hepatitis C Settlement Agreement ("the Settlement Agreement").

[2] Pursuant to the terms of the Settlement Agreement and the Plan, the "Class Period" (January 1 1986 to and including July 1, 1990) is the only period of time in respect of which compensation may be available. Further, while there are many possible sources of infection with respect to the Hepatitis C Virus ("HCV"), the Plan only provides compensation for individuals who received transfusions during the Class period of defined blood products, generally, but with an exception, where the donors have been tested and found to be infected with the HCV.

[3] While living in Manitoba, in August, 1987, the Claimant was seriously injured in a motor vehicle accident. She underwent surgery at Morden Hospital, to repair injuries to one leg, specifically the anterior and posterior cruciate ligaments, posterior capsule and lateral capsule, and to perform a split-thickness graft to the left lower leg and to debride and repair an extensive laceration and injury to the upper thigh. The Claimant maintains that it was during this surgery that she received a transfusion of blood.

[4] However, by letter dated January 21, 2004,[1] the Administrator denied the claim, having carefully reviewed the material provided in support of the claim, for the following reasons:

> … You have not provided sufficient evidence to support your claim that you received blood during the Class Period.
>
> In your original application you indicated you were transfused at Morden District General Hospital in 1987, now known as Boundary Trails Health Centre. The medical documents submitted with your claim did not include transfusion records for your hospitalization in 1987. In January 2003 you initiated your own traceback with CBS. In a letter dated April 14, 2003 from CBS it is stated: "The Morden Hospital identified that no blood or blood components were transfused to you during your stay at the above hospital". In cases where the claimant is having difficulty obtaining documents to support they received a transfusion, the traceback department contacts CBS to request their assistance in

[1] The initial Claims Centre File, consisting of 114 pages, was entered as Exhibit 1 at the hearing. The January 21, 2004 letter is found at pages 20 and 21.

obtaining transfusion information directly from the hospital. The final response to this request was received from CBS October 14, 2003. They confirmed that Boundary Trails Health Centre has searched their blood bank records from January 1987 to January 1988, their health records from August 18, 1987 to September 11, 1987 and you were not transfused. Also, in a letter addressed to you by the Medical director at the MSA General Hospital Dr. J.S. Grewal, he stated, "Our records indicate that you did not receive a transfusion in this hospital according to the records dating back to September 8, 1995. The hospital no longer has a complete record of any hospitalization admissions prior to 1983". Therefore, you do not meet the Criteria for compensation, based on Article 3.01(1a) of the … Settlement Agreement, because you did not have a transfusion of "blood" between January 1, 1986 and July 1, 1990.

[5] Fund Counsel relies on Section 3.01 (1) (a) of the Plan text:

ARTICLE THREE
REQUIRED PROOF FOR COMPENSATION

3.01 Claim by Primarily-Infected Person

(1) ***A person claiming to be a Primarily Infected Person must deliver*** to the Administrator…

(a) medical, clinical, laboratory, hospital, The Canadian Red Cross Society, Canadian Blood Services or Hema-Quebec ***records demonstrating that the claimant received a Blood transfusion in Canada during the Class Period***:

[emphasis added]

[6] Both parties agree that the case turns on the issue of whether or not the Claimant has met the "notwithstanding" provisions of Section 3.01:

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***.

[emphasis added]

B. Facts, Summary of Evidence

[7] An "in-person" hearing was held in Saskatchewan on May 17, 2005. The Claimant testified on her own behalf. Carol Miller, Appeals Coordinator of the Hepatitis C January 1, 1986 - July 1, 1990 Claims Centre (the "Claims Centre"), testified on behalf of the Administrator.

[8] The matter will be adjudicated upon based on the written materials and testimony tendered by the parties, together with certain documents obtained post-hearing, about which more will be said shortly.

(a) Documentary Evidence

[9] The following documentary evidence was tendered at the hearing:

Exhibit 1 - Initial Claims Centre File (pages 1 – 114)

Exhibit 2 - Supplementary Claims Centre file, including health records and other materials not included in Exhibit 1 (169 pages)

Exhibit 3 - Letter from Dr. G.B.M., Surgeon, dated November 1, 2004, supplied by the Claimant's lawyer.

Exhibit 4 - For identification only – typewritten notes prepared by Claimant.

