IN THE MATTER OF A REFERENCE
PURSUANT TO THE PROVISIONS OF THE
TRANSFUSED HCV PLAN ESTABLISHED BY VIRTUE OF
THE HEPATITIS C, JANUARY 1, 1986 – JULY 1, 1990
CLASS ACTIONS SETTLEMENT

Claim Number:	1400543
Province of Alleged Infection:	Saskatchewan
Province of Residence:	Saskatchewan
Claimant's Representative:	William Selnes
Fund Counsel Representing Administrator:	Belinda Bain
Referee:	Daniel Shapiro, Q.C., C. Arb.
Date of In-Person Hearing:	February 27, 2006
Date of hearing resumption by teleconference:	June 16, 2006
Date of Decision:	September 16, 2006

COVER PAGE OF DECISION

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DECISION

A. Introduction

[1] The Claimant, now a Saskatchewan resident and 47 years of age, applied for compensation as a Primarily-Infected Person pursuant to the Transfused HCV Plan ("the Plan"), which is Schedule A 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] In January 1986 the Claimant received 4 units of blood at Saskatoon City Hospital, in connection with treatment for two fractured femurs, following a serious motor vehicle accident (MVA). Canadian Blood Services ("CBS") carried out a traceback on these units and reported, on February 28, 2002 [1]that the donors of 3 of these units had tested negative for Hepatitis C Virus ("HCV") and that the donor of the remaining unit was deceased (and therefore could not be tested). As this traceback was inconclusive, given the proof of transfusion during the Class Period, in the absence of any evidence of non-prescription intravenous (IV) drug use, the Administrator would have allowed the claim. However, in his application and elsewhere, the Claimant admitted having engaged in certain non-prescription IV drug use.

[4] There was a lengthy delay between the time of the Claimant's Application[2] and the Administrator's denial of the Claim, while the Court Approved Protocol – CAP - Non-Prescription Drug Use was being developed (which appears to have been adopted in late February 2004) and the Claimant obtained and supplied to the Centre certain additional health records and documentation. Ultimately, in a letter dated August 11,

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[1] The Claims Centre file, consisting of 654 pages, was entered as Exhibit 1 at the hearing. The CBS report is at pp. 64 and 65.

[2] The Application (TRAN 1), is at pp. 28-31.

2005[3], the Administrator provided the Claimant with the following reasons in support of its decision to deny the application for compensation:

> The Settlement Agreement requires the Administrator to determine a person's eligibility for class membership. The CAP for non-prescription IV drug use provides that the Administrator shall weigh the totality of evidence obtained from the additional investigations required by the 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 that you provided to support your claim. A Committee reviewed your claim and concluded as follows:
>
> Dr. McClean, the doctor who completed the Treating Physician Form noted that your history of non-prescription IV drug use in the 1970s. You confirmed this information in your Tran 3 declaration form. When you completed your Other Risk Factor Inquiry Form you indicated the IV drug use took place in 1978.
>
> 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. You submitted complete medical records and an affidavit dated May 10, 2004.
>
> In accordance with the CAP, the Administrator has considered all of the evidence submitted, including the opinion of a medical specialist experienced in treating and diagnosing HCV. In summary, your Traceback results were inconclusive as no positive donor was found and the HCV medical specialist's opinion was "I would say that it is more likely that he in fact was infected from his injection drug use than from the possibility of being infected from a single unit of blood that was not traceable." Therefore your claim is denied because the Administrator cannot conclude that you are infected by HCV for the first time by a blood transfusion received in Canada in the Class Period.

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

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[3] pp. 3-5

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:

(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]

[6] It is agreed that in these circumstances, the Claimant has complied with the provisions of Article 3.01 (1) (a), (b) and (c) (ii), (iii) and (iv). However, in light of his admitted non-prescription IV drug use, this case turns on the issue of whether or not the Claimant has met 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]

B. Facts, Summary of Evidence

[7] The Claimant sought a review of the Administrator's denial of his claim by a Referee and requested an "in-person" hearing. An "in-person" hearing was held in

Saskatchewan on February 27, 2006. The Claimant testified on his own behalf as did his former spouse. 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. At the end of the day on February 27, 2006, it was determined that further evidence would be given by way of teleconference on April 21, 2006, specifically, from Dr. McClean on behalf of the Claimant, as well as perhaps the Claimant's mother and a former employer, and Dr. Garber on behalf of the Administrator.

[8] The further evidence did not proceed as contemplated, either in terms of the specific witnesses or the timetable, as set out below. However, the evidence and submissions did ultimately conclude on June 16, 2006. The matter will be adjudicated upon based on the written materials and testimony tendered by the parties.

(a) Documentary Evidence

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

Exhibit 1 - Claims Centre File (pages 1 – 654)

Exhibit 2 - Medical file sent by Administrator to Dr. Garber (pages 1-405)

(b) *Viva voce* testimony

Claimant's Evidence

[10] The Claimant was born in Saskatchewan on March 22, 1959. He has 6 siblings, 2 full brothers, 2 half-brothers and 2 half-sisters. After his parents divorced when he was less than 2 years of age, he lived with his non-biological grandparents in North Battleford. After Grade 6 his mother took him to Prince George for Grade 7 and part of Grade 8. He lived in Edmonton for the rest of Grade 8 and part of Grade 9. At this point his home life fell apart. He fell in with a bad crowd of teens in Edmonton, doing casual weekday labor at a lumber yard or the airport and partying on weekends. The partying consisted of drinking beer and occasionally smoking marijuana. His grandmother encouraged him to avoid tattoos and drugs. He did not use IV drugs as a teen. He tried non-prescription pills (likely barbiturates) for about a week in the mid-70s, until he blacked out once and stopped. He tried Talwyn and Ritalin in pill form a couple of times, but again did not like how it felt and stopped. He also experimented with LSD, by blotter and microdot. He moved to Calgary when he was 18 or 19 and worked in construction for 1.5 - 2 years, and drank on the odd weekend. It was in Calgary that he experimented with Fiorinal intravenously over a period of about a week, although it was only off and on during that week. He had a friend hold his arm while he injected himself. After the 4th or 5th time, his arm became so badly swollen that he had to go to the emergency room at a local

hospital, where the doctor asked him if he could not find anything better than Fiorinal and told him that he had likely blocked a vein by not injecting himself properly. Eventually the swelling in his arm eased, but he was very concerned by what happened and has not used IV drugs at any time since. Over the one week that he did use IV drugs, he had purchased a 10-pack of sterile needles, he had not used all the needles by the time of the incident with his arm swelling up and he threw the rest of the needles out. Over that time, he did not share needles or drugs with anyone.

