CLAIM # 1401053
Province of Infection: Ontario
Province of Residence: Ontario

IN THE MATTER OF A REFERENCE TO REVIEW THE DECISION OF THE ADMINISTRATOR

Before:	Tanja Wacyk
Heard:	August 28 and October 15, 2007, at Toronto, Ontario
Appearances:	John C. Plater for the Claimant Belinda A. Bain and Carol Miller for the Administrator

Decision

Background:

1. On November 7, 2005, the Administrator of the Hepatitis C Fund denied the Claimant compensation under the 1986-1990 Hepatitis C Settlement Agreement (the "Agreement") on the basis there was insufficient evidence that he was infected by Hepatitis C ("HCV") for the first time by a blood transfusion received in Canada in from January 1, 1986 - July 1, 1990 ("the Class Period").

2. In denying the claim, the Administrator found that the Claimant did not satisfy the criteria established under Article 3.01(3) of the Transfused HCV Plan (the "Plan"), which requires that a primarily infected person who used non-prescription intravenous drugs establish, 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.

3. The Claimant requested that a Referee review the decision of the Administrator, and a hearing for that purpose took place in Toronto on August 28 and October 15, 2007.

EVIDENCE:

4. The Claimant testified on his own behalf, and relied on the report of Dr. S. V. Feinman. The Administrator of the Fund relied on the evidence of Dr. Gary E. Garber and Carol Miller, the Claims Co-ordinator for the Fund.

5. It was agreed that the Claimant has had a difficult life, and the following facts were not in dispute:

- The Claimant is infected with Hepatitis C ("HCV");
- The Claimant received seven blood transfusions in April 1989;
    - Of the seven transfusions, six tested negative for HCV and the seventh was untraceable;
- the Claimant has a history of using non-prescription drugs;
- the Claimant has attempted suicide numerous times, using implements such as razor blades, or glass that he would pick up and smash;
- the Claimant is gay, and in the early 1970s, after running away from home at the age of 14, supported himself for 5 – 6 years by working as a prostitute, primarily for male clients;
    - He concedes this was prior to society's awareness regarding the possibility of the sexual transmittal of infectious diseases and the need to practice safe sex, but maintains he did not engage in anal sex;
- the Claimant associated with individuals who were intravenous drug users;
- the Claimant was incarcerated in 1995 or 1997 for trafficking in cocaine.

Claimant's Evidence

Claimant's Testimony

6. The issue of the Claimant's drug use featured prominently in the hearing.

7. In January 1978, the Claimant was hospitalized after a suicide attempt. At that time, the hospital records show he admitted to heavy alcohol use but denied drug use.

8. In March 2001, the Claimant saw Dr. S.V. Feinman, Director, Liver Study Unit, Mount Sinai Hospital, and Professor of Medicine, University of Toronto. At that time, he denied intravenous drug use and intranasal cocaine use.

9. On his application form for compensation from the Fund, dated December 2002, the Claimant checked off the following statement as true: "I declare that to the best of my knowledge, information and belief, the HCV Person has never at any time used non-prescription intravenous drugs" (emphasis in original).

10. The Administrator subsequently became aware of a history sheet completed by the Claimant's prior physician in April 1989, which indicated that he used "street drugs". The Claimant was then asked to complete an "Other Risk Factor Inquiry Form". On that form, the Claimant indicated that he had engaged in intranasal cocaine use once, in the late 1970s, and also in intravenous cocaine use once, in the early 1990s.

11. The Claimant maintained he was not being dishonest when previously denying drug use, because "experimenting with and trying drugs is not "doing" drugs". However, in cross-examination, when it was pointed out that the declaration on the application form was very specific and emphasised "never" having used intravenous drugs, he indicated that at the time he had simply forgotten about the incident.

12. Regarding the intranasal cocaine use, the Claimant testified that a friend had given him the cocaine and he did not know where the friend obtained it. The Claimant maintained that he went home and consumed it alone, using a spoon from his own kitchen.

