THE 1986-1990 HEPATITIS C CLASS ACTION SETTLEMENT

IN THE MATTER OF AN APPEAL
FROM THE DECISION OF THE ADMINISTRATOR

CLAIMANT REPRESENTATIVE: No. 15688

REFEREE: C. Michael Mitchell

SEPTEMBER 17, 2024

DECISION

1. This is an application for review of the decision of the Administrator denying the claim of the estate of Primarily Infected person ("PIP"). Born (Date), PIP passed away in May (Date) at the age of ( ) The death certificate indicates that acute cocaine toxicity was the cause of death (from inhalation, not IV injection). Renal failure, congestive heart failure and hepatitis C were listed as contributing factors.

2. There is no issue in this case that PIP had hepatitis C, and that she had a blood transfusion during the class period, specifically in 1988, from a blood donor infected by HCV. The issue in this case arises because the claimant conceded that PIP had taken a drug, namely cocaine, intravenously on one occasion in 1991. As a result of that admission, the Administrator, as required, obtained the opinion of a qualified medical practitioner as to whether it was more likely that PIP became infected from intravenous drug use than it was that she became infected from the blood transfusion. After receiving the opinion of the physician that it was more likely that PIP became infected by IV drug use than the blood transfusion, the Administrator, based on the totality of evidence determined that the claimant had not satisfied the onus of demonstrating that PIP was initially infected with the virus by a tainted blood transfusion in the class period. It is that decision of the Administrator which is appealed here.

The Evidence

3. Born in (Date), PIP had a troubled and unfortunate medical history which resulted at the age of (#) in chronic renal failure in (Date). A kidney transplant occurred shortly thereafter, but it resulted in rejection, partially as a result of low compliance by PIP not strictly maintaining an anti-rejection drug regime. Some years later, PIP had a second kidney transplant which succeeded for a time. As an adolescent and as a young adult in the class period (1986-1990) PIP had a long history of dialysis and a large number of blood transfusions totalling 69. It should be noted that once a single tainted blood transfusion was identified as occurring in the class period in 1988, in accordance with the plan provisions none of the other multiple transfusions that PIP had during the class period were checked for tainted blood.

4. PIP later had a cardiac valve replacement as well and eventually developed congestive heart failure. She had a second kidney transplant in (Date).

5. Looking at the detailed medical records, progress notes from the (Hospital) in February 1985 when PIP had just turned ( ) noted that she smokes cigarettes, acknowledges frequent use of cannabis and hashish, and "acknowledges experimenting with street drugs (beans etc.) although she denied use of these in previous weeks". There was no reference to IV drug use.

6. In a (Date), nursing note from (Hospital) it is stated that PIP was frequently late for dialysis appointments and got along well with peers but had difficulty with authority figures. She could be uncooperative especially when overwhelmed and

frightened. On (Date), when hospitalized for her transplant surgery, a further nursing note discussed PIP 's drinking habits noting a boyfriend brought in a thermos of homemade wine. It was noted that PIP became upset that she would not be allowed to drink this,

7. In a consultation note from Adolescent Medicine at (Hospital) on (Date), it was noted she was being discharged from (Hospital) (that day) after kidney transplant surgery. She was noted as a pleasant young lady in no apparent distress and looking very well. The interviewer was aware she had been “acting out on the ward” and that medically there were real concerns with her compliance with the immune suppressive regime.

8. It is noted in the records that she stopped going to school in 1984 in grade 9 and had previously repeated grade 8 and grade 9. She indicated she gave up school because she was not interested. At the time she lived with her mother and the mother's boyfriend, with two of her sisters, and the boyfriend's children.

9. A Social Work Report from (Date), after the transplant, noted that at the time of the referral, PIP had not arrived for consistent outpatient appointments and was refusing to participate in a renal biopsy and renal scan. At the time of the referral, PIP continued to live at home with her mother and the mother's common-law partner. Three other adolescents were living in the family home. Her maternal grandmother had also demonstrated in the past an appropriate concern for PIP. At that time she was not attending school, was not employed and was understood to have an extremely “independent streetwise lifestyle”. At the time of the interview in (Date), she was not compliant with her rejection medications having an inconsistent pattern of intake and maintenance. She refused to be admitted to the hospital for a renal scan and refused to have a renal biopsy completed. Despite being urged by her physician to be compliant and attend the clinic regularly and comply with her medications, that was not the case.

