Claim No. 13351

DECISION

A. Introduction

[1] By way of Application dated January 15, 2004,[1] the Claimant, a Manitoba resident who was then 32 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] There is no dispute that the Claimant has been diagnosed with HCV infection, at Level 2. There is also no dispute that the Claimant received a Blood transfusion in Canada during the Class Period. The donors of the 8 units of blood that were recorded as transfused were all found to be negative following a traceback. The "quirk" in this case is a suggestion in the records that the Claimant may have received 2 additional units of blood which were not documented in the records and which therefore could not be the subject of a traceback. Therefore, while no positive traceback could be proved, at the same time the traceback was deemed by the Administrator to be "inconclusive". However, the application was denied, not on the basis of failure to prove an HCV positive transfusion, but rather, on the basis of the Claimant's admitted non-prescription intravenous (IV) drug use. In the view of the Administrator, this IV drug use occurred after the Claimant's blood transfusion but before his diagnosis of HCV infection. After extensive communications and inquiries, voluminous medical records were obtained and reviewed by an expert consulted by the Administrator. In the opinion of the medical expert, on a balance of probabilities, it is much more likely that the Claimant was infected with HCV through his injection drug use in the 1990's. By way of letter dated August 11, 2005,[2] the Centre denied the Claim for the following reasons:

> **Reasons for Decision**
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> The Settlement Agreement requires the Administrator to determine a person's eligibility for class membership. The Court Approved Protocol ("CAP") for non-prescription intravenous drug use provides that the Administrator shall weigh the totality of the evidence obtained from the additional investigations required by the

[1] Claim Centre File for the Claimant, Ex. 1, pp. 28-32
[2] pp. 3-5

provisions of the CAP and determine whether, on a balance of probabilities, the HCV Infected Person meets the eligibility criteria.

The Administrator carefully reviewed all the material you provided to support your claim. A Committee reviewed your claim and concluded as follows:

Dr. Pinette, the doctor who completed the Tran 2 Treating Physician form indicated that you had used non-prescription IV drugs in 1991and 1992. You confirmed this statement in your Tran 3 declaration form. When completing the Other Risk Factor Inquiry Form you wrote you used IV Talwin and Ritalin in 1996.

On March 4, 2004 the Administrator notified you in writing that your claim would be rejected unless you returned the Further Evidence of First Infection Form in which you indicate whether you want to provide further evidence which establishes on the balance of probabilities that you were infected for the first time with HCV by a Blood Transfusion received in Canada between January 1, 1986 and July 1, 1990. Complete medical records and an Affidavit dated April 21, 2004 were submitted and reviewed.

In accordance with the CAP, the Administrator has considered all of the evidence submitted. In summary, your Traceback results were inconclusive as no positive donor was found and the HCV medical specialist's opinion was that it was much more likely that you were infected with Hepatitis C through your injection drug use in the mid 1990's. Therefore, it is determined that, on the balance of probabilities, you do not meet the eligibility criteria. The Administrator cannot conclude that you were infected by HCV for the first time by a blood transfusion received in Canada in the Class Period and your claim is denied.

[4] By way of Notice of Appeal dated August 30, 2005,[3] the Claimant sought a review of the Administrator's decision by an Arbitrator. The file was received by the Arbitrator in mid-September 2005, after which attempts were made to establish contact with the Claimant, who does not have either a telephone or email. Ultimately, with the assistance of Ms. Dupasquier, a RN working with a community-based Hepatitis C Clinic where the Claimant attends, a teleconference was held on November 11, 2005 with the Claimant, Ms. Dupasquier, Fund Counsel, Carol Miller (Appeal Co-ordinator) and the Arbitrator. Ms. Dupasquier is not legally trained and stressed that she was not representing the Claimant. However, she was kind enough to volunteer to assist him, as a