(b) V*iva voce* testimony

Administrator's Evidence

1. Carol Miller, RN

[10] Ms. Miller testified as to her broad background in most areas of hospital nursing as well as her experience with the Claims Centre since May 2000, including her current position as Appeals Coordinator. She is very familiar with practices of recording blood in Blood Bank and hospital records throughout the period from the 1970s to the 1990s. Blood Bank records are kept separately from the patient chart.

[11] In this case, the Claimant's application was denied as there as no evidence of a transfusion during the Class Period. The Tran 5[2] showed one transfusion in 2003, outside the Class Period (also after the Claimant had been diagnosed as HCV positive)

[2] Exhibit 1, pp. 31 and 32, @ page 32

and one between August 17-21, 1987 at Morden Hospital. The Tran 2[3] completed by the Claimant's Saskatchewan physician, shows that the Claimant received a transfusion during the Class Period and that there was nothing in the Claimant's medical history that indicates that she was infected with HCV prior to January 1, 1986. Having received this information from the Claimant's physician, the Centre contacted the physician by fax of December 2, 2003, [4] to inquire into the source of the above information. The physician wrote back stating: "I have no medical documentation – only her (the Claimant's) statement.

[12] Ms. Miller testified that she understood the theory of this claim to be based on an alleged blood transfusion during knee surgery. In this regard, she described in considerable detail the usual steps required, were blood to be given. This includes a sample of the patient's blood being taken by a lab technician or nurse, blood to be recorded on a transfusion record, a requirement that the information on that record must coincide with the information recorded on the patient's armband, two professionals to sign on the requisition to confirm that the sample came from the patient and the sample is then labeled and tested. Normally, if blood was requested, the number of units requested and the blood type would be shown, the Blood Bank would then test the patient's blood against donors to ensure that there would be no reaction, the results of which would again be recorded. The cross-match (which tests the patient's blood as well as the donors') requires an order on the physician's order sheet. If the blood passes the cross-match test, a label goes onto the patient chart, which would be the patient's label with the Canadian Red Cross blood unit #, which may be in the form of stickers with bar codes on the back. For blood to be transfused during surgery, it would need to be signed off on by an anesthetist, as he would be the one to request, give and record blood during surgery. A technician at the Blood Bank would read out loud the Blood Bank records, to ensure that it matches up with the blood required for the patient. The requisition for blood is kept on the patient chart and in the Blood Bank records. If given during surgery, notes are kept on the anesthesia record. When blood comes from the Blood Bank to the O.R., a nurse again reads the information on the blood out loud and two people record the time the transfusion started. This would also be recorded in the operative record and the discharge summary.

[13] Having reviewed the available records in this case, Ms. Miller commented on the Medication Orders form that was completed when the Claimant was admitted to her floor,[5] noting that a request for a cross-match, if blood had been required, would normally be recorded on such notes. However, here there was nothing to suggest this. Similarly, the Anaesthetic Record[6] would show if there had been significant blood loss. Blood

[3] Page 99
[4] Page 114
[5] Page 73
[6] Page 69

pressure would drop and pulse would increase significantly. However, here, the blood pressure remained in a range and at no point dropped below 112/80. There is a separate area on this form to record fluids, where blood, had it been given, would normally be recorded. Here there was no such record. Ms. Miller also observed that the admission history, dictated after surgery, would normally mention both significant blood loss and details of a transfusion, had they occurred, whereas here,[7] there was no suggestion of either. The Discharge Summary[8] would also normally record a blood transfusion, had one taken place. Again, it did not here. The Progress notes,[9] although all post-operative, make no mention of blood being required and no suggestion in the hemoglobin levels that there had been a need for blood. The Operative Report,[10] although exhaustive and detailed, three pages in length, refers to a tourniquet being applied, which controls circulation almost completely, such that there would have been almost no bleeding. Also, the last page of such a report would normally mention blood, had it been required, but did not here. While there were certain records missing, such as nursing notes, recovery room record and lab records, in her view there were ample key records available that would have recorded the need for and/or the giving of blood, had it been required.

