IN THE MATTER OF A REFERENCE TO REVIEW

THE DECISION OF THE ADMINISTRATOR UNDER THE HCV 1986-1990

TRANSFUSED SETTLEMENT AGREEMENT

Claim No. 1300300

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

Hearing Date: June 29, 2005 at Vernon, British Columbia

Decision

Claim ID:1300300

I. INTRODUCTION

1. The threshold issue in this reference is whether the Administrator was correct in denying a claim under the Transfused HCV Plan (the "Plan") on the basis that the Claimant did not prove she received transfused Blood within the Class Period, January 1, 1986 to July 1, 1990.

2. The Claimant applied for compensation under the Plan as a Primarily-Infected Person. By letter dated June 15, 2004, the Administrator denied her claim on the basis that the Claimant had not provided sufficient evidence to show she had received Blood within the Class Period from a donor determined to be HCV antibody positive.

3. The Claimant requested a review of the Administrator's denial of her claim by a referee.

4. An in-person hearing was conducted on June 29, 2005 in Vernon, British Columbia. The Claimant testified. The Administrator was represented by Mr. William Ferguson, British Columbia Fund Counsel. Ms. Carol Miller, of the Administrator's office, also attended and gave evidence. The hearing was adjourned to obtain the complete medical records of the Claimant for the period February 6, 1988 to February 14, 1988 from BC Women's Hospital and Health Sciences Centre (the "Hospital"), formerly known as Grace Hospital, in Vancouver, British Columbia, where the Claimant had surgery during the Class Period.

5. On July 12, 2005, I caused to be issued a Summons to the said Hospital to produce the complete records of the Claimant for the period as noted. The records were to be produced and delivered to Fund Counsel.

6. On October 12, 2005, I caused a further Summons to be issued to the medical director of the Blood Bank of the Hospital for the complete blood bank records

pertaining to the Claimant for the above-noted admission to the Hospital in February 1988. The Hospital records, including the blood bank records, were produced and delivered as directed. The Blood Bank records were actually produced by Children's Hospital, considered to be part of the Hospital for record keeping. After receipt and delivery of the hospital records, I invited the parties to make further submissions. The parties had no further submissions to make.

II. FACTS

7. The Claimant is infected with Hepatitis C.

8. In February 1988, the Claimant was admitted the Hospital, to deliver a baby. She delivered by caesarean section and had a tubal ligation.

9. The Claimant honestly believes that she must have had a transfusion at the time of her surgery at the Hospital in February 1988. She cannot conceive of any other reason for her Hepatitis C. She suggests that there are errors and deficiencies in the hospital chart and one should draw an inference that she had a transfusion although it is not properly recorded in the records.

10. In addition to the Claimant's evidence given at the time of hearing, the Claimant stated in her Request for Review: (Claim's file, pp. 6-10, Tab 2, Exhibit. 1)

> The hospital records show the wrong date for surgery, as well as the report also indicates that information was missing from the first report, and that this is a replacement. At the time of the 2nd report the information is still wrong, [therefore], blood records could also be inaccurate.
>
> The correct date of surgery was February 8/88. The Grace Hosp. report indicates February 7/88.
>
> I was awake for the entire C-section. The Hosp. report indicates that the procedure was 'well tolerated' – this is completely inaccurate. I had a severe reaction to the epidural morphine which lasted three days. At the time of surgery, my blood pressure dropped, I went into seizure, my heart had to be kept pumping by giving a shot of medication and every fluid in the room was needed to keep up blood volume enough to keep my heart going.

> I know that blood was already typed for me and was in the room ready to be used in an emergency-which did occur but has not been reported in the surgery report.
>
> In fact, the report (hosp.) was so faulty that it had to be redone once and even then the day of surgery is still wrong and the emergency incident was not reported. My daughter's father and grandmother are witnesses to this near-death experience.

11. The Claimant points to the operative report of February 8, 1998 and the anaesthesia record of the same date. She had hypotension as noted on the anaesthesia record and estimated blood loss was 500cc according to the operative report. She also points out discrepancies between the anaesthesia and operative records, namely that the anaesthesia record shows no blood loss and the operative report indicates 500cc of blood loss. She suggests her blood loss may have been more and that during a previous caesarean section in 1985, the anaesthetist estimated a blood loss of 1,000cc. She points to an operative report for the previous caesarean section in December 1985 and notes that the surgeon indicated an estimated blood loss of 500cc whereas the anaesthetist said the estimated blood loss was 1,000cc. She also claims that in February 1988, the surgeon, Dr. Reimer (also the surgeon in 1985) noted that the patient tolerated the procedure well but the Claimant says that she was vomiting, having seizures and there was concern for her survival.

12. The Administrator requested that Canadian Blood Services ("CBS") conduct a Traceback in relation to the claim. CBS summarized the Traceback results in a letter dated May 27, 2004 and in an attachment (Claim's file, pp. 42-43; Tab 2, Exhibit 1).