[3] pp. 6-9

support person throughout this process. At that time, the Claimant advised that he was requesting an "in-person" hearing, but asked that the hearing date be set far enough in the future to permit the Claimant (or Ms. Dupasquier) to attempt to locate and supply medical support for the Claimant's position and respond to the report obtained by the medical expert to whom the Centre had referred this file for review, namely Dr. Gary Garber. A hearing date was set for February 13, 2006 in Winnipeg. The parties and Ms. Dupasquier were provided with written notice of the hearing details by way of letter dated November 15, 2005 from the Arbitrator.[4] On January 3, 2006, the Arbitrator received a letter dated December 8, 2005 from Dr. Gilles Pinette,[5] a physician with the Winnipeg Hepatitis C Clinic, in support of the Claimant's position. By way of letter dated January 6, 2006,[6] the Arbitrator wrote to the Claimant, Ms. Dupasquier and Fund Counsel, enclosing a copy of Dr. Pinette's letter and inviting the parties to advise if either wished to arrange for the participation of Dr. Pinette at the hearing. Neither the Claimant nor Ms. Dupasquier replied, and ultimately new Fund Counsel advised that he did not require Dr. Pinette's participation.

[5] Ms. Miller, Fund Counsel and the Arbitrator traveled to Winnipeg on February 13, 2006 and arrived before the appointed time for the hearing. While Ms. Dupasquier was in attendance, unfortunately the Claimant did not attend and did not provide notice of or reasons for his non-attendance. Ms. Dupasquier telephoned the Claimant's mother, who advised that he had left home that morning, evidently for the hearing. The group then waited a full hour with no contact from the Claimant. At that time, rather than dismissing the appeal or considering it abandoned, it was determined that the appeal would proceed on the basis of the written materials supplied by both parties to date coupled with oral submissions made that day. In addition, Ms. Dupasquier was provided 14 days within which to supply any additional materials on behalf of the Claimant and Fund Counsel was provided with 14 days after that with which to reply to any new materials received. Ms. Dupasquier also said that she wanted to check with the Claimant to find out whether he wanted the issues to be decided by an Arbitrator or a Referee.

[6] On February 23, 2006, Ms. Duspasquier provided further written materials,[7] advising that she had spoken to the Claimant, who advised that he wished the matter to be decided by a Referee instead of an Arbitrator (I have agreed to this request), and who apologized for his absence at the hearing. He told her that he had no money for transportation to the hearing and had gone to the clinic instead. Ms. Duspasquier advised that she checked into the Winnipeg needle exchange and was advised that it started as a pilot project in 1990 was taken over by the Mount Carmel Clinic in 1992. She also provided with her new materials references including MediFind.com, *Physician's Guide to*

[4] Ex. 2
[5] Ex. 3
[6] Ex. 4
[7] Ex. 5

What's on Line, Hepatitis C, and *Management of Viral Hepatitis, Recommended Guidelines for Physicians*, Canadian Association for the Study of the Liver, 1999, and *Hepatitis C Medical Information Update*, Canadian Liver Foundation. Fund Counsel responded to the materials supplied by Ms. Dupasquier. The matter will therefore be adjudicated upon based on the written materials and submissions received.

B. Document Summary

[7] The Claimant was diagnosed as being infected with HCV in 2003. He maintains that he contracted the virus by way of blood transfusions while hospitalized between April 18 and April 26, 1986. The Claimant, then 14 years old, received 8 units of Blood (packed cells) at St. Boniface General Hospital ("the Hospital") in Winnipeg, in the course of treatment for a gunshot wound to the knee. However, it is from this point forward that some uncertainty arises. As noted in the correspondence from the Hospital dated July 25, 2003,[8] "**It appears that two additional units of packed cells may have been transfused on April 18, 1986. However, if these two additional units of blood were in fact transfused, the unit numbers were not documented on the 24 Hour Fluid Balance Record dated April 18 to 19 (1986) (see attached)".* The Transfusion Summary[9] conducted as part of the Traceback process, identified the 8 units of blood (packed cells) that are confirmed to have been transfused to the Claimant by unit number, and reported the HCV status of the donor in each case as "negative". The unit numbers of the other two units, assuming they were in fact transfused, are unknown and are therefore untraceable and could not be tested. The Summary ended with the following note:

> * Please note that according to the…Hospital …it appears that two additional units of packed cells may have been transfused on April 18, 1986. However, if these two units were in fact transfused, the unit numbers were not documented on the chart."