13. At the first day of hearing, the Claimant maintained that he used cocaine intranasally only once, because it made his nose bleed. However, in July 2005, the Claimant swore an affidavit indicating that, from in or about 1990, he "continued to use other non-prescription drugs including cocaine". When this was drawn to his attention on the second day of hearing, he testified that he continued to use cocaine once or twice a year until approximately 2002.

14. Regarding his intravenous cocaine use, the Claimant maintains that, as he indicated on the "Other Risk Factor Inquiry Form", he injected the cocaine using a needle he purchased at a pharmacy. In the July 2005, affidavit, referred to above, the Claimant indicated he "only recalled" injecting cocaine once, and did not share the needle and equipment he used. The Claimant testified that while all his friends were doing intravenous drugs, he was not, because what he saw frightened him.

15. The Claimant failed to indicate on the "Other Risk Factor Inquiry Form" as requested, that he had been incarcerated. His explanation for this omission was that he is not good with dates.

16. The Claimant admitted to a history of heavy drinking, consuming a 40 ounce bottle of rum and 6-8 pints of beer on a daily basis for more than 20 years. He conceded this resulted in his forgetting portions of what occurred, such as which bar he had been at, but maintained he had never blacked out.

Dr. S.V. Feinman's Report

17. The Claimant also relied on the opinion letter of Dr. Feinman, dated June 18, 2007. Dr. Feinman had seen the Claimant in March 2001, and reviewed his file for the purpose of rendering the opinion letter. Dr. Feinman noted that while chronic Hepatitis C varies greatly in its course and outcome, about 20% of patients may develop liver cirrhosis within 20 years of the onset of the infection. He further noted that some patients may develop liver cirrhosis within 10 or 15 years, and that immuno-compromised patients may develop cirrhosis within 2 to 5 years following infection. He further opined that the Claimant's clinical and histological findings were "compatible with an infection acquired in 1989".

Evidence for the Fund

Dr. Gary Garber's Testimony

18. Dr. Gary Garber, Professor and Head, Division of Infectious Diseases University of Ottawa/The Ottawa Hospital, also reviewed the Claimant's file and provided an opinion letter. He testified at the hearing via conference call. In addition to his responsibilities for administration and research, Dr. Garber treats patients. In the last six years, he has been treating predominately HCV patients.

19. It is Dr. Garber's view that the Claimant's drug use history, and specifically the admitted intranasal cocaine use in the 1970s, and intravenous cocaine use in the early 1990s, as well as the use of other street drugs, combined with his incarceration for dealing cocaine, paints "a picture of an individual who certainly had a prolonged perhaps intermittent use or exposure to cocaine either by intranasal or intravenous and street sales of the product". Dr. Garber opined that this is a history that is certainly more in keeping with use beyond what the Claimant admits to.

20. Dr. Garber also noted that the Claimant has evidence of exposure to Hepatitis B, and in his report maintained this is "certainly additional evidence of his exposure to infected blood or body fluids". Dr. Garber did note that the "mitigating factor with this information is his history of sex with men which is also well-known to be a risk factor for transmission of Hepatitis B".

21. Dr. Garber indicated that tests indicated that the Claimant had developed "moderately advanced" liver disease in the period of 1999-2000. It was Dr. Garber's opinion that in most cases it takes 15 or more years to develop significant complications related to HCV, and that while the Claimant's history of excessive alcohol intake would accelerate this process, and bring him closer to the 15 year mark, it would be distinctly unusual to have that degree of HCV-related disease within 10 years of a transfusion.

22. Dr. Garber concluded:

> Based on all the information reviewed, the risk of exposure to hepatitis C from a single unit of blood is certainly very small [he testified approximately 1-2 per

> 1,000 at the time at issue] and in comparison this is an individual who seemed to have multiple exposures to cocaine through a variety of routes. His admission to a single use of IV cocaine on one occasion lacks credibility because of the multiple denials and changing histories over a period of time. Based on the course of disease, it would suggest that he is was (sic) more likely exposed to hepatitis C prior to 1989 which would make his exposure more likely due to exposure not related to blood transfusion.
>
> Therefore on the balance of probabilities it is far more likely that he was exposed to hepatitis C through exposure to body fluids, likely through his use of cocaine.