[11] The Claimant returned to North Battleford to live with his grandparents in 1979, at age 20 as he found he was drinking too much in Calgary. He spent 2 years training to do stucco application before the firm he was working with went under. He found that LSD gave him anxiety, so he stopped using this in 1981 or 1982. He moved to Saskatoon in mid-1981 or 1982, where he stayed with his mother. He did odd jobs and hung out in bars. He met his first wife at this time. He saw her at parties and they developed a relationship. They partied and drank extensively in Saskatoon but there was no IV drug use. Although he knew "hypes", (IV drug users) they did not hang around with his crowd. By 1983 he was in a committed relationship and by 1984 was living common law in North Battleford. He and his partner had a daughter together in 1985 and a son in 1987. Over this time they lived on social assistance and partying was limited to drinking, mainly beer. In January 1986 he was involved in a serious MVA in which he and his brother were trying to push their car out of the ditch and were hit from behind by a vehicle reported to have been traveling at a speed of 60 mph. He suffered two fractured femurs and other injuries. He has vague memories of being in the ditch and his next memory is 2 days later, when he was in hospital. He was hospitalized for approximately 2 months and cannot remember being told that he was given blood, but states that he was in a haze from medication. He remembers that about a week after the accident, his senses came back but his body did not feel right. He described it as feeling "dirty." He has never donated blood. After he returned home from hospital he was in physiotherapy for about 6 months and did not work again until 4 or 5 years later. He stopped drinking for a while but as time passed he got into binge drinking, 2-3 days every 2-3 weeks, in which he consumed up to 1-2 cases (12 to 24 bottles) of beer. By the late 1980s, during the times he had stopped drinking, he was seeing different doctors. He thought he was developing liver problems which might be alcoholic hepatitis but the doctors he saw said there was nothing wrong with him. He remembers seeing Drs. Bernardo, Puranha, Wolfe and later, Stephens. Dr. Bernardo did not believe him and he thinks this started to give him anxiety problems. He was seen by a psychiatrist who said there was nothing wrong with him. Dr. Stephens thought there was something wrong with him and told him that while his liver was not normal, it was not completely out of whack. He was sent to a Saskatoon specialist, Dr. Sharma. By then he was convinced that he was dying and was very frustrated that most of the doctors he had seen had not taken his complaints seriously. In order to make sure he was taken seriously, he exaggerated his IV drug use with Dr. Sharma, telling him that he had taken Talwyn and Ritalin intravenously when in fact he had not, and claiming to have taken drugs intravenously more often and more recently than in fact he had. He believed he would get more help this way. By this point he was

having anxiety and panic attacks, fearing his liver was going. He was getting severe dizzy spells and sometimes could not get up or walk properly for long without collapsing. He thinks this lasted for about 2 years. In the year before he saw Dr. Sharma, he lost 30 lbs in one month and another 10 lbs the following month. Nobody in his family had liver problems that he was aware of. The pain in his liver went away and his anxiety subsided.

[12] The Claimant acknowledges that he went to jail a few times, mainly related to unpaid fines. In 1983 he went to jail for more than a month for impaired driving. He had a pile of "driving while disqualified" convictions and pleaded guilty to trafficking parsley to an undercover officer. He pleaded guilty when he was guilty of offences he was charged with. The last time he was in trouble with the law was in 1994 or 1995. Over his whole life, he estimates that he spent 60 to 70 days in jail. He never used drugs in jail. He was adamant that the only time he ever used IV drugs was for that brief period in the late 1970s.

[13] The Claimant remembers going into City Hospital again to have the pins removed from his legs and meeting a Dr. Sommerville before the surgery. He remembers telling him about LSD and marijuana but does not remember discussing IV drug use with him. He was drinking in the early '90s and went on some benders but ultimately became sick. His skin was cracking, he was constantly thirsty and he remembers going cross-eyed in the bar in the middle of the day. He saw a doctor. His sugar was very high and he was diagnosed as diabetic. He knew diabetes and alcohol did not mix and, to his credit, quit drinking in 1992 or 1993. He was separated from his first wife for about 6 months in 1990 and for a few months a few years later. Eventually they broke up in 2000 as she had lots of drinking problems and he had sworn off alcohol many years before. He worked at a tree farm from 1992 to 2003, at a hog processing plant for 14 months afterwards and since May 2005 as a night watchman and security person on his First Nation. He has achieved his Grade 12 and completed welding training. He now lives in a positive relationship, with his second wife and has 2 children with her. He is active coaching aboriginal children in hockey and track. He and his wife look after a child of his cousin who passed away and sometimes take other teens in. He went back to occasionally smoking marijuana (only ¼ joint a night), but has not done so for a few years.

[14] In cross-examination or in response to questions from the Referee, the Claimant acknowledged:

- He first spent time in jail in 1978, for unpaid fines for "driving while disqualified".
- He was also convicted twice of assault, one on his then wife in 1994.
- Although he remembers that his Affidavit [4] states that he was convicted of common assault around 1983, it is inaccurate in that he was not convicted of assault in 1983. He thinks there could have been another assault conviction in 1993.

[4] Ex. 1, p. 80, para. 11 a)

- He spent about 30 days in the Saskatoon Correctional Centre before his then wife bailed him out.
- He had no explanation for the discrepancy between the testimony at the hearing, in which he stated that he spent probably 60-70 days in total in jail and his Affidavit, in which he swore that he "served approximately 6 months in total on the driving while disqualified charges".
- He drank a lot in the 70s and 80s. Often this was binge drinking, although he is adamant that he never drank to the point of blacking out. Although he drank "a case or 2" at a time, he learned to handle alcohol well. He only drank beer, not whiskey.
- When he lived in Calgary, he did associate with a few IV drug users, who were native people that partied with his friends. He did not see a lot of IV drug use. He lived with his mother and often partied there.
- He tried IV drugs once when drinking, the first time on a weekend. However, he did not drink during the other times that he used IV drugs. He used IV drugs during the weekdays and remembers 3 days in a row. He used IV Fiorinal no more than 5 times after the first time and all in a span of between 7 - 10 days. He did not feel good after taking it and thinks that if he had enjoyed it, he would still be using it. He denies that Fiorinal ever left him feeling hazy or foggy.
- As to how he could remember specifically buying a 10-pack of needles 25 years ago, he said that he clearly remembers going to a hospital in northwest Calgary, probably Foothills, with his arm seriously swollen, and that he threw out the remaining needles when he got home. He was told he had probably plugged a vein due to his inexperience with injections.
- He believes that if he had contracted HCV in the 1970s he would be dead now.
- Fiorinal was in caplet form. He mixed it with tap water and ran it through a cigarette filter, using a tablespoon that he took off the shelf and then returned to the same spot.
- He saw many doctors with concerns about his liver. Dr. Khurana suggested he might have a virus. Dr. Sharma did not take his concerns seriously, as was the case with the other doctors he had seen. He was worried that if he did not really "lay it on thick" with Dr. Sharma, he would get "sloughed off", as had happened before.
- When asked whether he thought it was important to be accurate with a specialist so that the specialist could provide the best treatment, he replied that he wanted to get into a hospital to get his liver thoroughly checked out. As it was, he felt that he got the revolving door from Dr. Sharma too. The Claimant "bumped up the years" during which he said he took IV drugs, and inaccurately added Talwyn and Ritalin to the list, to try to make Dr. Sharma think he was a recent, but not too recent user. He thought that in this way, Dr. Sharma might be more willing to try to help him immediately. He did not know much about HCV but knew that if left untreated, one can die from it. He thought he needed to be hospitalized because his back was inflamed, his liver was tender, food went right through him and he thought he was going to die.
- Although Dr. Sommerville's chart material from 1991[5] also refers to Talwyn and Ritalin, he did not remember talking to him about that and suspects that Dr.

[5] Ex. 2, p. 57

Sommerville simply picked that information up from Dr. Sharma's records on the same hospital's chart. The only time he was on Talwyn was after the MVA, from 1986-1988. He also received morphine, Tylenol 3 with codeine and other medications at that time. He did not remember if he spoke to Dr. Sommerville about LSD use.