[8] The Hospital records show two separate requisitions, for 6 and 2 units of packed blood cells respectively.

[9] The Claimant acknowledged that he had used non-prescription IV drugs, in the following terms:

> (a) In his Tran 3,[10] sworn January 1, 2004, the Claimant checked off "false" after "4. I declare that …. The HCV has never at any time used non-prescription intravenous drugs" (although he did not disclose details of the time);

[8] Ex. 1, p. 74
[9] Ex. 1, p. 144
[10] Ex. 1, p. 41

(b) The Tran 2,[11] dated September 18, 2003 (Treating Physician's Form) completed by Dr. Pinette, states that the Claimant had cocaine IV drug use (IDU) and Talwin and Ritalin IDU, ***1991-1992***;

(c) In the Other Risk Factor (ORF) Inquiry Form,[12] dated January 29, 2004, the Claimant identified non-prescription IV drug use by filling in " 'Talwin and Ritalin', for 6 months in ***1996,***" checked off "more than 30 times" but advised that he did not share needles;

(d) In his Affidavit sworn April 21, 2005,[13] the Claimant deposed that he used non-prescription IV drugs once every second day for a two-year period in ***1998*** and ***1999***. He further stated that he obtained his needles from the Winnipeg needle exchange, that the drug paraphernalia he used was only used once and was sterile, and that he never shared needles with other non-prescription IV drug users.

[10] In the ORF Form, the Claimant also indicated that he received 6 tattoos at home, when he was 10 and 11 years old. While he did not check off anything else on this form under "other trauma or surgeries", in records from the Health Sciences Centre in Winnipeg that were obtained later, there is an emergency room report of November 1995[14] in which the Claimant, who was reported to have been sniffing glue at the time, was attended on for facial injuries inflicted with the blunt end of an axe. Sutures were applied.

[11] There are also references to the Claimant, reportedly heterosexual, having had a history of sexually transmitted diseases (STDs), including gonorrhea and Chlamydia in 1990, when he was 19, at which time he gave a history of STD approximately two years previous, gonorrhea in 1991, when he was 20 and Chlamydia in 1992, when he was 21. However, when he attended at the Health Sciences Centre for suspected tuberculosis in April 2003,[15] the Claimant reportedly denied a history of STDs.

[12] In the Hospital records from 1986 related to the gunshot wound, there is a reference to the Claimant "sniffing glue or gas for past year."[16]

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[11] Ex. 1, at p. 37
[12] Ex. 1, pp. 65, 66

[13] Ex. 1, p. 269
[14] Ex. 1, p. 188
[15] Ex. 1, p. 227
[16] Ex. 1, p. 85

[13] In the face of the foregoing records and information, by letter dated June 13, 2005,[17] the Administrator wrote to Dr. Gary Garber, of the Ottawa General Hospital, requesting that he review relevant medical documentation to determine if in his opinion, and on a balance of probabilities, the Claimant's HCV infection and disease history are more consistent with infection at the time of the Claimant's 1986 blood transfusions, or with infection as a result of his non-prescription IV drug use. Dr. Garber is a medical specialist experienced in treating and diagnosing Hepatitis C. He stated in his report of July 26, 2005:[18]