10. She was described as a (#)year-old female young adult who demonstrates irresponsible and inappropriate behaviour in the management of her medical needs. The psychological history was said to present a young child who experienced significant prolonged separations from a consistent parenting figure and has grown up in an atmosphere of inconsistency and irregularity. She approaches her environment from a position of hostility and ambivalence. She actively anticipates rejection and disapproval. She is frequently angry with helping professionals and is suspicious of their motives. She anticipates rejection as she cannot tolerate the supposition that a supportive caring relationship is possible. Consequently, it is difficult for the team to assist her.

11. The social worker believed that PIP would be uncooperative in the process of transferring care from (Hospital) once she attained the adult age of (#). The long-

term prognosis for her management was very guarded as she was predicted to resist the helping efforts of any healthcare professional.

12. On (Date), PIP appeared at the (Hospital) emergency department with kidney problems. She was hospitalized from that date until (Date). The Final Summary of her hospitalization noted she had a strong history of chain smoking, alcohol, and other street drug abuse. There was no reference to IV drug use.

13. PIP was seen again in the Emergency Department at (Hospital) in (Date). A History Sheet apparently from (Date), shows her being recommended for admission to the hospital with blood work including drug screening, specifically for cocaine, talwin, and amphetamines. The results of the drug screen did not reveal any IV drug use (nor any other drug use) but Dr. G, (see below) speculated the full drug screen report may not have been in the file as it did not show a result for the presence of cocaine or talwin or amphetamines. At some point in 1986, PIP lost the use of her transplanted kidney and was on constant dialysis thereafter. In 1991 PIP had a second kidney transplant. I was not referred to records of her second kidney transplant and any findings of IV drug use at that time.

14. In (Date), PIP was admitted to the hospital because while she had done well on hemodialysis according to the hospital records, she was admitted because of the difficulty in maintaining patency of her left forward AV graft. Dr. G explained that these grafts were a part of dialysis treatment and were difficult to maintain as they clogged up. There is no indication as to whether the difficulty with the graft arose as a result of dialysis or from IV drug use. The surgeon’s report at the time does not give any indication of the source of the difficulty or any indication or evidence of IV drug use.

15. Dr. G referred to the existence of medical records showing PIP leaving the hospital unexpectedly and without permission. I was not referred to or taken to these records or the precise times or circumstances of those absences, but Dr. G was not cross-examined on them either. I was not taken to any records that showed these absences were linked by hospital staff at the time to symptoms of drug withdrawal exhibited by PIP.

16. Later in her life, PIP married, although the marriage did not last. She carried a child to term, a son, who now brings this application for compensation on behalf of his mother's estate.

17. To summarize the above evidence, nothing is indicated directly in the entire very large medical file that showed there was IV drug use before the blood transfusion in (Date). or before (Date). There are, however, multiple references to the use of “street drugs” without any specificity to indicate what this constituted and whether it went beyond marijuana, hashish, “benes” or “ecstasy” to include IV drug use.

18. PIP received multiple blood transfusions, 12 in the pre-class period from (Date) to (Date), of which three were untested. She received 69 transfusions in the class period from 1986 to 1990 which were untested except for the one which tested positive. As indicated above, once there was an identification of tainted blood from a transfusion in (Date), none of the other 68 blood donor files was reviewed to indicate whether the donor's blood was tainted.

19. The claimant called several witnesses. Members of PIP s family including her sister and brother who lived with PIP at various periods testified that PIP did not use intravenous drugs, and they stated that had she done so they would have known. Her younger sister, in particular, who lived with PIP during the relevant time testified that the two sisters shared a bedroom, and were very close such that she would have known had her sister taken cocaine with needles. A family friend testified that PIP had a tattoo on her buttocks, but her sister denied this saying she had a tattoo of a rose on her breast. This is but one indication in my view as to the greater accuracy of the sister's recollections as opposed to the far more distant friend of the family who also testified. The friend of the family, a teacher who had a relationship with an uncle of PIP's, testified that he observed PIP often, but most of his information regarding PIP came from his partner, who did spend a lot of time with PIP and who accompanied her to dialysis appointments and when she was hospitalized. The source of much of the friend's information, therefore, was hearsay evidence from the partner who did not testify. I found most of the friend of the family's evidence regarding PIP's possible IV drug use unpersuasive except for one thing: he and all the family members testified that PIP had a particular hatred and fear of needles as a result of her extensive dialysis treatments.