[14] From the additional records supplied by the Claimant, being Exhibit 2, the Admission/Separation Abstract[11] would normally list Blood Bank or transfusion records, whereas here it does not. There is a lengthy Consultation Record dictated by the Surgeon, dated August 18, 1987[12] which makes no mention of excessive bleeding. There is a neurological consult[13] regarding the bump on the Claimant's head, which makes no reference to blood loss, and the O.R. Count Sheet[14] would normally record blood, had it been given. Here it did not. This does record the tourniquet being in place for 91 minutes.

[15] Finally, Ms. Miller noted that there was a reference to other surgery, specifically a vaginal hysterectomy in 1995.

[16] Under cross-examination, Ms. Miller acknowledged that the decision to give blood would be dependent on the individual patient – some patients may have fairly constant blood pressure and still need blood. Although Morden Hospital did not have its own blood bank and would only have emergency supplies, if blood was needed in Morden, it would go in a cooler from Winnipeg, by Red Cross courier or taxi. She confirmed that in

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[7] Pages 63-64
[8] Page 65
[9] Pages 66-67
[10] Pages 85 -87
[11] Exhibit 2, page 11
[12] Exhibit 2, pages 12-13
[13] Exhibit 2, page 19
[14] Ibid, page 21

the four provinces she practiced nursing in, including Manitoba, two professionals always signed off on the applicable blood records. Although the surgeon could request blood during surgery, it is invariably the Anesthetist who would give and record it. She has never run into a case where an Anesthetist would not record the giving of blood, although acknowledged that there has been at least one case under this process where a Referee found otherwise, based on a physician's testimony.

Claimant's evidence

(b) Claimant

[17] The Claimant testified as to her pre -1987 medical history. She experienced no life-threatening injuries and had such issues as a bad scald and bumps and bruises. She also had surgery to remove her tonsils and adenoids when she was younger and gave birth to two children without c-section. Her first major surgery was in 1987 and she had a hysterectomy in 1995.

[18] On August 18, 1987, she recalls consuming 1.5 bottles of beer and then she believes that she was drugged, as her next memory was when she was on the highway, seriously injured after a vehicle had evidently collided with her when she was a pedestrian on the highway. She had a broken jaw, which was very painful as the doctors could not immediately give her painkillers due to the other drugs that they believed were in her system. She forgets the first four days she was in hospital. Dr. P was her physician and Dr. J performed the surgery on her knee. She remembers Dr. P waking her up and telling her that he had someone looking for blood for her in Winnipeg due to the total reconstruction of her knee. Dr. P had no reason to lie to her – she thinks he told her this before the surgery and drilled it into her head so that she made sure she remembered it. She remembers this because her grandmother is a Jehovah's Witness and does not believe in blood transfusions and this was the first time the Claimant received blood. In reviewing the Manitoba Health physicians' billing records [15] she notes an entry for August 18, 1987 referring to a "special call (special trip") billing entry with respect to Dr. P and remembers Dr. P telling her he had to make a special trip to Winnipeg to get blood for her.[16] Upon discharge from hospital, she had a hip to ankle brace. She remembers going for follow-up x-rays at which time Dr. J told her that she "would have complications later on", which she interpreted to mean that he was suspicious that she had received tainted blood. She could not work and went bankrupt. Later, she developed many health problems and one of her doctors told her she had a form of rheumatoid arthritis. Dr. M in Swan Lake told her not to work in the food industry. She and her common law spouse moved to B.C. She slept all the time and was always ill. In 1992 she moved within B.C.

[15] Exhibit 1, pp. 38-41, at page 38
[16] Dr. Pauls subsequently reported that "special trip" meant a trip to the hospital when he would not otherwise have been there.

and her new doctor told her she never had arthritis. She had irregular menstrual cycles. She went to see a gynecologist who referred her for surgery right away (hystersectomy). She moved to Saskatchewan in 2002 at which time her present GP told her she had HVC. Thankfully, her spouse tested negative. She now takes extensive vitamins and has healthy nutrition, as a result of which she feels that she is doing better than most. She has never taken intravenous drugs. She has written to Dr. P for records [17]and information as to what happened to her, but feels that he has been stonewalling her. Dr. P moved to BC, and the Claimant attended on him there in 1994 and asked him why she was given blood, at which time he said that she was not given blood as she had not needed it. She was floored because he had previously been so good and kind to her. She suspects that by 1994 he had become suspicious of HCV and did not want to be sued, especially as he had recently gone through other legal problems. She had also contacted Dr. J,[18] who gave her the O.R. records,[19] and told her that if she had received blood, it would be in the hospital records.

