CLAIM #14506

Province of Infection: Ontario
Province of Residence: Ontario

IN THE MATTER OF AN ARBITRATION
TO REVIEW THE DECISION OF THE ADMINISTRATOR

Before: Tanja Wacyk

Heard: April 17, 2007 at Kitchener, Ontario

Appearances: The Appellant and her daughter appeared on the Appellant's behalf
Belinda A. Bain and Carol Miller for the Administrator

DECISION

BACKGROUND:

1. The Appellant applied for compensation as a Primarily Infected Person under the Transfused HCV Plan ("the Plan"), as set out under the terms of the 1986 - 1990 Hepatitis C Settlement Agreement ("the Settlement Agreement").

2. By letter dated January 27, 2006, the Administrator of the Fund (the "Administrator") denied her application. The basis for the denial was that, as the result of a negative traceback, the Administrator could not conclude that the Appellant was infected for the first time with HCV by a blood transfusion received in Canada during the Class Period i.e. January 1, 1986 - July 1, 1990.

3. The Appellant requested that a Referee review the decision of the Administrator in an in-person hearing.

4. A hearing was originally scheduled for December 5, 2006. The Appellant failed to attend, and by decision dated December 6, 2006, I dismissed her appeal as abandoned. It subsequently became apparent that the Appellant was in hospital on December 5, 2006, and unable to attend the hearing scheduled for that day. Consequently, my earlier decision of December 6, 2006 is hereby rescinded and replaced by this decision.

5. An oral hearing in this matter was held in Kitchener on May 17, 2007.

APPLICABLE PROVISIONS:

6. Article 3.01 of the plan provides:

> **3.01 Claim by Primarily-Infected Person**
>
> 1. A person claiming to be a Primarily-Infected Person must deliver to the Administrator an application form prescribed by the Administrator together with:
>
> > (a) medical, clinical, laboratory, hospital, The Canadian Red Cross Society, Canadian Blood Services or Hema-Québec records demonstrating that the claimant received a Blood transfusion in Canada during the Class Period; …
>
> 2. Notwithstanding the provisions of Section 3.01(1)(a), if a claimant cannot comply with the provisions of Section 3.01(1)(a), the claimant must deliver to the Administrator corroborating evidence independent of the personal recollection of the claimant

or any person who is a Family Member of the claimant establishing on a balance of probabilities that he or she received a Blood transfusion in Canada during the Class Period.

7. Article 3.04(1) of the Plan provides:

> **3.04 Traceback Procedure**
>
> Notwithstanding any other provision of this Agreement, if the results of a Traceback Procedure demonstrate that one of the donors or units of Blood received by a HCV-Infected Person or Opted-Out HCV Infected Person before 1 January 1986 is or was HCV antibody positive or that none of the donors or units of Blood received by a Primarily-Infected Person or Opted-Out Primarily Infected Person during the Class Period is or was HCV antibody positive, subject to the provisions of Section 3.04(2), the Administrator must reject the Claim of such HCV Infected Person and all Claims pertaining to such HCV Infected Person or Opted-Out HCV Infected Person including Claims of Secondarily-Infected Persons, HCV Personal Representatives, Dependants and Family Members.

EVIDENCE:

Documents Relied upon by the Administrator

8. The Appellant experienced a partial hysterectomy at the Kitchener Waterloo (now the Grand River) Hospital on November 9, 1987. The hospital records demonstrate that in preparation for that operation, two units of blood (units 985726 & 974404), were cross-matched (claim file – page 49). This is a procedure by which compatible blood is requested and held in a hospital blood bank in the event it is required to be transfused.

9. It appears that these two units were not used in the Appellant's initial surgery, which occurred from approximately 10:40 a.m. to 12:20 p.m. (claim file – pages 95 & 96). However, complications arose, and the Appellant underwent a subsequent procedure, again in the operating room, under anesthetic, on the same day. That procedure, the evacuation of a post-operative haematoma, i.e. removal of a blood clot, occurred between 16:35 (4:35 p.m.) and 17:35 (5:35 p.m.). (claim file – pages 102 & 103).

10. The hospital records also indicate that the Appellant received a blood transfusion during the second procedure, and that unit 974404 was started on November 9/87 at 17:10 (5:10 p.m.). The records state that unit 985726 was "not given" (claim file – page 49).