20. Dr G was retained to provide the medical opinion required by the Hepatitis C protocols for the Administrator to obtain because of the admission of the claimant to a single instance of IV drug use in (Date). Dr. G is an Internist and Professor at the (University) with a specialty in infectious disease retained by the Administrator to advise it. He also testified at the hearing and was cross-examined. His written opinion was as follows:

> I have reviewed the extensive file you provided me related to the above-named Claimant's family. Briefly this is a woman who developed renal failure at the age of (#) related to IgA nephropathy (Date). She had a renal transplant in (Date), but the kidney failed in under a year due to poor adherence to immunosuppressant medication. At that time, it was reported that she was a heavy smoker, drinker and drug user. There are no details on the type of drug use. She then started hemodialysis and had regular blood transfusions in the 1986-90 period and one of those units in retrospect came from a donor found to have Hepatitis C antibodies. She also had several blood transfusions in 1984-86 and 9/12 were tested negative and 3 were not tested or found.

Her medical history is complicated by valvular heart disease, successful second renal transplant in (Date). She had a successful pregnancy. She also had enterococcal endocarditis and subsequent valve replacement surgery (aortic and mitre' valves). Her kidney started failing in around (Date) and she ended back on hemodialysis. She died in (Date) from an acute Cocaine overdose and renal failure.

She was diagnosed to be Hepatitis C antibody positive. I do not see any antigen testing or viral loads nor a genotype. Her ALT was normal through most of this period but was 77 in early (Date) and intermittently slightly above the upper limit of normal but not 1.5 time the upper limit of normal. Her liver on autopsy showed minimal fibrosis and 1+ Inflammation.

The question is on the balance of probabilities did she get HCV from a blood transfusion or from injection drug. The question is on the balance of probabilities did she get HCV from a blood transfusion or from injection drug. Her IV drug use history is indirectly documented in the medical chart on several occasions and there is one reference to hepatitis in the chart in 1988. No other description is found. Her poor adherence to medication and pattern of leaving hospital against medical advice would also go along with an active substance use disorder. That behavior certainly predates the documented HCV infected donor unit of blood transfused to her in (Date). There is also 3 units of blood in the (Date) period which were not tested.

Of note is the minimal progression of liver disease identified in (Date). This would be anywhere from 18-22 years after her infection. Therefore, I cannot with any precision differentiate a possible infection date in the period of (Date) as the date of her source of infection. I did not identify any antigen or viral testing, and I wonder if she could have been one of the 25% of HCV infected individuals who spontaneously cleared their viral infection.

Regardless, her renal disease and renal failure predated any hepatitis C infection, so level 6 compensation is not appropriate as HCV is not the precipitating cause. She also does not have bridging or non-bridging fibrosis noted on autopsy, so level 3 or 4 is not applicable. This would leave level one or two depending if actual virus had been identified. I also think it is quite clear that the cause of death was not related to liver failure or active liver disease.

21. Dr. G was asked to provide a supplementary opinion where he said as follows:

> I have provided an opinion in connection with the above matter to the Administrator of the 1986-1990 Class Action Settlement Fund, dated June 5, 2020. I have been asked to expand on my response to the question of "whether the HCV infection and the disease history of PIP 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".
>
> Based on the evidence presented to me in the medical chart, this individual had a history of drug [use]. Her poor adherence to medication and pattern of leaving hospital against medical advice would also go along with an active substance use disorder. That behavior certainly predates the documented HCV infected donor unit of blood transfused to her in 1988. There is also 3 units of blood in the 1984- 86 period which were not tested. Thus it is my opinion that this patient more likely was infected prior to the class period (1986-1990) most likely through her injection drug use but I cannot rule out the possibility related to the 3 units of blood that could not be tested.