[19] Under cross-examination, the Claimant stated she remembered headlights coming towards her in the accident and being hit. She does not remember the incident as it was described in the hospital records,[20] which reported that apparently there had been some jokes played on her and she was drunk and ingesting, left to stand on the highway to prove her ability to walk while under the influence of alcohol, tried to flag down several cars and was unsuccessful, so she ran out in front of a car that eventually hit her. She remembers lying bleeding on the highway for a long time. Her next memory was in hospital when they were stitching her jaw. Her clothes had all been soaked in blood in the E.R. and she was mainly unconscious. Her next memory after that is when she signed the consent for surgery a few days later. She was receiving heavy-duty morphine intravenously. She was in hospital for 24 days and left before her doctor recommended, as she had teenaged children at home. She thinks her eyes were yellow when she got home. She remembers Dr. P telling her, 'New Jersey Continental, Connaught." Her regular GP at the time told her afterwards, 'those bastards gave you blood,' and he was upset that he was not told about her accident by the physicians at the hospital, but he had no privileges at that hospital. He evidently had spoken to Dr. P after the Claimant's discharge but Dr. P denied that she had been given blood. He told her not to work in the food industry and that she should get blood work done every six months. There is a Dr. S that told her in 1995 that he had tested her for HCV and she was negative, but she has not been able to find records of this. In 1999 Dr. S sent her for ALT tests as she had constant flu and a lump under her arm. She was sleeping 12-14 hours per day. He prescribed Diazepam for chest pain she was experiencing. She now thinks this was caused by problems with her liver as she is now experiencing similar problems. She was

[17] Letter of December 3, 2002, Exhibit 2, page 146
[18] Letter of December 3, 2003, Exhibit 2, page 27
[19] Exhibit 2, pp. 28-34
[20] Exhibit 1, page 63

finally diagnosed with HCV in 2002, after being seen by Dr. M, a Hepatologist in Regina. Although she remembers her conversation with Dr. P while she was in hospital, in relation to the issue of blood, he denied it completely by the time she saw him in BC. Dr. J said that if she had been given blood it would be in her records.

[20] At the conclusion of the in-person hearing, given the difficulties that the Claimant had experienced in obtaining what she felt was the co-operation of Drs. J and P, and in order to leave no stone unturned to ensure that the Claimant could advance her claim with the best available evidence, with input of counsel for both parties, to write to Dr. J, the surgeon and Dr. P, the attending physician at Morden, to request direct answers to the questions that the Claimant had raised. Each was provided with copies of all available health records from the Morden Hospital, as well as the Manitoba Health printout. Each was invited to supply copies of any health records for the Claimant other than those already produced. Dr. J, the Surgeon, was asked the following questions:

> 1. Did (Claimant) receive blood (or blood products) at any time? If so:
>
> a) When?
> b) What did you tell her?
> c) Why was blood required? and
> d) What if any recollection do you have as to when and how blood was administered, under whose orders and in what quantity?
>
> 2. If you do not recall telling (Claimant) that she had received blood, or if you recall that she did not receive blood, please advise us how you can recall this or what causes you to conclude that she did not receive blood. Given the nature of the injuries sustained by (Claimant) and the surgery performed, in your opinion is it probable that blood would have been required?
>
> 3. What is a "special trip" as noted on the August 18, 2005 Manitoba Health Statement of Benefits Paid?

[21] Dr. J's office advised that they had no additional records for the Claimant. Dr. J's reply, dated June 28, 2005 [21] states:

> …As you know, (Claimant) was in an accident and was treated in the Morden Hospital. She was admitted on August 18, 1987 and discharged September 11, 1987. I have reviewed the

[21] This letter is entered into evidence as Exhibit 5, as if it had been tendered at the hearing.

charts…. She had extensive injuries involving the left lower leg, mainly affecting the knee. It was a car/pedestrian accident with extensive damage to the ligaments in the knee.

She underwent surgical repair. ***As far as I could assess from the chart she never received any blood transfusion and there were no blood products given***. So according to question #1 a,b,c, and d do not come into play as she was not given any blood transfusion. ***According to the notes, blood loss was minimal and from the nature of the surgery performed, it is my opinion that it is <u>not</u> probable that blood products would have been required***.