- He is not sure if he was diagnosed with Hepatitis B although he did go for some tests for this and it could be the case.[6] His brother, who lived in the same house with the Claimant in Saskatoon, contracted Hepatitis B, evidently from his girlfriend, in the early '80s. His brother was not an IV drug user.
- Dr. McClean recently told the Claimant that he did not have Hep B, as if he did, he would not be able to go on HCV treatment.
- As to family members other than his brother who have had liver problems, he had a sister who evidently contracted HCV in hospital and passed away.

Claimant's first spouse

[15] The Claimant's former spouse testified that she met the Claimant in 1981 in a bar and they started up a friendship. They were often together at beer drinking parties in Saskatoon. Although there was probably some marijuana, people were not using IV drugs at these parties. She did not know anyone that used IV drugs. She and the Claimant started living together about a year later. She had 2 children from a previous relationship and they had 2 children together. They remained together from 1982 to 1990, at which time they broke up for a couple of years. She had a drinking problem, which was a big part of the reason for separating. They got back together until 2000, when they separated for good because there was too much arguing. During the period they lived together, although the Claimant drank, the only drug she ever saw him use was marijuana. She never saw him use IV drugs and did not hear him talk about them except to say that he did not care for them as, 'they could kill you' and he was very concerned that they were destroying some of his friends' lives. To her, he never appeared to be under the influence of such drugs. Although she knew people in the late '80s who took IV drugs, the Claimant did not party with them. When she and the Claimant drank, typically they were together. She recalls that in the mid to late 1980s, particularly after his 1986 MVA, the Claimant was always raising health concerns and saying that he did not feel normal within his body. She remembers him saying that it felt like his body was heating up inside. She recalled that the Claimant's doctors appeared to think he was a hypochondriac. After the accident he took better care of his health and improved his eating habits. She described the Claimant is being "as honest as he could be" with her in their relationship and said that she could rely on what he told her.

[6] Lab reports at Ex. 1, p. 507 show that he was negative for Hepatitis B in January 1999.

Administrator's Evidence

1. Carol Miller, RN

[16] 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 describes the lengthy process by which the Claimant's application was considered and ultimately denied. She is also on the committee that deals with all claims that are denied. There is a different process for people with a history of IV drug use. In these situations, the claimant must show on a balance of probabilities that he was *first infected by transfusion.* Although she did not know the exact date, she believes it was in February 2004 that the IV CAP was adopted by the court. Pursuant to the CAP, all medical and hospital records for 10 years before the transfusion to the present were obtained and reviewed. The Centre organized the key records chronologically and arranged to send them, along with summaries of documents dealing with IV drug use or liver problems, to Dr. Gary Garber, the head of Infectious Diseases at Ottawa Hospital. Ms. Miller arranged the summary that was provided to Dr. Garber.[7]

[17] Dr. Garber provided a report dated July 28, 2005[8], in which he stated:

> "...The claimant has indicated a history of injection drug use starting in the 1970s but reports no needle sharing. Specifically he relates to using Fiorinal in 1978 ***more than 10 times***. A note in the chart in 1988 indicated injection drug use for 2-3 years and quit 6 years ago. There is also a history of exposure to hepatitis A and as well perhaps hepatitis B. He had a sister who died of liver failure and one note reports that this was related to hepatitis C as well. He had liver biopsy in 1999 that indicated very little disease, however repeat biopsy in 2004 showed progression of disease at grade 2 stage 2...
>
> ...The key issue is ***when did he get infected***? There is one outstanding unit of blood and this has to be weighed on balance with his injection drug use. ***If one were to assume that he was infected in 1986 and with his history of alcohol use I would have expected some changes seen on liver biopsy by 1999***. However, the fact that there is progression of disease between 1999 and 2004 certainly (sic) infection around 1986 (assuming at least a 15 year period would pass before significant changes would occur) would be viable. On the other hand, ***if he had exposure***

[7] Ex. 1, pp. 504-507
[8] Ex.1, pp. 508-509

> ***risk through injection drug use after his blood transfusion in 1986 this would be an equally viable or perhaps a more viable cause of infection. If in fact one is to believe that his only injection drug use was in the late 1970s and only for the short period of time that was initially claimed, this would on balance make the unit of blood at least equally as likely as the period of time in 1978.***
>
> ***The issue is the conflicting history in the 1980s. If in fact he had injection drug use for several years in the 80s then clearly this would be a much higher risk of infection than would come from any single unit of blood.***
>
> Therefore, on the balance of the information received ***as there are several entry points in the medical history suggesting injection drug use in the 1980s*** in which the patient did not claim, ***I would say that it is more likely that he in fact was infected from his injection drug use than from the possibility of being infected from a single unit of blood that was not traceable.***
> [emphasis added]

[18] The records provided to Dr. Garber, together with Dr. Garber's opinion, were then reviewed by the IV Drug Use Committee, consisting of the Director of the Centre, the Director of Claims, the Senior Claims Processor (who also deals with Quebec appeals) and Ms. Miller. This Committee then uses a document it created by pulling together the concepts from the CAP.[9] Completing this form involves a balancing process. This involves an assessment of the factors that weigh both in favor of and against the Claimant's position that he was first infected by a Blood transfusion during the Class Period. This is not simply a numerical process, but is rather intended to be an overall assessment based on the totality of the evidence. Having reviewed all the records provided, including Dr. Garber's report, on August 10, 2005, the Committee concluded that there was no evidence to show on a balance of probabilities that the Claimant was first infected by a Class Period Blood transfusion. The Committee decided to deny the Claim. The Report is summarized below:

> **<u>Supportive</u>**
> Although none of these factors may prove conclusive in any individual case because the Administrator must consider the totality of the evidence, the following factors are examples of evidence that would be supportive of a finding that the person claimed to be an HCV Infected Person is eligible:

[9] Ex. 1, pp. 510-513

1. **Identification of a Class Period Blood transfusion from an HCV antibody positive donor .** No – No positive donor found

2. **The HCV infected person was under the age of 18 at the time of the receipt of ...the Period Blood transfusions.** No – 26 years old

3. **Reliable evidence establishes that the nonprescription IV drug use took place after July 1, 1990.** No – Dr. Stated 1970's, ORF form 1978 and Affidavit states late 1970's.

4. **An HCV disease history which is more consistent with... the Class Period Blood transfusion(s) for which an HCV antibody positive donor has been located or for which the status of the donor remains unknown ... than with the time of nonprescription IVDU.** No – See Dr. Garber's report paragraph 3 & 4; unable to determine because of the inconsistent history of IVDU in the 1980s.

5. **Reasonably reliable evidence that the non-prescription IVDU history is subsequent to the ... date of Class Period Blood transfusion(s)...** No – Took place in the 1970's and possibly the 1980's.

6. **Reasonably reliable evidence that the non-prescription IVDU was limited to a single location and was done with sterile equipment which was not shared.** No – ORF form stated more than 10 times[10]; Affidavit states more than 5 and less than 10.

7. **No medical history of unspecified hepatitis, Hepatitis B or Non-A, Non-B hepatitis prior to ...the Class Period Blood transfusion(s)** ... Yes – 1st comment on Hepatitis B is in 1988; paragraph 7 of summary – pg 53 file sent to Dr. Garber. Date of transfusions 1986.