22. Dr. G's oral evidence was that in his earliest days after medical school as an intern he first encountered Hepatitis C which was emerging as a dangerous disease. In those early days, no one knew the cause of the disease and it was referred to as Non-A and Non-B hepatitis. There was no diagnostic testing in those years until (Date). In V(City) where he worked at that time, it was known that the disease appeared to be contracted through blood but there had to be a breach of the skin and not just contact with blood, and the overwhelming number of patients with the disease appeared to be men who had sex with other men. IV drug use where needles were shared appeared to be another source of the disease as were tattoos. Sharing straws was known to be a source of transmission.

23. He testified that transmission through blood transfusion is the most efficient way of contracting the disease as one is getting a full unit of blood and not just a few drops as with the exposure from a needle.

24. He testified that he never saw the patient in this case, but PIP was on dialysis and would have had a dialysis catheter and then a venous fistula which is a connection between blood vessels, in the crick of the elbow, because increasing this enables the insertion of a larger needle. Normally one has dialysis three times of week, so it makes for very easy access to the bloodstream if one is inserting needles also for intravenous drug use. Dialysis would make possible the easiest access for injection for an IV drug user.

25. He noted that when an individual is going through withdrawal from substance use, the need for narcotics precipitates behaviour such as demanding to leave the

hospital early or just leaving to get a fix. This is the type of behaviour not typical for someone who had a transplant. To leave the hospital precipitously is distinctly unusual for a transplant patient. A history of drug use would be a viable explanation to explain that type of behaviour.

26. Dr. G added that one of the remarkable things about this case was the lack of medical evidence of the progression of this disease in PIP. The autopsy showed little fibrosis of the liver. This suggests that perhaps there was no active disease present. On the other hand, 25% of people who had the virus cleared it and this medical phenomenon is not understood.

27. In terms of whether or not the infection was more likely to have occurred in 1988 or 1984 when there may have been IV drug use, he could not say, especially where there was so little disease.

28. He testified the addendum opinion was no different from the initial opinion.

The Relevant Legal Provisions

29. The relevant provisions of Article 3 of the Plan are as follows:

> 3.05 Claim by HCV Personal Representative of HCV Infected Person
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> 1. A person claiming to be the HCV Personal Representative of a HCV Infected Person who has died must deliver to the Administrator, within three years after the death of such HCV Infected Person or within two years after the Approval Date, whichever event is the last to occur, an application form prescribed by the Administrator together with:
>
> (a) proof that the death of the HCV Infected Person was caused by his or her infection with HCV;
>
> (b) unless the required proof has already been previously delivered to the Administrator:
>
> (i) if the deceased was a Primarily-Infected Person, the proof required by Sections 3.01 and 3.03
>
> …
>
> 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:

…

(c) a statutory declaration of the Claimant including a declaration

(i) that he or she has never used non-prescription intravenous drugs
…

3.05 Claim by HCV Personal Representative of HCV Infected Person

…

5. For the purposes of Sections 3.05 (1) and (2), the statutory declaration required by Sections 3.01(1)(c) and 3.02(1)(a) must be made by a person who is or was sufficiently familiar with the HCV Infected Person to declare that to the best of his or her knowledge, information and belief the HCV Infected Person did not use non-prescription intravenous drugs and was not infected with Hepatitis Non-A Non-B or HCV prior to 1 January 1986. If such a statutory declaration cannot be provided because the HCV Infected Person used non-prescription intravenous drugs, the HCV Personal Representative must deliver to the Administrator other evidence establishing on a balance of probabilities that the Primarily-Infected Person was infected for the first time with HCV by a Blood transfusion in Canada during the Class Period or the Secondarily-Infected Person was infected for the first time with HCV by his or her Spouse who is or was a Primarily-Infected Person or Opted-Out Primarily-Infected Person or by a Parent who is or was a HCV Infected Person or an Opted-Out HCV Infected Person.