With regards to #3 you have asked about the "special trip" on August 18. This is the benefit for an emergency call that Manitoba Health pays when you are to make a special trip to the emergency patient.
[emphasis added]

[22] Dr. P, the G.P. at the Morden Hospital, was sent a letter setting out:

(Claimant) has provided evidence to the effect that when she was hospitalized in Morden, you told her that she needed a blood transfusion. She recalls you telling her to remember the names "New Jersey Continental" and "Connaught". Canadian Blood Services has reviewed Blood Bank records and Health records and advised that there is no record of blood transfusion received by (Claimant) during that hospitalization. Given the conflict between (Claimant's) evidence and the available records, your input is required.

I have full powers of subpoena and it may be necessary for you to testify in this matter. However, if you are able to respond expeditiously to the questions raised in this letter, we may be able to eliminate the possible need for you to testify.

… My questions for you at this time are as follows:

1. Did (Claimant) receive blood (or blood products) at any time? If so:
   a) When?
   b) What did you tell her?
   c) Why was blood required? and

d) What if any recollection do you have as to when and how blood was administered, by whom, under whose orders and in what quantity?

2. If you do not recall telling (Claimant) that she had received blood, or if you recall that she did not receive blood, please advise us how you can recall this or what causes you to conclude that she did not receive blood. Given the nature of the injuries sustained by (Claimant) and the surgery performed, in your opinion is it probable that blood would have been required?

3. What is a "special trip" as noted on the August 18, 2005 Manitoba Health Statement of Benefits Paid?

4. Do you recall any discussions with (Claimant) relative to the issue of blood at any time during her hospitalization or later, whether in Manitoba or British Columbia?

[23] Dr. P sent two letters in reply, dated May 30, 2005 and June 1, 2005, which included some correspondence and chart materials.[22] In the first letter he stated:

In response to your letter … requesting chart information regarding (Claimant)'s treatment in August and September of 1987. I left Morden 1990 and my entire practice was resumed by another physician who took over total patient care as well as the original charts … and those charts remained in the clinic at that time….

Your request for information from this file is not available to me; therefore I am not able to advise you on the Hepatitis C Settlement. Whatever information that I may have had, had I seen her here in Abbotsford, also has been researched and found that I no not have reference for any information available to me, therefore my ability to resolve any conflict between (Claimant's) evidence and records is unfortunately beyond my control.

I do not recall telling (Claimant) that she had received blood or any information with reference to that…

[22] These have been entered into evidence as Exhibits 6 and 7 respectively, as if they had been tendered into evidence at the hearing.

[24] In the second letter, Dr. P reviewed chart information that I had provided to him and further indicated that he was able to find some records for the Claimant for the period August 1992 to August 1993, which he reproduced. He states:

> … In review of the chart information you sent from the Morden … Hospital, ***I find no references to any laboratory testing, blood group and match orders, or blood transfusion orders***. I do note post-operatively that she did have reference to starting Orifer iron intake…. I would assume that her haemoglobin and iron stores were low requiring replacement iron in her diet…
>
> Item 3: your reference to ***a "special trip"*** August 18, 2005; this is the incorrect date and should be August 18, 1987. I was present and attended her at the Morden Hospital on that date that ***was on an Emergent response basis as reflected in the billing code***.
>
> Item 4: ***Do I recall any discussions with (Claimant) relative to the issue of blood? The answer is no***. In her work-up for rheumatoid and joint disability issues when she was attended on here in August 1992 reference was made to the diagnosis that she had rheumatoid arthritis and that she had in the past been tested for AIDS in 1992. She was not a drug user and was told that she was negative at that time… My care for (Claimant) in …BC entailed the time interval of August 1992 through to August 1993. … I do not see any reference to HIV, or Hep-C, Hep-B testing being ordered here … as there was no apparent indication for doing same.
>
> …***My impression is that no blood transfusion was given and there are no records in the Morden OR and hospital ward records of this having occurred***.
> [emphasis added]

[25] Counsel for both parties were invited to comment on these replies, and suggest any further follow-up that may be in order with respect to either Dr. J or Dr. P. Counsel ultimately advised that no further follow-up was required. I invited counsel to advise whether they wished to make further arguments in writing or whether they wished to make further oral submissions. Both counsel advised that they were content to have me proceed to decide the matter without further argument or submissions.