Not supportive

Although none of these factors may prove conclusive in any individual case because the Administrator must consider the totality of the evidence, the following factors are examples of evidence that would not be supportive of a finding that the person claimed to be an HCV Infected Person is eligible:

1. **Failure to identify a Class Period Blood transfusion from an HCV antibody positive donor.** Yes – No positive donor found.

2. **An HCV disease history which is more consistent with infection at the time of non-prescription IV drug use than with the timing of ... the Class**

[10] This is incorrect. In the ORF form, at pp.56 and 57, the Claimant checked off the box, "More than X5". He did not mark off the next box, which was "More than x 10".

Period Blood transfusion(s) for which an HCV antibody positive donor has been located or for which the status of the donor remains unknown...– No – See Dr. Garber's letter paragraph 3 & 4; unable to determine because of the inconsistent history of IVDU in the 1980's.

3. Reasonably reliable evidence that the non-prescription IVDU took place on more than one occasion or was done with non-sterile or shared equipment. Yes – 1970's.

4. A medical history of unspecified Hepatitis, Hepatitis B or Non-A Non-B Hepatitis prior to the ... Class Period Blood transfusion(s)... No – 1st comment on Hepatitis B is in 1988; paragraph 7 of summary – pg 53 file sent to Dr. Garber. Date of transfusions 1986.

5. A refusal to permit the Administrator to interview any person the Administrator believes may have knowledge about the non-prescription IV drug use or disease history of the HCV Infected Person. N/A

6. A CBS ... file which indicates that the HCV Infected Person ... had tested positive for the antibodies to Hepatitis C or had donated blood prior to the Class Period blood donations or recipients of the pre-Class Period blood donations have subsequently tested positive for HCV antibodies. N/A – Never a Blood donor.

7. The file is in any other way consistent with HCV by non-prescription IV drug use <u>prior to</u> the ... Class Period Blood transfusion(s)... No. Paragraph 4 & 5 Dr. Garber's Report.

[19] In cross-examination, or in response to questions from the Referee, Ms. Miller acknowledged:

- Talwyn and Ritalin come in pill form. Fiorinal is in capsule form.
- She prepared the referral letter to Dr. Garber[11] which states that the Claimant wrote in his ORF Form that he used Firoinal C ½ during the summer of 1978 **more than 10 times.** She acknowledges that this was inaccurate to the extent that the ORF form actually stated[12] that this happened "**more than X5**" and the Claimant did not check off the box stating "more than X10".
- There is no evidence beyond Dr. Sharma's report that the Claimant used non-prescription IV drugs more than 10 times.

[11] Ex. 1, pp. 504-507, @ p. 504
[12] Ex. 1, p. 57

- There is no evidence of IV drug use after 1982 or 1983 (Dr. Sharma's 1988 report said that there had not been any IV drug use for the last 6 years, which would take it back to 1982).
- The latest evidence of IV drug use contained in the records is therefore in 1982 to 1983. All the information of IV drug use contained in the records (apart from what Dr. Sommerville wrote, which may have been taken from Dr. Sharma's report) came from Dr. Sharma.
- When Dr. Garber's report refers to "multiple entry points in the medical history suggesting injection drug use in the 1980s", the only one that clearly relates to the Claimant's report of IV drug use in the '80s is Dr. Sharma's note of June 15, 1988.
- In 1988 there was no direct test for HCV, and as far as she knows, it was not identified as a virus until 1989.
- Dr. Sommerville's report of September 1991[13] states, "***a note was made*** that he (Claimant) abused a variety of drugs over the years with IV drug abuse mentioned and Talwyn, Ritalin and Fiorinal specifically documented ... ***He says*** that he has been off alcohol entirely in the last three years and has not used any drugs (other than prescription items by his attending physicians) for about 8 years." She was asked whether Dr. Sommerville was referring to Dr. Sharma's report of June 15, 1988[14] or intending to reflect his interview of the Claimant on that occasion. Dr. Sommerville's handwritten of that attendance state "says off alcohol x 3 years and drugs for 8+/- years,"[15] whereas they do not refer to Talwyn, Ritalin or Fiorinal. Ms. Miller had no information on whether Dr. Sommerville got his information directly from the Claimant or from Dr. Sharma's earlier report.
- The IDU committee is to apply its own collective experience and not simply rely on Dr. Garber's report.
- Nobody from the committee interviewed the Claimant directly with respect to IVDU. The Committee followed the CAP, which does not direct or require an interview of a claimant or a family member of a claimant.
- Dr. Garber was asked to rely solely on the written records and was not asked to interview the Claimant.
- When asked whether the lack of an interview meant that there is no opportunity to assess credibility, for example, on the issue of whether the Claimant was sharing a needle, Ms. Miller testified that they did have the Affidavit material and medical records to go on. She acknowledged that under the process used, if a claimant says there is no needle sharing, the Administrator cannot see that person to assess credibility in that area, at least until there is a review by a referee or arbitrator.
- Ms. Miller was asked whether because there was no test available that a claimant could produce to show that he was infected with HCV between 1986 and 1990, this meant that the Administrator is effectively always assessing the credibility of a claimant. Her response was that the Centre does not assess credibility but evaluates

[13] Ex. 2, pp. 56, 57
[14] Ex. 2, pp. 51, 52
[15] Ex. 2, p. 58

medical evidence. If the courts (through the IV CAP) say that person is out, he has to prove his way back into the Plan. The Claimant could bring himself back within the Plan if he could produce other evidence of first infection.

- At the time of the HCV transfusion in 1986, there was no evidence of HCV or Hepatitis B. The CAP says that Hep B before a transfusion is one factor to consider.
- When asked whether the risk of IVDU relates exclusively to sharing a needle with somebody who was infected with HCV, Ms. Miller qualified her answer by stating that the issue had to do sharing of needles or paraphernalia.
- The Committee did not consider the Claimant's incarceration to be of significance, given the short period of incarceration (6 months) reported in his Affidavit.
- Had there been no indication of IVDU use here, because it was not possible to trace back one of the 4 transfused units of blood, the trace back would have been deemed "inconclusive" and the claim would have been allowed. However, in this case, the big issue was whether the Claimant had shown that the blood transfusion was the source of first infection, which the committee felt he had not. In view of the admitted IVDU, the claim is automatically rejected unless the Claimant can "prove his way back in," which in this case he did not.
- In this case, the medical evidence shows that the Claimant stopped IV drugs in 1983 at the latest, he was transfused in 1986 and there was no indication of HCV at that time.

[20] The hearing was adjourned to April 21, 2006 for the purposes of obtaining evidence by telephone from Dr. Garber, as well as the Claimant's specialist, Dr. McCLean and perhaps the Claimant's mother. In addition, the Claimant advised that he thought the hospital he attended at in Calgary was the Foothills Hospital. With the Claimant's consent, I wrote to the Foothills Hospital to request production of all records of the Claimant's attendance at the facility. Foothills Hospital replied that it had no records of the Claimant's attendance there.[16] However, the April 21, 2006 teleconference did not materialize due to emergent circumstances of Fund Counsel. Ultimately, counsel for the Claimant advised that the Claimant no longer planned to have either Dr. McClean or the Claimant's mother testify. Ultimately, Dr. Garber's testimony and closing arguments were re-scheduled for June 16, 2006.