30. Sections 8 through 10 of the IVDU CAP provide as follows:

8. If the Claim or Late Claim is not rejected under the applicable Traceback protocol, the Administrator shall perform the following additional investigations:

(a) obtain such additional information and records pursuant to section 3.03 of the applicable Plan as the Administrator in its complete discretion considers necessary to inform its decision; and

(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 or Blood (Hemophiliac) (under the applicable Plan), the Class Period Blood transfusion(s) or Blood (Transfused) transfusions (under the applicable Plan) or the secondary infection or more consistent with infection at the time of

> the nonprescription intravenous drug use as indicated by the totality of the medical evidence.
>
> 9. The Administrator shall weigh the totality of evidence obtained including the evidence obtained from the additional investigations required by the provisions of this protocol and determine whether, on a balance of probabilities, the HCV Infected Person meets the eligibility criteria.
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> 10. In weighing the evidence in accordance with the provisions of this protocol, the Administrator must be satisfied that the body of evidence is sufficiently complete in all of the circumstances of the particular case to permit it to make a decision. If the Administrator is not satisfied that the body of evidence is sufficiently complete in all of the circumstances of the particular case to permit it to make a decision, the Administrator shall reject the Claim or Late Claim.

Analysis

31. I agree with the argument of the Administrator that given that PIP used non-prescription intravenous drugs (at any time), the onus is on the Claimant to establish on a balance of probabilities that PIP was infected for the first time with HCV by a Blood transfusion in Canada during the Class Period and not by IV drug use.

32. In order to do this, the claimant can rely on several factors. First, in my view, the fact that a transfusion that PIP had in (Date) was from tainted blood while insufficient in itself to establish a case on the balance of probabilities given the indication of IV drug use, is a very important fact in establishing that the disease could well have emanated from tainted transfused blood in (Date). After all, the entire basis of the settlement that gave rise to this compensation scheme is that persons who had a blood transfusion in the class period could well have received tainted blood which caused the disease. Here PIP had the disease and had a transfusion of blood in the class period which was tainted.

33. Second, while I do not accept the calculations of the probability of a blood transfusion being the source of the disease in PIP as calculated by counsel for the claimant in his oral argument, there is a basic common sense to counsel's contention that this individual, in and out of hospital and having had 69 blood transfusions in the class period, likely had more than one transfusion with tainted blood. Indeed, the probabilities are that she had more than one transfusion with tainted blood because she had 68 other transfusions in the period and none of them were checked for tainted blood. The possibility that one or more of those transfusions were from tainted blood is a significant potential additional source of infection. To summarize, the fact of 68 other transfusions of blood in the class

period is suggestive of infection in the class period from another blood transfusion in addition to the established tainted transfusion.

34. Third, the claimant has attempted to satisfy the onus to show it is more likely than not that the claimant was infected for the first time by a blood transfusion and not by IV drug use by calling the evidence of family members and friends that she was not an IV drug user. I find that this evidence of family members and friends can only go so far. First, the adjudicator must be aware that they have a natural tendency to be supportive of the claim. Second, they concede that PIP would be unlikely to want her family members or friends of the family to be aware that she was an IV cocaine user, if she in fact was, and she would have made efforts to conceal that fact if it were true. Third, as counsel for the applicant concedes, it is extremely difficult to prove a negative, i.e., that PIP was not an IV drug user.

35. I have given their collective evidence some but not a great deal of weight. What I found most significant from their evidence and what I believed from all of the witnesses was that PIP had a profound dislike for needles because of her intense, unhappy, and constant exposure to dialysis. This dislike and fear of needles would suggest a real reluctance to use IV drugs when other drugs were available. Her fear of needles from her experience with dialysis is ironic because Dr. G testified that the fact that she underwent dialysis meant that the point of entry for that treatment would have provided an easy effective insertion location for IV drug use. I discuss this further below.