> '…he has a longstanding history of substance abuse and when he was first admitted to hospital in 1986 it was documented that he smelled of glue and that he had been sniffing glue and gasoline. Subsequent chart indicates ongoing problems with sniffing but as well there is documentation of use of IV drugs including cocaine, Talwin and Ritalin. The patient has filed saying that he had used IV drugs more than 30 times for a six-month period in 1996, however there is (sic) records in the chart indicating that he had perhaps … used drugs in 1991, 1992. More interestingly in 2003 his liver function tests were completely normal at a time when he was diagnosed with TB and treated accordingly. During that time one of his liver function tests was elevated and hepatitis B surface antigen was negative as was antibody. He was both PCR and antibody positive for hepatitis C. I do not have the information on the genotype or level of virus.
>
> Based on Hep C positive antibody and antigen, he would be compensable at a level 2. One of the key questions is what is the likelihood of where he was infected. Based on confirmed units of blood received, these are all negative. There are two units of blood that were questionably given and have not been tested. On the other hand despite persistent substance abuse, his liver function tests in 2003 were normal. This would be relatively unlikely for someone who would have been infected with hepatitis for almost 20 years. Therefore on the balance of probabilities ***it is much more likely that he was infected with hepatitis C virus through his injection drug use in the 1990s, most likely in the mid 90s which would be a more viable explanation of completely normal liver function tests in 2003 which would only be approximately 8 years after exposure***.
> [emphasis added]

[17] Ex. 1, pp. 270-273
[18] Ex 1, pp. 275, 276

[14] Having received Dr. Garber's Report, the Claims Centre's IDU (Intravenous Drug Use) Committee met on August 3, 2005 to review the overall claim and consider the factors that were both supportive of and non-supportive of the Claimant's position that he was first infected by way of a transfusion. Weighing all of these factors, the Committee concluded that the review of the evidence delivered to the Administrator does not establish on a balance of probabilities that the Claimant was infected for the first time with HCV by a blood transfusion in Canada during the Class Period. The Committee voted to deny the Claim.[19] The IDU Committee Review is appended in its entirety.

[15] Dr. Pinette's letter of support for the Claimant dated December 8, 2005[20] states:

> I have been asked to provide some information regarding generalities of hepatitis C for you. I am the Director of the Community Hepatitis C Clinic in Winnipeg, Manitoba and we have been following people with hepatitis C for the last six years. I've researched hepatitis C extensively and teach physicians across Canada on primary care management of hepatitis C.
>
> There seems to be some question as to time lines of when a person is infected with hepatitis C and when they experience symptoms. In fact, the majority of people do not experience symptoms from acute hepatitis C infection or chronic hepatitis C infection. Those who do become symptomatic of acute hepatitis C tend to have malaise, weakness and anorexia; however, this only affects approximately 25-35% of people. In addition, those who are symptomatic are also more likely to clear the virus. Unfortunately, 75 to 85% of people that do become infected with hepatitis C infection go on to develop a chronic hepatitis C infection. Of the small percentage that do have symptoms with their chronic hepatitis C infection, fatigue and pruritis are the most common. Laboratory abnormalities sometimes include an elevated ALT and AST during chronic infection, but many times their ALT and AST are normal. There does not seem to be a correlation of elevation of ALT with disease symptomatology. If hepatitis C RNA testing was done, that would have been positive from approximately two to four weeks after the time of initial infection. Unfortunately, hepatitis C RNA testing was not widely utilized to diagnose or confirm chronic hepatitis C infection until the late 1990's.
>
> I hope this helps you clarify some issues on the complex management of hepatitis C…

[19] Ex. 1, pp 277-280.
[20] Ex. 6

C. ANALYSIS

[16] There is admittedly some confusion in the health records as to whether the Claimant did in fact receive 2 additional units of blood that were not recorded and which therefore could not be traced. The Claimant would no doubt be understandably upset and concerned about this.

[17] However, in this case, even if the Claimant had clear evidence that he received additional units of blood and even if those units had been traced back to their donors and one or both donors had tested HCV positive, the Claimant's history of non-prescription IV drug use changes the way his claim is dealt with and necessarily takes the Administrator down a certain path. In other words, a proven transfusion coupled with a positive traceback in these circumstances would only be one factor in the Claimant's favour, to be weighed against the totality of the evidence, bearing in mind that given the circumstances, the Claimant now bears the burden of proof in this respect.