2. Dr. Gary Garber

[21] Minutes prior to Dr. Garber's testimony, counsel for the Claimant advised that he wished to cross-examine Dr. Garber on the findings of the Krever Commission and some of the journal articles referred to therein. After hearing submissions, I ruled that as Dr. Garber's testimony had been scheduled for some time, and in view of the fact that it was known that his testimony would be given by telephone, I was not

[16] My letter to Foothills Hospital and the reply from Foothills Hospital have been marked collectively as Exhibit 3, as if they had been entered into evidence at the hearing.

prepared to allow Claimant counsel to cross-examine on documents that were not before Dr. Garber and with which he was not familiar.

[22] Dr. Garber was deemed qualified to offer opinion evidence in the field of Infectious Diseases, with particular expertise in relation to the HCV. He completed his B. Sc. at McGill University, his MD at the University of Calgary, his specialty in Internal Medicine at the University of Toronto and his specialty in Infectious Diseases at the University of British Columbia, the latter in 1986. He has been practicing in the field of Infectious Diseases since 1986 and has always been involved peripherally with patients with Non-A and Non-B Hepatitis. He has been head of the Department of Infectious Diseases at the University of Ottawa since 1990. For the past 5 years, he has been actively involved in the management and treatment of patients with HCV and has established an HCV clinic.

[23] Dr. Garber's mandate in providing an opinion to the Centre with respect to the Claimant's case was to review the file and determine, if possible, the most likely cause of the Claimant's HCV infection. In the event of IVDU, his mandate is to provide his opinion based on the balance of probabilities, having reviewed the evidence as a whole. He had no pre-conceived ideas, no knowledge of the Claimant apart from what he could glean from the records and was only able to assess the data provided.

[24] In undertaking this assignment, Dr. Garber reviewed lab results[17] for 1988 and 1989 which showed slightly elevated SGPT[18] readings, which test liver enzyme function. If the liver is inflamed, such enzyme levels may be higher than the normal population. A slight elevation may or may not have any clinical significance, as this could be related to HCV infection, drug therapies, non-prescription drugs, alcohol or non-specific infection. More pertinent were Dr. Sharma's notes of June 15, 1988,[19] in which the Claimant reported a history of "alcohol binging over several years... he has been binging about two to three weeks per month and on average during this period, he drinks about 12-20 bottles of beer per day." In Dr. Garber's view, it seemed that the enzyme levels waxed and waned and appeared to improve with periods of sobriety. Therefore, in his opinion the slightly elevated SGPT tests were more likely explained by the Claimant's significant alcohol intake. Even more pertinent, the 1999 liver biopsy report[20] showed minimal changes –"chronic hepatitis, Grade 1, Stage 0-1, consistent with Hepatitis C Etiology. Grade 1 is out of a possible range going to Grade 4, the highest signifying cirrhosis or very advanced disease. Usually, one would not expect to see significant damage to the liver from HCV for, on average, 10 to 15 years from the point of infection. There are, however, 3 factors that are associated with

[17] Summarized by C. Miller at p. 507 of Ex. 1
[18] Same test at ALT
[19] Ex. 2, Medical Experts file provided by Centre to Dr. Garber for his review, p. 51
[20] Ex. 2, pp 278, 279

more significant damage being manifested earlier – (1) male; (2) older; (3) more alcohol or toxin intake by the liver. He noted that in 1999, no treatment was indicated by Dr. McClean. In short, the nature of the progression of the disease is such that it is very unusual to see significant liver damage in someone who has recently been exposed to HCV. Chronic disease takes some time to manifest itself.

[25] Dr. Garber's understanding of the Claimant's IVDU history, based on the admission notes of June15, 1988, and Dr. Sharma's notes of the same date[21] was that the Claimant had used Talwin, Ritalin and Fiorinal in the past, but not for the preceding 6 years; i.e. not since 1982. His review of the chart material gave him the impression of IVDU that was longer than for a short period of time in 1978.

[26] In this case, he was considering one unit of blood that could not be traced. If it had been possible to trace back that unit, one would know with certainty that the transfusion was not the source of the Claimant's infection. Even if it had been possible to test that unit and it had tested positive, the issue of most probable source of infection remains very much open for discussion. The statistics of infection rate of 1/10,000 from transfusions had to be weighed against other risk factors, in this case the history of a short period of IVDU in 1978. Thus, in his report[22] he stated, "If in fact one is to believe that his only injection drug use was in the late 1970s and only for a short period of time that was initially claimed, this would on balance make the unit of blood at least equally as likely as the period of time in 1978". He felt that this was a coin toss, that he could not tell one way or the other.

[27] When asked why he was of the view that it was more likely that IVDU in the 1980s would be a more viable cause than a single unit of transfused blood that had not been proven to be HCV positive, he testified that the '80s were different. By then, HCV had become more prevalent. HCV had been a lower event statistically before then. The Centre incorrectly reported to him that the ORF Form stated the Claimant used non-prescription IV drugs more than 10 times while his Affidavit stated >5 and <10, whereas in fact the Claimant checked off >5 (and did not check off anything in the boxes of >10 or >30). This error was repeated in his report. However, being made aware of this error did not cause him to change his opinion. Often one sees multiple usages over a short time and one runs into memory gaps and sometimes less than clean needle use. Here the history was of Talwin (an upper) and Ritalin (a downer) together. When he worked in Vancouver, this was known as "poor man's speed" or "poor man's cocaine." In his view, if there were in fact several years of IVDU during the '80s when the transmission of HCV was much more prevalent in the population, this would suggest a higher degree of probability of infection through IVDU versus transfusion.

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[21] Ex. 2, pp. 50-52
[22] Ex.1, pp. 508,509

[28] During cross-examination, Dr. Garber acknowledged:

- In answer to the question of where he got the information in his report which states: "Specifically he relates to using Fiorinal in 1978 more than 10 times," Dr. Garber replied that he may have taken this from the Centre's summary and appears to have simply repeated the Centre's inadvertent error.
- The most recent indication of IVDU in the records reviewed by Dr. Garber was contained in Dr. Sharma's notes from 1988, in which it is reported that the Claimant quit 6 years previous, or 1982.
- In 1988 there was still no direct test for HCV, which was still known as "Non-A" or "Non-B" Hepatitis."
- He was not sure if there was any Hep A serology, and not certain where he got the information noted in his report to the effect that "there is also a history of exposure to hepatitis A as well as perhaps hepatitis B," although he recalls seeing something in the chart about the "acute exposure" (Hep A). [Ms. Miller pointed out that there is a reference to "hepatitis exposure @ daughter's admission to hospital, in clinical notes of June 16, 1989.[23]] In the event of a negative test for hepatitis A, usually a vaccination is done. In this case, it appears that only Hep B and C were tested for in January, 1999.[24] Dr. McClean did note[25] that one sister died in 1997 at the age of 32 of end-stage liver failure secondary to hepatitis C.
- When asked whether it was fair to say that Dr. Garber could not pinpoint any reference to exposure to hepatitis A in the Claimant's medical records, he replied that it was his supposition that the claimant's daughter had hepatitis B but he did not know if the Claimant was in fact exposed to it.
- Dr. McClean stated in her report of July 12, 1999[26] that the Claimant "thought that at one point (when his enzymes were in the range of 300) he was actually diagnosed with hepatitis A, although once again I don't have copies of those results." He could only find one reference in the chart to Hep A. From this, he concluded that there was perhaps a history of exposure to Hep A.
- He did not see any reference in the chart materials to Hepatitis B exposure before 1988.
- Exposure does not necessarily equal infection. 90% of people clear the antigen and therefore clear the infection. Having antibodies means that you had the infection at one point.
- He was asked about the following conclusion in his report,[27] "Therefore, on the balance of the information received ***as there are several entry points*** in the medical history suggesting injection drug use in the 1980s... I would say that it is more likely that he in fact was infected from his injection drug use than from the