13. The Claimant requested further information from CBS. By letter from Fund Counsel, dated February 10, 2005 with enclosures (Tab 3 of Exhibit 1), this additional information was provided. A letter dated January 27, 2005 from CBS was attached and which reads in part:

> Our CBS Vancouver Centre received a phone message from a Transfusion Services Technologist at Children's Hospital. The Technologist stated that she had re-checked the Blood Bank and Health Records for [the Claimant]. She stated that there are no records of transfusing this patient. She also stated that there are records of group

and screens done, but no transfusions given, and that either the claimant or lawyer could request the entire patient chart from the hospital if necessary.

14. Carol Miller of the Administrator's office testified at the hearing. She has considerable training as a nurse. She testified that if there was a transfusion it would have been recorded in the hospital records. A transfusion request would be completed by the Blood Bank of the Hospital. A request for transfusion would be recorded by the anaesthetist. The nurses are required to record a transfusion in the chart. Blood would have to be cross-matched in the Blood Bank. The blood would have to be signed for on a transfusion record. Ms. Miller reviewed the hospital records that were available before the hearing on June 29, 2005 and there was nothing that seemed to be missing. All relevant records appeared to be extant.

15. In order to be absolutely sure that all hospital records were produced, including the blood bank records, I directed all records to be produced. As indicated, they were. There is absolutely nothing in the entire records which indicates the Claimant had a blood transfusion during her admission to the hospital in February 1988.

16. The hospital records indicate that on February 7, 1988 a group and screen was ordered as per Dr. Reimer's orders (p. 10, Tab 5, Exhibit 1). A Blood Bank record, completed February 7, 1988 at 19:10 hours, indicates that there was a "blood group and antibody screen" for the Claimant. A copy of the Blood Bank document is also found in the hospital records (p. 20, Tab 5, Exhibit 1). A sample of the Claimant's blood was collected at 16:45 hours on February 7, 1988. The record indicates that the patient had blood group O positive and her antibody screen was negative. As explained by Carol Miller, a sample of her blood was to be held for 48 hours in the Blood Bank, but there was no evidence of cross-matching. The document in question notes that the above order was reserved until 08:00 hours, February 9, 1988. A printout from the transfusion medicine computer shows no record of Blood products being issued for the Claimant. The contemporaneous record is consistent with the letter of CBS dated January 27, 2005, which indicated that there were no records of transfusions for the patient, only records of group and screens done.

III. ANALYSIS

17. To be entitled to compensation under the Plan as a Primarily-Infected Person, a claimant must provide records as set out in Article 3.01(1)(a) proving that he or she received a blood transfusion in Canada during the Class Period. If a claimant cannot provide the records required by Article 3.01(1)(a), Article 3.01(2) states that a claimant must deliver corroborative evidence, independent of the Claimant's personal recollection or that of family members, establishing, on a balance of probabilities, that he or she received a blood transfusion in Canada during the Class Period. If a blood transfusion was not received during the Class Period, then the claimant is not entitled to receive compensation.

18. The Claimant has not provided records as required by Article 3.01(1)(a) proving that she had a blood transfusion in Canada during the Class Period. The Claimant's evidence and submissions concerning errors and deficiencies in the medical records do not meet the onus of proof on a balance of probabilities in accordance with Article 3.01(2).

19. I am satisfied that upon review of the medical records there are no egregious errors or gaps in the chart to justify drawing an inference that an important medical procedure, such as a blood transfusion, took place but that no one on the entire medical team bothered to record it. This argument suggests there was a complete failure of procedure which would have involved the nurses, doctors and the Blood Bank staff. I cannot conceive that such a total breakdown of the medical system would have occurred. That is not to say I am so naïve as to believe that errors cannot occur in a hospital chart, but such a colossal breakdown of the entire system, or a conspiracy to not record a medical event, is unfathomable. In short, the Claimant puts forward speculation and inference but no real evidence to satisfy me on a balance of probabilities that she in fact received a blood transfusion during the Class Period. The Plan requires more than personal recollection of the Claimant to justify compensation in the absence of records. I believe the Claimant is an honourable person and honestly believes a transfusion must have occurred in 1988 to explain her HCV. However, the evidence does not support her belief.

20. Fund Counsel points to medical literature that indicates that in a relatively high percentage of cases (approximately 10-20%), the source of infection of Hepatitis C cannot be identified. It is unfortunate, but I agree with Fund Counsel, that it may not be possible to determine the cause of Hepatitis C in many cases. Nonetheless, it has been established by the Plan that a claimant is entitled to compensation only if it can be established, as a threshold matter, that the claimant had a blood transfusion during the Class Period.

21. On the basis of the facts before the Administrator, the Administrator had no alternative but to deny the claim. There was simply no proof that the Claimant received a blood transfusion in Canada during the Class Period. Neither the Administrator nor a referee, called upon to review a decision of the Administrator, can alter or ignore the terms of the Plan.

22. Accordingly, I find that the Administrator has properly determined that the Claimant was not entitled to compensation under the Plan. I uphold the Administrator's denial of the claim.

DATED at Vancouver, British Columbia, this 9th day of January, 2006.

Vincent R.K. Orchard, QC, Referee