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

> **ARTICLE THREE**
> **REQUIRED PROOF FOR COMPENSATION**
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> **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:
>
> (b) an HCV Antibody Test report, PCR Test report or similar test report pertaining to the claimant;
>
> (c) ***a statutory declaration of the claimant including a declaration* (i) *that he… has never used non-prescription intravenous drugs***, (ii) to the best of his… knowledge, information and belief, that he …was not infected with Hepatitis Non-A Non-B or HCV prior to 1 January, 1986, (iii) as to where the claimant first received the blood transfusion in Canada during the Class Period, and (iv) as to the place of residence of the claimant, both when he…first received a Blood transfusion in Canada during the Class Period and at the time of delivery of the application hereunder…. [emphasis added]

[19] In light of the Claimant's admitted non-prescription IV drug use, this case substantially turns on the issue of whether or not the Claimant has met the burden imposed upon him by the "notwithstanding" provisions of Section 3.01 (3) of the Plan, which provides:

> 3.01(3) ***Notwithstanding the provisions of Section 3.01 (1) (c), if a claimant cannot comply with the provisions of Section 3.01(1)(c) because the Claimant used non-prescription intravenous drugs, then he… must deliver to the Administrator other evidence establishing on a balance of probabilities that he… was infected for the first time with HCV by a Blood transfusion in Canada during the Class Period..***
> [emphasis added]

[20] 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 and Section 3.01(3) of the Plan text, *supra*.

[21] The CAP dealing with Non-Prescription IV Drug Use sets out the mechanics as to how Section 3.01(3) of the Plan is in practice to be applied. This CAP is in conformity with the Plan, although in fairness to the Claimant, did not exist at that time his application was filed and only appears to have been approved by the Court in February or March 2005. Portions that are of particular relevance to this case provide:

Applicability of CAP

1. This CAP applies where:
   a. there is an admission that the HCV Infected Person used non prescription intravenous drugs;…

Eligibility Criteria Where this Cap Applies

2. The Administrator must be satisfied on the balance of probabilities: …

   b. the HCV Infected Person was infected with HCV for the first time:
      i. by a Blood Transfusion received in Canada in the Class period…

3. The burden to prove eligibility (where this CAP applies) is on the claimant. The Administrator shall assist the claimant by advising what types of evidence will be useful in meeting the burden of proof in accordance with this CAP.

TRACEBACK

…

5. If the Traceback CAP does not apply, the Administrator shall perform the additional investigations required by paragraph 8 below….

7. The Administrator may not accept a claim based on the results of the traceback investigation without performing the additional investigations required by … paragraph 8 below.

Additional Investigations

8. If the claim is not rejected under the Traceback CAP, the Administrator shall perform the following additional investigations:

    a. obtain such additional information and records pursuant to s. 3.03 as the Administrator in its complete discretion considers necessary to inform its decision; and

    b. obtain the opinion of the medical specialist experienced in treating and diagnosing HCV as to whether the HCV infection and the disease history of the HCV Infected Person is more consistent with infection at the time of the receipt of … the Class Period Blood transfusion(s)… or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence.

9. The Administrator shall weigh the totality of evidence obtained including the evidence obtained from the additional investigations required by … this CAP and determine whether, on a balance of probabilities, the HCV Infected Person meets the eligibility criteria.

10. In weighing the evidence in accordance with the provisions of this CAP, the Administrator must be satisfied that the body of evidence is sufficiently complete in all of the circumstances of the particular case to permit it to make a decision. If the Administrator is not satisfied that the body of evidence is sufficiently complete in all of the circumstances of the particular case to permit it to make a decision, the Administrator shall reject the claim.

Examples of Additional Investigations

11. Examples of evidence the Administrator may require to inform its decision include the following:

a. an independent medical examination with a physician of the Administrator's choice, to obtain opinion evidence on any medical issues which the Administrator believes will assist in making its decision;

b. …medical and clinical records ….

c. The donation history, transmissible disease information …

d. An affidavit from the HCV Infected Person and a person who knew the HCV Infected Person at the time he/she used non-prescription intravenous drugs describing:
   i. Whether the drug paraphernalia used was sterile;
   ii. Whether the HCV Infected Person shared needles; and
   iii. The best estimate of the number of occasions and time period during which the HCV Infected Person used non-prescription intravenous drugs;

e. a consent to conduct a criminal records search …

f. an affidavit or interview of any person the Administrator believes may have knowledge about the non-prescription intravenous drug use or disease history of the HCV Infected Person.