[23] Ex. 2, p. 66
[24] Ex. 2, p. 287
[25] Ex. 2, p. 327
[26] Ex. 2, p. 245
[27] Ex. 1, p. 509

possibility of being infected from a single unit of blood that was not traceable." He acknowledges that some entries could simply have been be quoting another. For example, Dr. Sharma's 1988 notes[28] could have been repeating the notes of the admitting nurse or Resident. [29] Similarly, Dr. Sommerville's notes of September 20, 1991[30] appear to be quoting from Dr. Sharma's notes, where Dr. Sommerville stated: "...a note was made that he was (sic) abused a variety of drugs over the years with IVDA mentioned and Talwin, Ritalin and Fiorinal specifically documented."..."he says that he's been off alcohol entirely in the last three years has not used any drugs (other than prescriptions...) for about 8 years." Dr. Sommerville's handwritten notes at the same time simply state, "says off alcohol x 3 years and drugs (other than RX) for 8 years" (to 1983). The notes do not refer to IV drug use, pills, snorting or other means of ingestion and admittedly the dictated notes are much more detailed than the handwritten ones. Again, is not clear whether Dr. Sommerville was referring to what the Claimant told him at that time or whether he simply picked up on Dr. Sharma's earlier notes.

- He was asked about the following portion of his report, "On the other hand, if he had exposure through injection drug use after his blood transfusion in 1986 this would be an equally viable or perhaps a more viable cause of infection." He stated the Claimant's Affidavit referred to a narcotics conviction in the mid-1990s. If he used in the 1990s, ongoing use would increase the likelihood of IVDU as the most likely cause. The speculation is that there was some use at that time, although he did not know whether it was IV or not, however, the red flag was raised and needed to be explained.
- There is no evidence of IV drug use after 1982 or 1983. A charge of possession does lead to speculation as to IVDU, but this case necessarily falls within the realm of speculation based in the lack of evidence of an infected unit of blood.
- He agrees that in the rather extensive body of medical evidence, there is no suggestion of attendance at drug rehab centers or drug use assessments.
- He agrees that in the late '90s the Claimant reported[31] IVDU in the late 70s, but not in the early 80s.
- Talwin and Ritalin can be ingested in pill form as well as intravenously but this combination of usage is not usually oral. As to whether these could sometimes be used separately and sometimes together, he responded that they are normally used separately by prescription use. When used for a high, they are used together, which makes it less likely that they would be taken orally. Ritalin is not a fast acting drug but if used intravenously can create a rush. Typically, drug users do not want delayed reactions and therefore usually the pills are crushed, dissolved and then injected.

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[28] Ex. 2, p. 51
[29] Ex.2, p. 50
[30] Ex.2, pp. 56, 57
[31] To Dr. McClean, Ex. 2, p. 245

- If, as the Claimant says, he meticulously used sterile needles and did not share needles or paraphernalia, he would not have contracted the virus through IVDU.
- The evaluation process in this case had to be a paper process. As he did not have a chance to interview the Claimant, there was no opportunity to weigh his credibility.
- He was asked about his conclusion that exposure risk to IVDU after the 1986 transfusion would be an equally or perhaps more viable explanation of the infection. He was asked why he now says that the risk of a unit of blood in the 1980s being infected with HCV was 1 in 10,000. He was asked whether he agreed with the proposition that between 1986 and 1990 there were 1.3 million transfusions in Canada. He did not know the number and did not purport to be a transfusion expert. 1 in 10,000 does not mean that for 1 in every 10,000 people, one is infected. One in 10,000 units of blood collected would be infected. He does not quarrel with the proposition that if the 1.3 million figure is correct, most often a person would receive more than one unit of blood. Using round numbers, if 1,000,000 units were transfused, applying Dr. Garber's approach, this would result in 100 units being at risk for HCV. Dr. Garber replied that this is not necessarily the case because as the unit is processed it is re-fractionated and can be used in different ways. He was asked whether whole blood transfusions were more common in 1986. Again he is not an expert but believes that packed cells were used more often than whole blood. One infected unit of blood has the potential to infect more than one person. He was asked whether, hypothetically, if a unit of blood could be used for four people, this could then produce 4 million units of potentially affected blood and, in Dr. Garber's view, one in 10,000 units to be affected, or 400. He was asked whether he agrees that thousands of people have now been proven to have received infected blood over those 4 years. He replied that 1/10,000 is just an estimate. If you screen blood 5 to 10 years later, you do not know if the donor had Hepatitis C at the time. He did not come up with the 1/10,000 figure himself. This statistic came from others. 1/10,000 is not based on current numbers and is rather based on the 1980s. The number is much lower today with screening, as the present risk is 1 in 1,000,000 or lower.
- He was asked whether he agreed that the range of infection from transfusion in 1985 was between 5 – 10%. He is not aware of the references that support that assertion and would have to review them as those numbers seemed very high. He had not read the Krever report in the last 10 years but recalls reading the Blajkman-Feinman study of risk factors in the late 80s.

[29] In oral argument and after, Claimant counsel relies on the following data taken from the Krever report:

http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/index.html
Volume 2 -Parts 22 – 26, with specific references from pp. 623 - 713 to page 713

1) Krever Report p. 623, Dr. Barker Vice-President of Health Services for the American Red Cross spoke in 1978 about the risk in the U.S. Blood System being about 5-10% for infection by hepatitis through blood transfusion
2) Canada did not have statistics at that time
3) p. 630 - New England Journal of Medicine in 1981 published the results of a study from 1974 - 1979 that 10% of the over 5,000 transfused had post- transfusion hepatitis
4) p. 632 - National Institutes of Health study published in the Journal of the American Medical Association, of over 280 open heart surgery patients getting transfusions 12.7% had hepatitis
5) p. 639 - Dr. Mosley and Dr. Derrick said reasonable to assume same level of infection in the Canadian system given the relatively same incidence of Hep B in each nation's blood donor population
6) p. 641 - Annals of Internal Medicine in 1984 the TTV (transfusion transmitted viruses) study of 1,151 found 9.4% infection of non-A non-B.
7) p. 647 - Dr. Alter estimated 5% of recipients would be infected in 1986
8) p. 649 - Clinical and Investigative Medicine in 1988 published study from Montreal in which there was an 8% post-transfusion infection rate (only 24 tested)
9) p. 652 - Preliminary results of the Feinman study 4% in 1984 and in 1985 7.6% infection rate
10) p. 663 - Dr. Leclerc-Chevalier reporting to RC Medical Directors in 1987 over 9% infection rate in the study"
11) p. 674 - Several French studies showed over 5% infection rate
12) p. 678 - From 9% in 1984 to less than 2% in 1989 according to Feinman
13) p. 680 - Canadian Blood Committee meeting in late 1989 Dr. Hauser estimated infection rate at 4%"
14) p. 684 - Results of Blajchman-Feinman study say 2.02% infection rate in 1989 among a few hundred tested
15) p. 713 - Commissioner Krever accepts Gully's estimate of 2.2% infected with Hep C after transfusion from mid-1986 through mid-1990

[30] I provided Fund Counsel with the opportunity to review and, if so advised, respond to the statistical submissions supplied in argument by Claimant Counsel. Fund Counsel replied as follows:

> On behalf of the Administrator, I do not intend to make any detailed submissions in response, other than to emphasize that the Administrator is obliged to abide by the scheme set out in the Agreement, the Plan and the Traceback and the IVDU protocols. Likewise, there is no authority for a referee or arbitrator to go behind the terms of the Agreement and revisit the Krever report.
>
> As indicated in my closing submissions at the hearing ..., there is no expert evidence opposing Dr. Garber's opinion, but simply counsel's own interpretation of the Krever report. The Administrator remains of the position that the Claimant has failed to provide proof on a balance of probabilities that it was more likely that (he) was infected by the unit of blood he received in 1986, than by his use of intravenous drugs.