36. Finally, one additional source of evidence of the non-use of IV drugs by PIP is the medical file itself and the records before (Date). The Administrator relies heavily on these files to infer that the street drugs that PIP was involved with likely included IV-injected drugs. I will have more to say about this inference that the Administrator makes and asks me to make, but to me, it is noteworthy that with all the multiple encounters between the medical system and PIP prior to (Date), including her many times presenting for dialysis, her severe kidney disease, her transplant surgery, her hospitalizations, the rejection of her transplanted kidney because at least in part of her lack of adherence to the required drug regime, there is no observation of the use of IV drugs through physical observation of healthcare staff, or by questioning of PIP. It is not obvious from the file that PIP hid anything from the medical professionals who questioned her, and she seems to have owned up to her behaviour, as irresponsible as it was. Given her other admissions, she would have had no obvious reasons to lie about this conduct to the medical professionals. She would have had no knowledge at that time, that IV drug use was a source of deadly infection or necessarily more dangerous than other drugs she experimented with. It therefore strikes me as important and adds to the evidence that it is more likely than not that the source of the disease was a blood transfusion, that there is no reference at all to IV drug use in all the medical records before (Date).

37. Dr. G opined that medical professionals encountering PIP would have been reluctant to note IV drug use in the file because it would be stigmatizing. He is essentially suggesting that medical professionals would have withheld relevant information from the medical charts about her medical condition. I am not prepared to make such a conclusion based on pure speculation. Nor am I prepared to find that PIP would have been deceitful about this behaviour when she apparently had no qualms in being frank about all her other behaviours. I am certainly not prepared to speculate that there is no mention of IV drug use because everyone in the system hid that fact.

38. I have found, thus far, that there is evidence that tends to support the conclusion that a blood transfusion was the source of the disease and not IV drug use. That evidence is:

    (a) one blood transfusion in (Date) was found to be tainted;

    (b) 68 other blood transfusions that took place in the class period were untested and there is a significant risk that one or more of these was tainted;

    (c) the observations of her friends and family as to her non-use of IV drugs but especially her aversion to needles as a result of her extensive negative experience with dialysis; and,

    (d) the absence of any record of IV drug use in the medical records.

39. As against this, what evidence does the Administrator rely on to show that the claimant has not met the burden of proof on the balance of probabilities?

40. The Administrator relies on at least three elements. First, it relies on the opinion of Dr. G who found it was more likely than not that IV drug use was the source of the infection. Second, it submits that the repeated references in the medical records to the use of street drugs implies that IV drug use occurred before (Date). Finally, it relies on what it says is the inherent improbability that PIP only used IV drugs once in 1991 and not before that in the class period, and prior to (Date). I examine each of these in turn.

41. Dr. G's opinion was not at all convincing in my view. There is no doubt he is an expert in this disease, but he wandered from the scope of his expertise when speculating about the drug activities and drawing implications about IV drug use from the behaviour of a seventeen year old. In terms of the medical evidence, he was candid in saying there was no medical evidence that could be relied upon that pointed to a time before (Date) as the source of the infection. The lack of progression in the disease from the autopsy made such a conclusion impossible. It was, in other words, impossible to say from any physical findings that the infection was likely to have occurred before the tainted blood was transfused in (Date) which is

when the IV drug use would have to have taken place it if was to predate the blood transfusion as the source of infection. In my view, that should have been the end of the matter as the balance of his opinion is not truly related to his relevant medical knowledge.

42. In particular, in his opinion, he says that at the time of the renal transplant it was reported that PIP "was a heavy smoker, drinker and drug user. There are no details on the type of drug use."

43. First, it is not accurate that there are no references to the type of drug use. There are references to cannabis, hashish and "experimenting with street drugs (benes etc.)". There is correspondingly no reference to IV drug use.

44. Second, Dr. G goes on to say that "Her IV drug use history is indirectly documented in the medical chart on several occasions and there is one reference to hepatitis in the chart in (Date). No other description is found. Her poor adherence to medication and pattern of leaving hospital against medical advice would also go along with an active substance use disorder. That behavior certainly predates the documented HCV infected donor unit of blood transfused to her in (Date)."

45. In my view, there is no documentation, direct or indirect of IV drug use as the term "street drugs" is inherently unspecific. However, the medical records go beyond that and identifies the drugs as cannabis, hashish, and ("beans etc.") This is suggestive that there was not IV drug use. In short, his conclusion that the reference to street drugs must include IV drug use is not a medical opinion or a medical conclusion but simply conjecture and speculation without any particular expertise. Combined with the reference to three different drugs but not IV drug use, the record, if anything, leads one to conclude there was an absence of IV drug use as I noted above.