Results of the Investigations

12. [Here the CAP sets out a list of criteria to be considered, which is mirrored in the IDU Committee Review form]

[22] Here the Administrator did what it was directed to do by the terms of the CAP. The IDU Committee appears to have carefully followed the provisions of the CAP. It did not simply make a mathematical calculation, but rather conducted a careful balancing of the totality of the available evidence. Clearly the Committee was concerned with the inconsistencies in the Claimant's various reports as to the timetable and extent of his IV drug use. Further, the Committee appears to have placed considerable reliance on Dr. Garber's report, which it was entitled to do under the terms of the Plan and the CAP.

[23] Even if the two questionable units could have been traced back to a positive donor, while this would have been one factor to consider, it would still have been necessary to also consider the other factors. In this case the medical evidence tends to suggest that a source of infection other than transfusion and tends to support a more likely alternative source of infection. The Committee noted the timing based on the disease progression, which was one factor that informed its decision. The Administrator can be guided by disease progression in determining both the source and timing of infection.

Because the diagnosis of HCV was only made in 2003, the only certainty is that the Claimant was infected at some point before 2003. This therefore reduces the issue to a consideration of possibilities and probabilities.

[24] The Medifind reference supplied by Ms. Dupasquier, under the heading "Maternal-Infant Transmission" states: "Perinatal transmission is rare and occurs in about 5-6% of births in infected mothers…Infected infants appear to clear the infection more frequently than newly infected adults. In addition, during childhood the disease is very mild, or even dormant. We do not expect the patients infected in childhood will develop significant liver disease for 40 or more years." This passage appears to refer to instances of maternal-fetal transmission and does not appear to be relevant. The second reference supplied by Ms. Dupasquier, *Management of Viral Hepatitis* states at page 12: "The rate at which the initial infection becomes chronic in infants is still unknown. Although progression of the disease seems to be more benign in children than in adults, some children do develop significant fibrosis…." This reference is in fact quite inconclusive. Nor does it address how the disease progresses into adulthood. The final reference, from the *Hepatitis C Medical Information Update*, states at page 16:"Studies of hepatitis C in children are extremely limited and most have been on post-transfusion patients. Preliminary data from the Hospital for Sick Children in Toronto suggests that children have a lower rate of progression to chronic hepatitis C following transfusion than adults. The disease appears to be mild in children." This reference is highly couched, based on "preliminary data" from "extremely limited" studies, in a single centre. Even this couched language does not address how the disease then progresses into adulthood, or indicate the age group being referred to. These references are therefore of limited assistance in these circumstances.

[25] Fund Counsel supplied written submissions which appended the CAP and an article, *Enhanced Surveillance of acute hepatitis B and C in four health regions in Canada, 1998 to 1999*,[21] Zou et al, Can J Infect. Dis Vol 12 No 6 November/December 2001. At page 31, this article lists a Table which outlines a study of distribution of mutually exclusive risk factors for acute Hepatitis C in the four health regions studied in 1998 and 1999, among the 72 patients interviewed, which listed the risk factors as follows:

[21] Exhibit 7

Table 3

Distribution of mutually exclusive risk factors for acute hepatitis C in four health regions, 1998 to 1999, among those who have been interviewed (72 of 102, 71%)