23. Dr. Garber also testified that recently, he has seen contagion resulting from common use of paraphernalia, such as spoons, and not just sharing of needles. He also testified that contamination of the drug itself has also been a real concern, as was the possibility of transmitting diseases though smoking of marijuana. He conceded such transmittal would be difficult to study, and indicated he was not aware of any such studies.

Carol Miller's Testimony

24. Ms. Miller is the Appeal Coordinator for the Fund and a Registered Nurse. She described the processing of the Claimant's application, and the Worksheet used in reviewing his claim. She testified the Worksheet captures the questions which are set out in the Court Approved Protocol for Non-Prescription Drug Use (the "Cap"). Ms. Miller testified that a review of those questions, in conjunction with his entire claim, resulted in a denial of the Claimant's application. Ms. Miller indicated that Dr. Garber's report, referred to above, also played a significant role in the determination.

25. This is evidenced in Question 4 of the Worksheet, which asked whether the Claimant has "An HCV disease history which is more consistent with the timing of 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 non-prescription intravenous drug use." It was determined he did not. The "Comments" section contained the following comments:

> Dr. Garber wrote "Based on the course of his disease, it would suggest he was more likely exposed to hepatitis C prior to 1989 which would make his exposure more likely due to exposure not related to blood transfusion.

26. Dr. Feinman's report was not reviewed prior to denial of the Claimant's application, as it was first submitted as part of the appeal process.

ARGUMENT:

Claimant

27. Claimant's counsel conceded that the probability of the transmittal of HCV is more likely through intravenous drug use using non-sterile equipment, than through a blood transfusion. However, he maintained that in this instance, there was no evidence the Claimant had ever engaged in such conduct.

28. While his counsel submitted the Claimant was "not the world's best historian", he pointed out there had been no evidence of intravenous drug use until the Claimant himself admitted that he had, on one occasion, used cocaine intravenously.

29. Claimant's counsel pointed out that Ms. Miller had confirmed that Dr. Garber' opinion was critical in the denial of the Claimant's application. However, he challenged Dr. Garber's assessment. His counsel pointed out that Dr. Garber had relied on the "Claimant's history of injection drug use", regarding which Dr, Garber indicated there was inconsistent evidence in the Claimant's medical records. However, Claimant's counsel pointed out that there were only two medical documents in which the Claimant had denied drug use. The only other denial was on the Application Form for compensation.

30. The Claimant's counsel submitted that the only evidence of any intravenous drug use is the Claimant's own admission, and there was no evidence that use had taken place in a non-sterile environment. Although Dr. Garber testified that, theoretically, HCV could be transferred by the cocaine itself, either when the Claimant used it or when he was dealing it, Claimant's counsel pointed out that Dr. Garber knew of no studies which supported this theory.

31. Claimant's counsel also pointed out that while Dr. Garber noted that the exposure to Hepatitis B, in light of the Claimant's history of sex with men, might suggest exposure to bodily fluids, he reached no conclusion regarding whether the more likely source of infection was drug use or sex with men. Counsel for the Claimant also pointed out that the only record of exposure to Hepatitis B came in 1994, well after the timing of the blood transfusion and the intravenous drug use, and submitted it could not be relied on.

32. The Claimant submitted that Dr. Garber was, in fact, opining on the Claimant's credibility, which was not his role. Further, Dr. Garber's conclusions relied on general observations regarding others in circumstances similar to the Claimant's, which is contrary to the Court's decision in *Parsons v. Canadian Red Cross Society*, 51 O.R. (3d) 261.

33. In *Parsons v. Canadian Red Cross Society*, 51 O.R. (3d) 261, the Court considered, *inter alia*, whether an expert's statistical probability calculations could be used as a tool for determining the eligibility of claimants who had multiple transfusions of blood over an extended period. The Court held they could not. The Court was of the view that in light of the overwhelming effect of expert evidence of this nature, especially where the evidence to the contrary is sparse or non-existent, the calculations would likely become the sole determining factor used by the Administrator, and have an unfair prejudicial effect. The Court held, at paragraph 37, that it would be "fundamentally unfair to exclude an individual on the basis of a group statistic without regard to the individual attributes or circumstances".