46. Third, the other indirect evidence of IV drug use is said by Dr. G to consist of: "Her poor adherence to medication and pattern of leaving hospital against medical advice." In his oral evidence he said the leaving of hospital was consistent with leaving to get a fix during addiction withdrawal.

47. Other than what I have reported above, however, there is no additional "indirect documentation". Is the evidence of not adhering to the drug regime to prevent or suppress rejection of the kidney and the leaving of the hospital without medical authorization evidence of IV drug use? Is the witness qualified to give such an opinion about the conduct a ( )-year-old girl with her social and medical history? I do not think so. There is nothing in his resume or medical practice which involved him with adolescent girls (he was on call to the Children's Hospital in Ottawa once a month) and he is not an expert in addiction, particularly of ( )-year-old girls and he did not purport to be an expert in "street drugs".

48. There is no doubt that PIP as a ( )-year-old had an independent lifestyle, used street drugs, (cannabis, hashish, benes etc.), did not adhere to her medication regime, and had difficulty with authority figures. There is no evidence of addiction, except perhaps to cigarettes. One could say that there are likely many ( )-year-old girls who have a similar lifestyle and attitudes but one could not conclude from this that most ( )-year-olds who display such characteristics are IV drug users. To ascribe to PIP the use of IV drugs based on her non-adherence to taking medications and leaving the hospital without authority is a leap in logic for anyone and is certainly not the expert medical opinion of a physician expert in Hepatitis C. It is rather simply speculation and supposition. I give it no weight.

49. I also point out that I was not taken to the medical records of PIP where she purportedly left hospital without permission and there was nothing pointed to in the medical records that PIP was going through “withdrawal” at any time she was hospitalized that would lead to the inference she left hospital to obtain an IV drug injection or” fix” as Dr. G put it. That part of his opinion is again pure speculation.

50. In his second opinion, and I agree with Dr. G that it is really no different from the first opinion, he states: “Based on the evidence presented to me in the medical chart, this individual had a history of drug [use]. Her poor adherence to medication and pattern of leaving hospital against medical advice would also go along with an active substance use disorder.” In my view this behaviour might be consistent with a substance use disorder, but it is not, standing alone, evidence of IV drug use, which is the necessary factor that must be present to counter the evidence of the claimant that she more likely had the disease as the result of a blood transfusion because there is no evidence of IV drug use before (Date) or (Date).

51. Dr. G also in his oral evidence referred to the opportunity which the constant exposure to dialysis presented to PIP to insert needles for IV drug use in the same location on the body. He inferred from this that she could have been and indeed was an IV drug user. In my opinion, this again is not evidence but pure speculation to go along with a theory for which there is no evidence.

52. The second argument of the Administrator is really the same argument made by Dr. G which is that the medical file containing the references to street drugs is evidence of IV drug use. I reject these assertions for the same reasons I rejected Dr. G’s views. It is not evidence – it is supposition, conjecture and speculation.

53. The final argument of the Administrator is slightly more nuanced. Counsel challenges the adjudicator not to be naïve, and not to believe that PIP only used IV drugs on one occasion in 1991. Counsel would perhaps have a point if the Board had any evidence before it that there was IV drug use earlier than (Date). It might

be naïve and too convenient to accept the idea that it only occurred once and after the class period was over.

54. The difficulty with this argument, however, is twofold. First, if one is not prepared to read the reference to “street drugs” in the file as including automatically without evidence the use of IV drugs, then there is no evidence at all of prior IV drug use. Of course, IV drug use must start sometime, but here the issue is whether it started or occurred before the occurrence of the blood transfusion in (Date) and one cannot in my view say that just because there was IV drug use in (Date), it must have or likely commenced before (Date) and that it is naïve to think otherwise. On the contrary, to find that because there was IV drug use in 1991 there must have been IV drug use before (Date) is simply a leap of logical thinking and would involve making unwarranted conclusions of fact. And while it may be naïve to accept that IV drug use only occurred once, it is not naïve to expect that there be some evidence it happened more than once, and some evidence that it happened more than once before (Date). It is not naiveite to require proof that goes beyond speculation and conjecture.

55. This claim is upheld.

DATED at Toronto this 17th[nd] day of September 2024

C. Michael Mitchell