Risk Factors	Number of Cases	Percentage of all cases	Percentages of cases with known factors
Injection Drug Use	*36*	*50.0*	*63.2*
Drug snorting	3	4.2	5.3
Occupational blood Contact	2	2.8	3.5
Blood transfusion	***1***	***1.4***	***1.8***
Hemodialysis	1	1.4	1.8
Tattooing	***2***	***2.8***	***3.5***
Body piercing	2	2.8	3.5
Incarceration	2	2.8	3.5
Sex with Hep C carriers	***2***	***2.8***	***3.5***
Hep C earlier in family	3	4.2	5.3
Hospitalization	1	1.4	1.8
History of dental visit	2	2.8	5.3
Unknown	15	20.8	
Total (exclude unknown)	57		100.0
Total (include unknown)	72	100.0	

[26] In terms of ***probabilities***, it becomes necessary to consider both the 1986 transfusions and the admitted intravenous non-prescription drug use in the 1990s. Dr. Pinette clearly has considerable expertise and qualifications in this area. However his statements are fairly general, as are the extracts from the medical authorities supplied by Ms. Dupasquier. These do not in an overall way detract from the specific conclusions reached by Dr. Garber, who also has considerable expertise in this area. Dr. Garber specifically found that the normal liver function testing in 2003 points to a high probability of more recent infection versus the 1986 transfusion. Further, while the data set out in the scholarly article provided by Fund Counsel is admittedly based on a small sample of patients, it does show injection drug use as a risk factor in 50% of all cases versus blood transfusion, which is listed at 1.4%. Even tattooing is double the percentage of blood transfusion as a risk factor. Although it is not known whether the Claimant had unprotected sexual relations specifically with hepatitis C carriers, it would appear that he clearly indeed engaged in unprotected sexual activity, which gave rise to a variety of STDs. Therefore, while it indeed remains ***possible*** that the Claimant was infected by way of blood transfusion, from a statistical perspective alone, I find that the ***probability*** is that he was not and that he was rather infected by way of non-prescription intravenous drug use.

[27] There is unfortunately no testimony from the Claimant to explain the discrepancies in his reports of such drug use. Further, while he claims to have only used sterile needles and denies sharing needles, given the many reports of substance abuse and the nature and extent of such abuse, while there is no suggestion of dishonesty on his

part, the Claimant's *reliability* as a historian in this regard is certainly very much open to question.

[28] As an aside, the CAP does allow the Administrator to direct the Claimant to an Independent Medical Examination and also allows the Administrator to conduct interviews. While neither of such steps is mandatory, had one or the other step been taken here, it would have allowed for more focused questioning of the Claimant (or others) from individuals who are qualified to consider the appropriate questions to ask. Consideration of such steps would be conducive to ensuring that no reasonable stone is left unturned in affording the Claimant every opportunity to fully understand and attempt to meet the burden placed upon him. Otherwise, the first real opportunity for a Claimant to address the specific issues in a comprehensive way may be at a Reference or Arbitration. I am not saying that such steps were required here. However, in some cases, a hearing could perhaps be avoided by undertaking such additional steps. Even if such steps would not obviate the need for a hearing, they may serve to provide additional focus for the hearing. I simply encourage the Administrator to give consideration to taking such steps in appropriate cases.

[29] The materials provided by Ms. Dupasquier and Dr. Pinette have raised interesting and important issues for consideration. Unfortunately for the Claimant, on the facts before me, these issues merely raise possibilities and do not rise to the level of probabilities required by the Plan and the CAP.

[30] In the circumstances, I am unable to find that the Administrator has failed to properly apply the terms of the Plan and the CAP to these facts. Further, I find that the Claimant has failed to meet the burden upon him to establish that he was probably infected with HCV for the first time as a result of a 1986 Blood transfusion.

[31] 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.

D. Decision

[32] Upon careful consideration of the Settlement Agreement, Plan, CAP and documentary evidence tendered, the Administrator's denial of the Claimant's application for compensation is hereby upheld.

[33] I would like to express my appreciation to Ms. Miller and Mr. Faille for their assistance and courtesy. I would be remiss if I did not express my special thanks to Ms. Dupasquier for her kind, thoughtful and capable support of and assistance to the Claimant throughout this process. She went well above and beyond the call of duty and is to be commended for her efforts.

Dated at Saskatoon, Saskatchewan, this 21st day of March 2006.

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