34. Counsel for the Claimant submitted that, consistent with the decision in *Parsons*, to the extent statistical probabilities are considered in this instance, it must be done carefully, avoiding generalities and including consideration of the Claimant's specific circumstances.

35. Claimant's counsel noted that in denying the Claimant's claim, a lot of weight was given to Dr. Garber's opinion that it is unusual to have the Claimant's level of disease at 10 years after infection. He noted that although Dr. Garber recognized that alcohol can accelerate the progression of the disease, he still maintained that that is not what generally happens, and this level of disease is not usually seen at 10 years after infection. Counsel for the Claimant pointed out that Dr. Feinman was less absolute, and indicated that it is possible.

36. Claimant's counsel also pointed out that Dr. Feinman indicated the incidence of transmission of HCV through a blood transfusion was 12.6 per 1,000 recipients. Further, the Referee in the decision in Claim No. 1300017 noted at paragraph 71, that Dr. Mark Joffe indicated that the risk of acquiring Hepatitis C from blood in Toronto, between 1984 and 1988, was 1.5% to 3%. Claimant's counsel pointed out that these statistics are at variance with Dr. Garber's number of approximately 1 - 2 transmittals per 1,000 recipients. Consequently, Claimant's counsel submitted that in Dr. Garber's mind, he was weighing a very small probability of infection through transfusion of one unit of blood against what he had concluded "seemed" to be multiple exposures to cocaine through a variety of routes.

37. Counsel for the Claimant also took issue with some of the comments on the Worksheet, which played a role in the refusal of the Claimant's claim. In particular, Counsel for the Claimant challenged the negative answer to Question 4, set out above in paragraph 23. Counsel for the Claimant submitted that given how the question is set out, it should have been answered "Yes".

38. Claimant's counsel pointed out there was no evidence regarding the Claimant's intravenous drug use that contradicted his express denial of intravenous use at any time other than the one incident in 1990. Consequently, Counsel for the Claimant submitted that the Claimant's application must have been denied on the basis he was not believed, or because of contamination by body fluids, or one of the other transmittal methods suggested by Dr. Garber.

39. Claimant's counsel also took issue with the negative response to both the Work Sheet questions of whether there existed "Reasonably reliable evidence that the non-prescription intravenous drug use was limited to a single occasion and was done with sterile equipment which was not shared", and whether there is "Reasonably reliable evidence that the non-prescription intravenous drug use took place on more than one occasion or was done with non-sterile equipment or shared equipment".

40. With regard to the first question, the worksheet contained the further comment that the "History in the file is inconsistent". Counsel for the Claimant reiterated that, other than the one incident regarding which the Claimant testified, there was no other evidence of intravenous drug use – and consequently, no inconsistency.

41. With regard to the second question, the comment on the Work Sheet was that the "[o]nly evidence on file that gives specifics about IV drug use is from claimant and the reliability of this evidence is questionable". Counsel for the Claimant submitted that the Administrator was, in effect, saying that because the Claimant has a troubled history, which includes contact with intravenous drug use and the accompanying culture, and has used other types of drugs, the Administrator does not believe him regarding the degree of his intravenous drug use.

42. Counsel for the Claimant maintained this was necessary for the result, because even if the Administrator was to find that that the Claimant did share a needle on the one occasion of intravenous drug use to which he has admitted, Dr. Garber's opinion regarding the progression of the disease indicates

he could not have been infected at that time. However, counsel for the Claimant again pointed out that there was nothing in the Claimant's medical records which suggested intravenous use beyond the one occasion.

43. In another Work Sheet question with which the Claimant took issue, the query of whether the Claimant's file is in any way consistent with infection with HCV by non-prescription intravenous drug use prior to the receipt of Blood for the …Class Period Blood transfusion(s), …" was answered in the negative. An additional comment was made that the Claimant's file is "(c)onsistent with infected prior to 1989 by exposure to body fluids, not specifically IV route (*sic*)". Claimant's counsel submitted this response demonstrates that the Administrator went beyond Dr. Garber's opinion to include all possible exposure in addition to the intravenous use, to create a "basket" of probabilities, each unsubstantiated regarding the source and probability of infection, and measured that against the quantifiable probability of transmission during this very critical time in Canadian History.

