IN THE MATER OF A REFERENCE PURSUANT TO THE HEPATITIS C 1986-1990 CLASS ACTION SETTLEMENT AGREEMENT
(Parsons v. The Canadian Red Cross et al.
Court File No. 98-CV-141369)

BETWEEN

Claimant File 14506

- and -

The Administrator

(On a motion to oppose confirmation of the decision of Tanya Wacyk, released on April 23, 2007)

Reasons for Decision

WINKLER C. J. O.:

Nature of the Motion

1. This is a motion to oppose confirmation of the decision of a referee appointed pursuant to the terms of the Settlement Agreement in the Hepatitis C litigation for the class period January 1, 1986 to July 1, 1990. The Claimant made a claim for compensation pursuant to the Agreement which was denied by the Administrator charged with overseeing the distribution of the settlement monies. The Claimant appealed the denial to a referee in accordance with the process set out in the Agreement. The referee upheld the decision of the Administrator and denied the appeal. The Claimant now opposes confirmation of the referee's decision by this court.

Background

2. The Settlement Agreement is Pan-Canadian in scope and was approved by this court and also approved by courts in British Columbia and Quebec. (See *Parsons v. The Canadian Red Cross Society* (1999), 40 C.P.C. (4th) 151 (Ont. Sup. Ct.)). Under the Agreement, persons infected with Hepatitis C through a blood or specified blood product transfusion, within the period from January 1, 1986 to July 1, 1990, are entitled to varying degrees of compensation depending primarily on the progression of the Hepatitis C infection.

Facts

3. The Claimant is an Ontario resident who is infected with HCV. The Claimant seeks compensation pursuant to the Transfused HCV Plan.

4. The Claimant asserts that she received three units of blood in November 1987 while hospitalized at the Kitchener-Waterloo Hospital (now the Grand River Hospital). The Administrator accepts that the Claimant was hospitalized at this time but claims that she only received one unit of blood, and that the donor of this unit tested negative for HCV antibodies.

5. The Claimant's assertion that she received three units of blood is based on her personal recollections. These recollections were summarized by the referee as follows:

> 14. [The Claimant] testified that following her surgery, she began to hemorrhage and blood was "squirting all over". According to the [Claimant], the doctor told her she was hemorrhaging because he made a mistake and forgot to close a valve.
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> 15. The [Claimant] maintained she was not taken back to the operating room for a second procedure, but rather to a room adjacent to the recovery room. According to the [Claimant] the doctor told her he could not give her any more anesthetic because she had just had anesthetic administered in her prior operation and any more would kill her. Consequently, she maintains that she had to remain awake and "aware" during the second procedure.
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> 16. The [Claimant] also testified that the doctor was shouting and indicating she needed a blood transfusion because she had lost too much blood. However, the nurse responded that they did not have any. The doctor then became very agitated and indicated she would die if she did not receive a blood transfusion. He also indicated that the [Claimant] did not take a special kind of blood, and insisted some compatible blood should be available. However, the nurse indicated they were "out of it". However, the doctor instructed the nurse to find some blood, and indicated the [Claimant] would not survive without it.
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> 17. The [Claimant] testified that she next saw the nurse coming down the hall with blood, and that the nurse indicated she had found some blood. The Claimant testified that they then began the transfusion. However, she was unable to provide any more details, as she did not look at the bag, or any of the procedure as she hates the sight of blood. She also could not recall how long the transfusion took.
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> 18. It may be worth noting that the hospital records also indicate that, prior to the second surgery, the [Claimant]

> had received a significant amount of morphine for someone her size … This may have made it difficult for her to recall details surrounding the event.
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> 19. The [Claimant] further testified that she had two additional transfusions following that initial transfusion, for a total of three. However, the third bag caused a negative reaction, and "Rose" another patient in the room, called the nurses to tell them the [Claimant] was very ill. Consequently, the third bag was removed before it was finished.

6. The referee reviewed the records related to the blood transfusion and concluded that those records only disclosed one transfusion to the Claimant.

7. The Claimant's claim was denied by the Administrator by way of a letter dated January 27, 2006 on the basis that the Claimant failed to provide sufficient evidence that she was infected as a result of receiving blood during the Class Period. The Administrator's decision was upheld by the referee.

Standard of Review

8. In a prior decision in this class proceeding, the standard of review set out in *Jordan v. McKenzie* (1987), 26 C.P.C. (2d) 193 (Ont. H.C., aff'd (1990), 39 C.P.C. (2d) 217 (C.A.) was adopted as the appropriate standard to be applied on motions by a rejected claimant to oppose confirmation of a referee's decision. In *Jordan,* Anderson J. stated that the reviewing court "ought not to interfere with the result unless there has been some error in principle demonstrated by the [referee's] reasons, some absence or excess of jurisdiction, or some patent misapprehension of the evidence."

Analysis

9. Having reviewed the claim file, I agree with the referee's conclusion that the majority of the Claimant's hospital records are illegible. However, the few records that are more legible show that at least two units of blood were cross-matched for the Claimant, if not more than two.

10. The Claimant's records include what appears to be a blood bank form in the Claimant's name. The form contains information about the single unit of blood that the Administrator accepts was transfused to the Claimant and another unit that hospital personnel, in a note dated some 18 years after the event, indicate was cross-matched for the Claimant but given to another patient. However, a name was signed with respect to each of the units of blood at the part of the form that prompts the person completing the form to indicate who started the transfusion. Moreover, "November 9, 1987" is written next to the part of the form that states "Date and time started" for each unit. Although there is a handwritten note relating to the second unit which the referee interpreted as

stating "not given", in my view it is illegible. Moreover, there are other notations in respect of the same unit that are not explained.

11. On the other hand, the uncontradicted evidence is that the Claimant was hospitalized for a surgical procedure, there were complications with the procedure and those complications required a blood transfusion. She has no other risk factors for the hepatitis C virus. At least two units of blood were prepared for the Claimant and only one has been the subject of a traceback.

12. In my view, the referee committed two reversible errors. First, given the state of the hospital records, they cannot stand in isolation as evidence that the Claimant did not receive a transfusion of 2 or more units of blood. In my view, it is a misapprehension of the evidence to arrive at the conclusion the referee reached without further supporting material or testimony. In that regard, a note made 18 years later by someone without personal knowledge is not sufficient. Secondly, it appears that the referee made an adverse credibility finding against the Claimant that is not referenced as being supported by any evidence in her reasons. Rather, the referee made an assumption as to the state and clarity of the mind of the Claimant during the time period in issue because of the administration of a certain quantity morphine to the Claimant during that time. Adverse credibility findings based on assumptions about a person's characteristics represent errors in principle.

13. Without these errors, there would have been sufficient independent evidence to corroborate the Claimant's contention that she was infected with hepatitis C by a blood transfusion in the Class Period.

Result

14. The Claimant's motion to oppose confirmation is granted. The Claimant's application for compensation pursuant to the Transfused HCV Plan is approved, subject to a determination by the Administrator of the amount of compensation to be paid to the Claimant.

Winkler C.J.O.

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