C. ANALYSIS

[26] The Administrator was obligated to apply the provisions of Section 3.01 of the Plan text, *supra*. Having initially properly done so, the onus shifts to the Claimant, to meet the burden set out in the "notwithstanding" provision contained in Section 3.01(2) of the Plan text, *supra*, which provides an exception to the general rule embodied within Section 3.01(1) (a).

[27] Therefore, the sole issue is whether or not the Claimant has nevertheless succeeded in providing "evidence independent of the personal recollection of the claimant or … a family member, establishing on a balance of probabilities that … she received a blood transfusion in Canada during the Class Period." There is a heavy, though not insurmountable burden upon the Claimant to establish that she fits within the "notwithstanding" provisions of Article 3.01(2).

[28] Here the Claimant supplied a letter from Dr. M, Surgeon to the Claimant's lawyer, dated November 1, 2004[23] in an effort to meet the burden of the "notwithstanding" provision. He states:

> …I have gone over the records with particular attention to her injuries sustained in Morden…The area of concern was whether or not there was likelihood given the severe nature of her injuries whether she required transfusion in relation to management of these areas. There was significant amount of blood loss both at the scene and extensive limb surgery and contusions with placement of a drain.
>
> The Manitoba records to the extent that were available were reviewed along with Dr. M's chart and the chart is as complete as you have found recorded. It is lacking in certain areas but I believe an operative report along with discharge summaries are noted… The operative reports and clinic notes are complete for the time. The operation involved a serious injury to the left thigh and knee surgery to debride and careful closure of primarily soft tissue injuries and fractures.
>
> The procedure was done with tourniquet control to facilitate limitation of blood loss and while detailed ***there is no mention of any transfusion and the anesthesiologist mentions none as well. It would be specifically required for complete anesthesia record to note this*** and given blood

[23] Exhibit 3

> control for transfusion records ***I think it would be doubtful that she would have received blood products over this hospitalization without specific documentation of this***. The record is incomplete however for all details. If collaborating nurses operative record, nursing notes over the hospitalization and subsequent hemoglobin and or CBC results over the time of her stay in hospital from admission to discharge could provide some collaborative evidence of use of blood or blood products.
>
> ***In short, I find nothing unusual in the record that would suggest blood or blood products being utilized or necessary*** but that the record is incomplete in several areas. [emphasis added]

[29] While the Claimant and her counsel went through extraordinary steps to attempt to obtain evidence that would support her position, regrettably for the Claimant, she was in the end unable to do so. Having carefully considered the totality of the evidence, I am satisfied that in circumstances of this case, the Claimant has not met this burden. In the only cases where the Claimant has been found to meet this burden, there was not only in general an absence of key records, but also there was cogent evidence of a ***probable transfusion***, that was ***independent of the testimony of the Claimant*** or a family member of the Claimant.

[30] In *Confirmed Referee Decision # 96*, July 23, 2003, Referee Miller carefully considered whether the circumstances in that case could meet the "notwithstanding" test embodied in Section 3.01(2). It is necessary to consider the unique factual background that gave rise to the Miller decision. The main issue in the decision revolved around the September 1987 facial smash surgery performed by a Dr. Kester, a plastic surgeon, at VGH following the MVA in which the claimant's vehicle collided with a moose. Dr. Kester testified at the hearing and submitted to cross-examination by fund counsel. In 20 years of experience as a plastic surgeon in the Vancouver area, he had personally performed surgery in several facial smash cases and he recalled 3 cases of facial smashes specifically involving moose-car accidents. While he did not specifically remember a blood transfusion occurring in the operating room under his supervision in the claimant's case, he did remember the claimant, her condition and the hospitalization under consideration. He remembered that the claimant's facial condition was such that her blood loss was severe. He reviewed all the hospital records that had been provided to him by fund counsel and noted that the absence of any reference whatsoever to the need for blood or the existence of a blood transfusion would be unusual, particularly in the anesthetist's records, but noted that he expected it would be referenced in the nursing notes, which were no longer available. His testimony was that he considered it ***highly probable*** that the claimant received a