44. Claimant's counsel also referred to several other decisions dealing with similar issues. The first was the Referee decision in Claim No. 1200033. The Referee was faced with a similar situation, in that the Claimant in that instance has a history of risk factors for HCV and had received transfusions from a number of donor who had tested negative, and one who could not be tested.

45. In that instance, the Administrator also tendered a report from Dr. Garber, in which he expressed his opinion that the Claimant's street drug use was more likely to be the source of his HCV than a single unit of blood that could not be traced. The Referee noted at page 5 as follows:

> I have read Dr. Garber's report with great attention and I do not find it compelling. The question as to whether claimant's drug use (as difficult to pinpoint as it may be) is more likely to be the source of his hepatitis C infection than the 1987 unit of blood that cannot be traced, is one to be answered by the Administrator, or at this stage by myself, and indeed I do not find much guidance in reaching such decision in Dr. Garber's report.

46. Claimant's counsel indicated that he was not suggesting that the failure to find Dr. Garber's report compelling in that instance is determinative in this case. Rather, he simply wished to point out that Dr. Garber's opinion regarding the determination which I must make is not helpful.

47. In the Referee decision in Claim No. 1000645, the disease progression was also an issue. In that instance, Dr. Garber testified regarding a similar time period to that in the instant case, and indicated it was possible the deceased in that instance became infected with Hepatitis C in 1968, if he used intravenous drugs at that time, and this led to his death in 2001 - as the disease may take 15 years or more to be fatal.

48. Dr. Garber further testified that while it was more unlikely that if the deceased were first infected with HCV in 1987, his death in 2001 resulted from that exposure, but acknowledged that it was "within the realm of possibility".

49. Claimant's counsel also referred to the Referee decision in Claim No. #1300017 which reviewed several other cases dealing with similar issues.

Fund

50. Counsel for the Fund maintained that given the inconsistencies in the Claimant's evidence, and his obvious attempts to minimize his drug use, it was open for to me to conclude the Claimant has a significant history of intravenous drug use.

51. Counsel for the Fund further argued that the "basket" of other risks Claimant's counsel took issue with was a necessary part of the analysis regarding whether the Claimant had satisfied the onus of persuading me, on a balance of probabilities, that he was first infected with HCV for the first time by a Blood transfusion received in Canada within the Class Period.

52. Counsel for the Fund also pointed out that the CAP specifically directs, under "Additional Investigations" in section 8b as follows:

> 8. If the claim is not rejected under the Traceback CAP, the Administrator shall perform the following additional investigations:
>
> …
>
> b. obtain the opinion of a 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 Blood, the Class Period Blood transfusion(s) or the secondary infection or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence.

53. Consequently, Counsel for the Fund argued the Administrator is expressly required to ask Dr. Garber for his opinion, and there was nothing inappropriate in his opinion. Rather, he is given a mandate to comment regarding what he believes is the more likely source of infection, and this requires that he consider and comment regarding what he believes is the likely incident of drug use.

54. Counsel for the Fund also pointed out that the Claimant did consult his own medical expert. However, Dr. Feinman was not asked to weigh the probability of infection through transfusion or drug use or other risk factors. While he indicated he believed it was possible the Claimant was infected through a Blood transfusion, this was not helpful, as the issue is the relative risk of Blood and drug use or other risk factors. Counsel for the Fund pointed out that not only did Dr. Feinman not discuss relative likelihood of infection, he was not even aware of the Claimant's drug use, as his records, as set out above, indicate the Claimant denied intravenous drug use and intranasal cocaine use.

55. Fund Counsel further submitted that contrary to the submissions of counsel for the Claimant, the CAP puts into place exactly what the Court proposed as an appropriate approach in *Parsons supra*, and requires that the Administrator consider applicants' particular circumstances. Fund Counsel further pointed out that the CAP was drafted by a number of stakeholders and approved by the Court.