C. ANALYSIS

[31] The Plan Text [Article 3.01(3)] places an onerous burden upon a Claimant who has a history of IVDU, to show that he was ***first infected*** by a Class Period Blood transfusion. At the same time, it is not an insurmountable burden. The framers of the Plan clearly did not intend to exclude an individual from the protection of the Plan solely by reason of the fact that he or she admitted to non-prescription IVDU at some point in his or her life. Such an intention would have been clearly signaled.

[32] Individuals with risk factors other than IVDU, such as tattoos, body piercing, intra-nasal drug use, prison / incarceration, unprotected sex and other surgical procedures, need only prove transfusion of infected Blood to *prima facie* bring themselves within the purview of the Plan. In circumstances where an untraceable unit of blood is deemed to constitute an inconclusive traceback, the Plan extends the benefit of the doubt to such individuals. Despite having obvious risk factors, such individuals do not face the significant "reverse onus" burden that is placed upon those with an admitted history of IVDU, to whom the benefit of the doubt is not similarly extended.

[33] Despite the high burden placed upon a claimant with a history of IVDU, Article 3.01 (3) of the Plan clearly recognizes the possibility of first infection being proven to be transfusion-related. Article 10.01(1) of the Settlement Agreement provides for a broad on-going supervisory role of the Courts, which extends as far as determining, among other things,[32] (A) whether the restrictions on payments of amounts should be varied or removed in whole or in part, and (B) whether the terms of the Plans should be amended due to a financial insufficiency or anticipated financial sufficiency of the Trust Fund". Specifically, the Settlement Agreement confers jurisdiction upon the Courts to "issue judgments or orders in such form as is necessary to implement and enforce the provisions of this Agreement and ... supervise the ongoing performance of this Agreement including the Plans" ... including a statement that the Courts will: ...

> (h) approve, rescind or amend the protocols submitted by the Joint Committee or by Class Action Counsel; ...
>
> (l) on application of the Administrator, Fund Counsel, the Auditors, any Class Action Counsel, the Joint Committee or the Trustee, provide advice and direction.

[34] By virtue of Article 10(2) of the Settlement Agreement, CAPs and orders granting direction on such matters determined by the Courts will take effect only when the order becomes final. The CAP-Non-prescription IVDU is an example of the type of

[32] 10.01(1)(i)

document the Courts are empowered to issue by the provisions of the Settlement Agreement to issue. This CAP sets out the procedures by which Article 3.01(3) of the Plan is to be interpreted and implemented, in conjunction with other provisions of the Plan. This CAP falls broadly within the supervisory powers of the Courts under Article 10 of the Settlement Agreement and is clearly binding upon the Administrator, Referees and Arbitrators. The CAP recognizes the unique challenges and burdens that are imposed upon claimants with a history of non-prescription IVDU and in fact, unlike other areas of the Plan, even provides that in such circumstances, 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".

[35] I begin my analysis of the evidence as applied to the Plan Text and CAP, by observing that the Administrator was not looking for ways to deny the claim in this case. Instead, it applied its responsibilities in interpreting and applying the CAP professionally and with an open mind. The same can be said about Dr. Garber. The Administrator and Dr. Garber both applied the provisions of the CAP appropriately. Although there was one error in the materials forwarded by the Administrator to Dr. Garber (as to the number of instances of IVDU reported by the Claimant), which was repeated by Dr. Garber in his report, I accept Dr. Garber's testimony that this error did not materially influence his opinion. Simply put, Dr. Garber and the Administrator are not in any way to be faulted for relying on the Claimant's own reports of IVDU during the 1980s. The Claimant provided his Affidavit on May 10, 2004.[33] He deposed to a brief period of IVDU in the late 1970s. The Saskatoon City Hospital Records that contained apparent admissions by the Claimant of IVDU in the 1980s were not received by the Administrator until December, 2004. Once received, such contradictions as to the time periods of IVDU were no doubt, and quite properly, a source of concern to the Administrator. The Claimant did not offer any explanation of this significant contradiction prior to his hearing. The Administrator did not seek to interview the Claimant, or request clarification by the Claimant in connection with this contradiction. Therefore, the issues surrounding this key contradiction were fully fleshed out for the first time at the hearing.

[36] In view of the contradictions inherent in the records and documents, the provisions of the Plan Text and the CAP, I was particularly attentive and alert to issues of credibility when receiving the Claimant's testimony. Indeed, there are issues of concern in that respect. Peripherally, there was a discrepancy as to the amount of time he spent in jail – in his Affidavit, he stated that he "served approximately 6 months in total on the driving while disqualified charges", while in his testimony he testified that he spent 60-70 days in jail. There was also a discrepancy in the date of one of his two assault convictions. There is also the fact that the Claimant thought he attended at Foothills Hospital in Calgary with swelling in his arm, which is contradicted by Foothills Hospital. More squarely on point, the most serious contradiction relates to the

[33] Ex. 1, pp. 79-80

Claimant's reported admission of IVDU in the 1980s and his firm denial of this, both in his Affidavit and in testimony. It is beyond doubt that the Claimant did report to Dr. Sharma on June 15, 1988[34] that he had not engaged in IVDU during the preceding 6 years, which would have put his most recent stated IVDU at 1982. There is an issue as to whether on September 19, 1991, when the Claimant saw Dr. Sommerville, he reported no IVDU for "8+/- years", or whether Dr. Sommerville was simply repeating what he may have read from Dr. Sharma's notes, which were, after all, part of the Claimant's record from the same hospital.

[37] Significant issues of credibility inevitably arise when assessing the testimony of claimants with a proven history of substance abuse. These issues relate to the honesty of a claimant, but perhaps more importantly to his or her reliability, given the lack of clear memory and poor judgment that may be associated with substance abuse. Those issues, however, do not automatically exclude an individual from qualification for Plan benefits and must be carefully weighed within the context of the individual circumstances of each case.

[38] Having had the benefit of carefully hearing and observing the Claimant at length, despite some concerns and contradictions, in the unique circumstances of this case, on balance, I find the Claimant to have been a credible witness. In short, I accept his evidence. At its core, his testimony was delivered in a blunt and even-handed way. He was self-deprecating. His emotions and body language were consistent with his testimony. He did not paint a flattering self-portrait, certainly at various stages of his life.