blood transfusion because it would be normal in a severe facial fracture of that type. He opined that in the Vancouver area in the context of a severe fracture and the accompanying blood loss, the infusion of one unit of blood would not be unusual and would not likely be regarded by any the surgeons or residents within the operating theatre either as a complication or as an emergency need. He found further support for his conclusion in that the hemoglobin readings recorded after the surgery went up, which he would not expect unless the patient had received an injection of blood. He also noted that if an emergency arose in the course of surgery, a unit of O blood could be ordered from the O.R. He noted that the claimant's preoperative hemoglobin level was recorded at 117 which he interpreted as being on the low side and following surgery he would have expected the hemoglobin readings be in the range of 105 to 110 whereas her reading was 120. He felt that this rise in hemoglobin levels was probably attributable to the injection of blood. He also stated that if the doctor had given a verbal order in the operating room, he would tell the anesthetist to do so, but the anesthetist would not know that he had typed and crossed the blood. In other words, if blood had been ordered in the operating room by the anesthetist, it may not have been noted. In addition to the testimony from Dr. Kester, although it was not relied on in reaching the decision, there was also oral testimony from the claimant's former partner who testified that he witnessed the blood transfusion occurring while awaiting the claimant's return from the operating room and described the details of his discussions with the nurse in that respect. Referee Miller stated, in allowing the claim:

> 60. In my view, Dr. Kester's evidence must be treated as the best evidence before me and where there are inconsistencies between his testimony and the hospital records, ***I find his oral evidence overrides because of his familiarity with the usual practices of surgeons at VGH in facial smash surgeries of this type, and in particular by reason of his specific recollection of this particular operation***. …I must conclude that his unchallenged opinion convinces me it is likely, or probable, that the claimant received a blood transfusion on September 13, 1987 in connection with the facial surgery performed by Dr. Kester. ***Without the weight of Dr. Kester's viva voce evidence, I would have been unable to conclude that there was requisite evidence on the balance of probabilities to satisfy the requirements of the Plan.***
>
> 61. My decision in this case may put a nearly impossible burden on the Administrator to undertake a trace-back of blood apparently transfused into this claimant for which no record can ever be found. ***In light of all the foregoing, I conclude this case must very likely be confined to its own peculiar facts***. [emphasis added]

[31] The Miller case clearly turned on the specific testimony provided by Dr. Kester, which was well supported by his specific recollection of the surgery in question, and other surgeries he had performed relating to facial smashes, even more specifically relating to moose-car crashes; like the Miller case here there were no nursing notes or other records. In the present case, the Claimant was unable to produce a physician that could support her position. The report from Dr. M does not rise to the level of proof necessary and is in fact on balance more supportive of the position of the Administrator than the Claimant. In fact, here, not only were the attending physician and surgeon not supportive, they were definitive that there was no transfusion and provided reasons for this.

[32] There is a second decision in which a referee has determined that a claimant met the "notwithstanding" burden imposed by section 3.01(2). In *Confirmed Referee Decisions # 150* (Nols, Referee, June 22, 2004), the claimant alleged that he had received a blood transfusion during a brief hospitalization in 1987. The claimant admitted that he had an operation which normally does not necessitate a blood transfusion, but for reasons which he could not fully explain, alleged that he had been transfused while under general anesthetic. The hospital wrote him advising that the records concerning all blood products that were administered to him were destroyed following the closure of the hospital in January 1997. Referee Nols pointed out that this was not a case where the hospital records were silent on the issue of whether the claimant received a transfusion or not, but rather was a case where such records, including blood bank records, had been purged or destroyed. Faced with the non-availability of his hospital records, the claimant called as a witness a friend of the family who had visited him while he was hospitalized in 1987. The friend recalled a nurse coming in, hanging some blood and "plugging it in". This witness eventually graduated in nursing in 1993 and admitted that while he did not have a "trained eye" in 1987, was familiar with blood transfusions and knew how to recognize one. The Referee was clearly impressed by the testimony of this witness and accepted it. There was no evidence to suggest that the claimant had a "lifestyle or a character such as to create additional risk factors" and no more plausible explanation given for the infection than that of a 1987 blood transfusion. On the unique facts of that particular case, including the lack of any health records or blood bank records of any kind and the affidavit and *viva voce* evidence of the claimant's friend, Referee Nols found that the claimant had met the "notwithstanding" burden of Section 3.01(2) and should therefore succeed in his appeal. Here, although some health records from the stay in question were no longer available, the key documents, on which one would have expected a transfusion or some reference to the need for one, were available and not only did not record blood, but were very detailed in many areas and yet despite this detail there was no reference to any significant bleeding or surgical complications that may have necessitated blood. Therefore, the Nols decision does not assist the Claimant.