11. A trace-back of unit 974404, the one shown to have been transfused, was conducted, and on February 11, 2005, the Canadian Blood Services (CBS) wrote to the Traceback Co-ordinator at the Administrator, advising that the donor of the single unit of blood transfused to the Appellant had tested negative for HCV. (claim file – pages 58-60)

12. Additional information was sought regarding unit 985726, the other unit which had been cross-matched for the Appellant. Documentation provided to CBS by the Grand River Hospital confirmed that unit 985726 had not been issued to the Appellant. Rather, the records indicated that particular unit was transfused to another patient on November 10, 1987. (claim file – page 63; Supplementary Submissions of Administrator – Tab 2, page 4)

13. CBS also confirmed that the hospital records did not identify any units other than unit 974404 as having been transfused to the Appellant. (claim file – page 61; Supplementary Submissions of Administrator Tab 2, page 2; Supplementary Submissions of Administrator Tab 3)

Appellant's Testimony

14. The Appellant's evidence was significantly at odds with the hospital records. She testified that following her surgery, she began to hemorrhage and blood was "squirting all over". According to the Appellant, the doctor told her she was hemorrhaging because he made a mistake and forgot to close a valve.

15. The Appellant maintained she was not taken back to the operating room for the second procedure, but rather to a room adjacent to the recovery room. According to the Appellant 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.

16. The Appellant also testified that the doctor was shouting and indicated 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 Appellant 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 Appellant would not survive without it.

17. The Appellant testified that she next saw the nurse coming down the hall with blood, and that the nurse indicated she had found some blood. The Appellant 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.

18. It may be worth noting that the hospital records also indicate that, prior to the second surgery, the Applicant had received a significant amount of morphine for someone her size i.e. 10 mg at 12:35 p.m. and 7.5 mg at 14:50 (2:50 p.m.) (claim file – page 102) This may have made it difficult for her to recall details surrounding the event.

19. The Appellant 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 Appellant was very ill. Consequently, the third bag was removed before it was finished.

20. The Appellant also testified that she called her daughter to tell her not to visit her, as she had had a blood transfusion and had become very ill as a result. This was corroborated by her daughter.

21. The Appellant and her daughter both expressed great frustration at the provisions of the Settlement Agreement, and the difficulty of having to demonstrate that the Appellant had contracted HCV as a result of her blood transfusion. This was particularly the case in the Appellant's case, as other than the blood bank records, the hospital records for her entire hospital stay were illegible.

22. Also, their efforts to locate Rose, who they maintained had witnessed the Appellant's blood transfusions, were frustrated because of the Hospital's refusal to release her last name, in order to protect her privacy. Similarly, they were frustrated by the lack of additional identifying information regarding who had actually received unit 985726, the second unit of blood which had been cross-matched for the Appellant. Again, this information is not provided in order to protect the privacy of that individual.

ANALYSIS:

23. The Appellant bears the onus of demonstrating the Administrator erred in denying her application. While her frustration regarding the difficulty of accessing information now, some 20 years later, is understandable, the Settlement Agreement was drafted with the understanding that would often be the case.

24. That having been said, the Appellant's Blood Bank records were available and indicate that, although two units were cross-matched, she received only one unit of blood, i.e. unit 974404. Furthermore, the traceback indicates that the donor of that unit tested negative for HCV.

25. While the Appellant testified that she received three units, given the passage of time, the fact she was undergoing surgery, and had received significant amounts of morphine prior to the time at issue, I find her recollection unreliable.

26. In any event, section 3.01(1)(a) of the Transfused HCV Plan provides that a person claiming to be a Primarily-Infected Person must provide the Administrator with, amongst

other things, "records demonstrating that the Claimant received a blood transfusion in Canada during the Class Period."

27. Section 3.01(2) of the Plan provides that if a claimant cannot comply with the provisions of section 3.01(1)(a), the claimant must deliver to the Administrator corroborating evidence independent of the personal recollection of the claimant or any person who is a Family Member of the claimant establishing on a balance of probabilities that he or she received a Blood transfusion in Canada during the Class Period.

28. Neither the Administrator, nor I, as a Referee, have discretion to grant compensation to individuals infected with Hepatitis C who cannot show they received a transfusion within the Class Period, or whose traceback results are negative.

29. In this instance, the Appellant has provided no documentation indicating she received two additional units of blood. Nor has she produced corroborating evidence which is independent of her recollection or that of her family. Consequently, I can not give any weight to her testimony that she received a total of three units of blood.

30. Furthermore, the donor of the one unit of blood recorded as transfused to the Appellant tested negative for the HCV virus. Consequently, as set out in Article 3.04(1) of the Plan, the Administrator and I must reject the Appellant's claim.

DISPOSITION:

31. The decision of the Administrator to deny the Appellant compensation pursuant to the Hepatitis C 1986-1990 Class Action Settlement is upheld.

DATED AT TORONTO, THIS 23RD DAY OF APRIL, 2007.

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Tanja Wacyk, Referee