ANALYSIS:

56. Article 3.01(3) of the Plan requires that a claimant who has used non-prescription intravenous drugs provide "other evidence establishing on a balance of probabilities that he or she was infected for the first time with HCV by a Blood transfusion in Canada during the Class Period".

57. It was not disputed that the burden of proof in this instance is on the Claimant. His admission that he had used cocaine intravenously reversed the onus, requiring the Claimant to demonstrate that it was more likely he was infected with HCV as a result of the untraceable unit of blood he received in 1989.

58. The CAP provides that the Administrator must be satisfied, on a balance of probabilities, that the HCV person was first infected with HCV by a blood transfusion received in Canada in the Class Period. The CAP also requires that the Administrator conduct a trace back. However, when the trace back is either negative or inconclusive, as was the case here, the Administrator is instructed to perform additional investigation, as prescribed under Section 8 of the CAP.

59. Section 8 of the CAP, as indicated above, requires that the Administrator, in addition to other steps, obtain the opinion of a 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 transfusions or with infection at the time of a non-prescription intravenous drug use, as indicated by the totality of the medical evidence.

60. I have no difficulty with Dr. Garber having expressed an opinion based on his experience and expertise, regarding what he believes is the more likely incidence of the Claimant's drug use, as this is an important element of the opinion he is mandated by the CAP to give regarding the likely cause of the Claimant's infection. It is difficult to imagine how this might be achieved without Dr. Garber making some assessment regarding the Claimant's credibility. It is then my role, as Referee, to consider his opinion, and determine the appropriate weight to give it, in light of the other evidence before me.

61. In this instance, I too have significant concerns regarding the Claimant's credibility. While it is clear the Claimant had significant difficulty recalling dates and details, his inconsistent statements regarding his drug use are difficult to attribute simply to poor memory.

62. I do not accept the Claimant's distinction between having "tried" drugs and using them, as a credible explanation regarding why he repeatedly denied drug use as set out above. This is particularly the case regarding his denial on the Application for compensation from the Fund, where he indicated he has "never" used non-prescription intravenous drugs. It is simply too difficult to accept that he did not deliberately intend to mislead with regard to his intravenous drug use. Consequently, I find that the Claimant's evidence regarding the degree and frequency of his intravenous drug use less than compelling.

63. It is equally apparent that even if the Claimant were telling the truth as he best recollects it, his testimony is not reliable. He conceded that his heavy alcohol use led to some memory loss regarding details such as which bar he had been at. If he is not able to recall where he was, I am not confident he can recall what may have occurred there.

64. A further example of the unreliability of the Claimant's evidence occurred within the hearing itself, as his evidence regarding his cocaine use was inconsistent from one day to the next. On the first day of hearing he testified that he had used cocaine on only two occasions. He subsequently testified, on

the second day of hearing, that he was using cocaine once or twice a year from approximately 1990 until about 2002.

65. It is apparent from the Claimant's own testimony that he had more than a casual acquaintance with the drug culture, as he testified that "all" his friends engaged in intravenous cocaine use; he had used cocaine both intravenously and intranasally, and had been convicted for trafficking in cocaine and incarcerated for doing so.

66. Further, the Claimant was exposed to multiple risk factors. In addition to associating with individuals who were frequent intravenous drug users these included, engaging in unprotected sex in the 1970s, and numerous suicide attempts using whatever was available, including razors and broken glass. These risks occurred earlier, and some much earlier, than the transfusion of untraced Blood. In conjunction with Dr. Garber's opinion that the course of his disease suggests the Claimant was more likely exposed to hepatitis C prior to 1989, I too find this makes the Claimant's infection more likely due to exposure not related to the blood transfusion.

67. The Claimant has provided no compelling evidence that it was more likely that the untraced blood caused the infection, rather than his intravenous drug use or the other risk factors. While the Claimant has persuaded me that it is possible this is the case, this falls short of satisfying the onus he bears, to persuade me that it was more likely than not that this was the case.

DISPOSITION:

68. The application is dismissed, and the Administrator's denial of the Claimant's application for compensation is affirmed.

Dated at Toronto, Ontario, this 28th day of October, 2007.

Tanja Wacyk, Referee