[33] In a recent unreported decision, I allowed the appeal of a Claimant where there was independent support for the Claimant's position by the Bleeding Disorders

Nurse at the Hospital that the Claimant claimed to have received Cryoprecipitate. However, in the present case, there was nothing produced that was independent of the testimony of the Claimant, that would allow me to decide in her favour in these circumstances. The report of Dr. M (particularly when considered against the backdrop of Ms. Miller's testimony, the existing detailed records that show virtually everything that happened but fail to report a transfusion, and the explicit reports of the Claimant's attending GP and Surgeon) does not rise to the level of proof necessary to meet the "notwithstanding" burden.

[34] Claimant's counsel filed a lengthy Brief, which focused extensively on the issue of spoliation of evidence, specifically related to the loss or destruction of certain hospital, ambulance and RCMP records, which, it is argued, place the Claimant in an impossible position of attempting to track down proof when she was only diagnosed 15 years after the surgery in question. I cannot find any basis to conclude that there was an intentional destruction of evidence. Furthermore, the existing records are in fact the key records and they argue strongly against any inference that blood was required or given.

[35] It must be said that the Claimant has been most honourable in her manner of approaching this claim and in researching and advancing her claim in the most vigorous and diligent way possible. In the interests of finding out the truth, she has been most forthcoming with information and documentation. There is absolutely no suggestion of intravenous drug use. Unfortunately, as there are many possible sources of infection, she will in all probability never know the definitive source of her infection with any degree of certainty. The Claimant has dealt with significant health and personal setbacks in a manner that has permitted her to retain a positive deposition and sense of humor, for which she is to be commended. If the applicable test was whether or not the Claimant was truthful in her belief that she obtained a blood transfusion, she would have succeeded, in that I have no doubt whatsoever as to the honesty of her views in that respect. Her evidence was provided in a candid and straightforward manner. There is no basis to doubt the sincerity of her views. In other words, if there is any way that the evidence would have allowed me to find in the Claimant's favor, I would have been delighted to have been able to do so. However, the evidence leads to two possible conclusions: (1) that the Claimant was mistaken in her recollection of events, which is understandable given the severe trauma she underwent, the significant narcotic medication she was under during the days leading to her surgery and the number of years that have elapsed since; or (2) that the Claimant was unable to meet the burden of proof placed upon her by the provisions of the Plan.

[36] Regrettably for the Claimant, in the final analysis, while the evidence did not establish the definitive source of her HCV infection, I find that she was unable to establish that she received a blood transfusion during her August 1987 surgical stay at Morden Hospital or at any other time during the Class Period. Unfortunately for the Claimant,

there was simply no evidence that could reasonably be interpreted so as to rise to the level necessary of proof necessary to meet the Miller and Nols tests.

[37] The appeal must therefore fail. The Claimant is not entitled to receive compensation. The Administrator has an obligation to assess each claim and determine whether or not the required proof for compensation exists. The Administrator has no discretion to allow compensation where the required proof does not exist. The financial sufficiency of the Fund depends upon the Administrator properly scrutinizing each claim and determining whether the Claimant qualifies. A Referee similarly has no jurisdiction to alter, enlarge or disregard the terms of the Settlement Agreement or Plan, or to extend or modify coverage, including the requirements of the "notwithstanding" provision contained in Section 3.01(2) of the Plan text.

[38] Finally, I would like to express my appreciation to counsel for both parties for the vigorous and capable, yet collegial manner in which they represented the interests of their respective clients throughout.

D. Decision

[39] Upon careful consideration of the Settlement Agreement, Plan, Court orders and the *viva voce* and documentary evidence tendered, the Administrator's denial of the Claimant's application for compensation is hereby upheld.

Dated at Saskatoon, Saskatchewan, this 27th day of July 2005.

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Daniel Shapiro, Q.C., C. Arb., Referee