[39] In addition to the foregoing considerations, I considered the following factors in finding that the scales of credibility tilt in the Claimant's favour in these unique circumstances:

- The Claimant has clear and vivid memories of a short, discreet period of IVDU with Fiorinal when he lived in Calgary, when he was 18 or 19, which would put the date at 1977 or 1978.
- In the ORF Form and in his Affidavit, the Claimant put this IVDU at > than X5 (but less than 10). In testimony, he stated that he stopped IVDU after 4 or 5 times. In his Affidavit and in testimony, he stated that he used Fiorinal for less than a week. In testimony, he stated that he did not use it every day during that week.
- The Claimant has been unequivocal throughout that at the time during the 1970s that he engaged in IVDU, he purchased a package of 10 sterile, individually packaged needles from a pharmacy, that he used new sterile needles each time, that he never shared needles, paraphernalia or drugs and

[34] Ex. 1, p. 127

that he did not use all 10 needles. He testified that after he had to go to Emergency, he threw out the remaining needles.

- The Claimant's testimony that he suffered a severe adverse reaction that caused the arm he had injected to balloon up, provides a traumatic and clearly identifiable temporal benchmark to which the Claimant has been able to trace his discontinuance of IVDU. Such a reaction would have caused considerable fear and concern on anyone's part. However, I find that the response to this unexpected and severe event caused by inexperienced injection was greatly exacerbated in this case due to the Claimant's heightened concern and in fact anxiety that was associated with his clear tendencies towards hypochondria. Indeed the Claimant provided compelling testimony as to the circumstances surrounding the discontinuance of IVDU, which provide a clear point of reference by which to explain the clarity of his memory in this respect.
- It was difficult and embarrassing for the Claimant to testify to his lie to Dr. Sharma as to the timing of his IVDU and the circumstances surrounding it. Still, the Claimant did provide a plausible explanation for this, that, while perhaps not justifiable objectively, subjectively rang true for an individual who was becoming increasingly ill, was on the tail end of a succession of medical appointments in which he felt he was not believed by his doctors, was desperate to be taken seriously so he could get help, but misguided as to how to achieve this.
- I am not in a position to conclude, one way or the other, whether Dr. Sommerville was noting information communicated to him at that time by the Claimant, or information from Dr. Sharma that was already on the Claimant's hospital chart, regarding IVDU in the 1980s. The report to Dr. Sharma is the only clear indication that the Claimant reported to anyone that there was IVDU during the 1980s. In my view, this lie has been satisfactorily explained by the Claimant.
- The Claimant's ex-spouse, while not with the Claimant for every second of the 1980s, was with him for much of this time, saw no evidence whatsoever of IVDU, and only heard the Claimant talking about IVDU in the most negative terms. She testified to the honesty of the Claimant in their relationship. Her relationship with the Claimant was tumultuous and ended badly. It appears that the Claimant was convicted of assaulting her. Her testimony was very straightforward, and given without guile or embellishment. I find that she was an impressive witness and I accept her testimony. Her evidence is supportive of the Claimant's testimony of lack of IVDU during the 1980s. Had this occurred, it is difficult to believe that she would not have been aware of it, at least by suspicion. She also testified to the Claimant's state of mind in the 1980s and in particular to the evidence pointing to hypochondria and concerns about not being believed by doctors, which sheds some corroborative light on the Claimant's lie to Dr. Sharma.
- In July, 1999, months before the Class Actions Settlement Order was made, in relation to Risk Factors for HCV reported by the Claimant to his Infectious

Disease Specialist, Dr. McClean,[35] the Claimant disclosed his blood transfusion in 1986 and that he used IV drugs in the 1970s but did not share needles. There was no mention of IVDU in the 1980s.

- In the voluminous medical records provided, there is no suggestion that the Claimant ever underwent IV drug rehabilitation, which one may well expect to see in an individual who may have had more chronic IVDU than he or she may have suggested.

[40] Dr. Garber's evidence as to disease progression cuts both ways. He testified that one would not expect to see significant damage to the liver from HCV for, on average, 10 to 15 years from the point of infection. There are, however, 3 factors that are associated with more significant liver damage being manifested earlier – (1) male; (2) older; (3) more alcohol or toxin intake by the liver. Here, had the Claimant been infected in the late 1970s, one would therefore usually have expected to see clear manifestations of this by 1987 to 1992. This may have been earlier in the case of the Claimant who is both male and had significant alcohol intake. Instead, there was only minimal damage by 1999. This tends to weigh in favour of ruling out the IVDU in the 1970s as the probable source of infection, although Dr. Garber thought, if he was dealing with 1970s IVDU only, it would still be a coin toss. A coin toss would not bring the Claimant within the purview of the Plan, given the burden of proof resting with him. Clearly, if IVDU had in fact occurred during the 1980s, which I find that it did not, this would have created both a higher risk of infection to the Claimant, and a higher legal risk of failure in this case, given the testimony on disease progression. Dr. Garber's testimony on the probable sources of infection is informed by the assumption that there may have been instances of sharing of needles or paraphernalia over a more prolonged period of time, an assumption that was not unreasonable to make in these circumstances, given the conflicting reports of IVDU. However, he candidly acknowledged that if sterile equipment was used and there was no sharing, the IVDU would not be the source of infection.

[41] I find that the Claimant has established, 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. In making the finding that the Claimant has met the reverse onus imposed him by Article 3.03 of the Plan, I wish to stress two points:

(a) I do not find it necessary to make any findings in connection with the literature survey from the Krever Commission Report put forward in argument by counsel for the Claimant, as to the risks of HCV infection from transfusion during the 1980s. I lack the contextual and evidentiary background that lead to such conclusions in order to undertake an informed analysis and interpretation of their import. Dr. Garber did not retract his reliance on the 1 in 100,000 figure. Further, those statistics did not provide an analysis of the relative risks of infection from transfusion versus

[35] Ex. 1, pp. 630-633

IVDU in order to properly assess the issue of possibilities as opposed to probabilities. Likewise, the number of people who are deemed to qualify for benefits under the Plan does necessarily shed light on the medical issues involved, since there are different considerations involved in the application of the Plan than would be involved in medical surveys, including such factors as extending the benefit of the doubt to non-IVDU claimants in the case of inconclusive traceback results.

(b) These are highly unique circumstances. The case is close to the line, although just over the line, insofar as the Claimant is concerned. This decision in this case must of necessity be confined to the unique facts I have found, and as such ought not to be interpreted as having general application or precedential value. Certainly for a Claimant with a more extensively documented IVDU history than was the case here, even with evidence of sterile use, the burden imposed by the Plan and the CAP will of necessity be much more difficult to meet, given the compounding of credibility issues, both as to honesty and more a propos, reliability. Generally, in the event of a non-supportive report prepared by an expert of the stature of Dr. Garber, a Claimant seeking to rebut such a report would be expected to tender strong expert evidence to refute such a report.

D. Decision

[42] Upon careful consideration of the Settlement Agreement, Plan, CAP and the *viva voce* and documentary evidence tendered, the Administrator's denial of the Claimant's application for compensation is hereby reversed. I find that the Claimant is entitled to benefits under the Plan. The Claimant is also entitled to costs. However, based on his failure to volunteer any explanation relating to his 1988 comments to Dr. Sharma to the Administrator at any point prior to the hearing, these costs are limited to 50% of the costs allowed by the tariff established for this purpose. In the event of any dispute between the Claimant and the Administrator as to the level of compensation to be awarded at this time, or costs, I reserve jurisdiction to decide such issues, upon written notice by either party.

[43] This was a difficult and complicated case. I struggled with the compelling arguments advanced by both parties. I am indeed indebted to both learned counsel for their courtesy and assistance throughout.

Dated at Saskatoon, Saskatchewan, this 18th day of September, 2006.

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

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