DECISION

Introduction

1. The Claimant in this case is infected with HCV. She received a blood transfusion during the Class Period. A traceback was inconclusive as to whether one of the units of blood she received was HCV antibody positive. These three undisputed facts would normally have been sufficient to establish her right to compensation. However, there is a fourth undisputed fact: the Claimant has a history of using non-prescription intravenous drugs (IV drugs). As result of this additional fact, the Claimant was required to prove on a balance of probabilities that she was infected *for the first time* by her blood transfusion. The Administrator concluded that she had not discharged this burden of proof and denied her claim. She appeals that decision.

The governing provisions of the Plan and the Court Approved Protocol

2. The Transfused HCV Plan is Schedule A to the 1986-1990 Hepatitis C Settlement Agreement made on June 15, 1999 between the participating governments and the plaintiffs in the Hepatitis C Class Actions. Section 1.01 of the Plan defines "Primarily-Infected Person" in a way which, subject to certain exceptions, presumes that "a person who received a Blood transfusion in Canada during the Class Period and who is or was infected with HCV" was so infected through his/her blood transfusion. Two exceptions have particular importance in this case.

3. The first exception applies to any person who "used non-prescription intravenous drugs". In that case, section 1.01 states that the person must "establish on the balance of probabilities that he or she was infected for the first time with HCV by a Blood transfusion received in Canada during the Class Period." This exception is repeated in section 3.01(3) of the Plan which states that a claimant who used non-prescription intravenous drugs must, in addition to providing proof of a blood transfusion in the Class Period, "deliver to the Administrator other evidence

establishing on a balance of probabilities that he or she was infected for the first time with HCV" by such a transfusion.

4. The second exception relates to the traceback procedure. That procedure is defined in section 1.01 as "a targeted search for and investigation of the donor and/or the units of Blood received by an HCV Infected Person." Section 3.04 of the Plan states that the claimant is not entitled to compensation if the traceback procedure demonstrates *either* that he/she received a transfusion of HCV infected blood *before* the Class Period or that *none* of the blood that the claimant received by way of transfusion *during* the Class Period was HCV infected. Since the traceback procedure conducted in this case was inconclusive as to whether the claimant received a transfusion of HCV infected blood during the Class Period, this exception does not apply. It will nevertheless be the subject of further comment during the course of this decision.

5. In addition to the governing provisions of the Plan, the courts have exercised their authority under section 10.01(1)(h) of the Settlement Agreement to issue "Court Approved Protocols" (CAPs) regulating the administration of the Plan. The CAP of importance for the present case is the CAP dealing with non-prescription intravenous drug use. I therefore set it out below, omitting only those provisions which do not apply in this case. Since the CAP refers to section 3.03 of the Plan, I quote the wording of that provision. I also add one explanatory note of my own in square brackets.

1. This CAP applies where:
    (a) there is an admission that the HCV Infected Person used non-prescription intravenous drugs;
    [(b) and (c) omitted]
2. The Administrator must be satisfied on the balance of probabilities that:
    [(a) omitted]

(b) the HCV Infected Person was infected with HCV for the first time:

(i) by a Blood transfusion received in Canada in the Class Period;

[(ii) and (iii) omitted]

3. The burden to prove eligibility is on the claimant. The Administrator shall assist the claimant by advising what type of evidence will be useful in meeting the burden of proof in accordance with this CAP.

4. The Administrator shall conduct a Traceback under the Traceback CAP, unless [(a) and (b) omitted]

5. [omitted]

6. If the result of a traceback investigation is such that the Traceback CAP requires the Administrator to reject the claim of the HCV Infected Person, the Administrator shall reject the claim. [Since the traceback procedure conducted in this case was inconclusive as to whether the Claimant received a transfusion of HCV infected blood during the Class Period, the Administrator would not have rejected the claim. Rather, but for the Claimant's admission of IV drug use, the Administrator would have allowed her claim.]

7. The Administrator may not accept a claim based on the results of a traceback investigation without performing the additional investigations required by paragraph 8 below.

8. If the claim is not rejected under the Traceback CAP, the Administrator shall perform the following additional investigations:

(a) obtain such additional information and records pursuant to s. 3.03 as the Administrator in its complete discretion considers necessary to inform its decision. Section 3.03 of the Plan states: "If requested by the Administrator, a person claiming to be a HCV Infected Person must also provide to the Administrator: (a) all medical, clinical, hospital or other such records in his or her possession, control or power; (b) a consent authorizing the release to the

Administrator of such medical, clinical, hospital records or other health information as the Administrator may request; (c) a consent to a Traceback Procedure; (d) a consent to an independent medical examination; (e) income tax returns and other records and accounts pertaining to loss of income; and (f) any other information, books, records, accounts or consents to examinations as may be requested by the Administrator to determine whether or not a claimant is a HCV Infected Person or to process the Claim. If any person refuses to provide any of the above information, documentation or other matters in his or her possession, control or power, the Administrator must not approve the Claim."

(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 HCV Infected Person is more consistent with infection at the time of the receipt of Blood, the Class Period 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.

9. The Administrator shall weigh the totality of evidence obtained including the evidence obtained from the additional investigations required by the provisions of this CAP and determine whether, on a balance of probabilities, the HCV Infected Person meets the eligibility criteria.

10. In weighing the evidence in accordance with the provisions of this CAP, 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.

11. Examples of the evidence the Administrator may require to inform its decision include the following:

[(a) omitted]

(b) the medical and clinical records from any or all hospitalizations and treating physicians for the HCV Infected Person for such time frame as the Administrator considers relevant.

(c) the donation history, transmissible disease information, deferral codes or the results of any lookbacks pertaining to blood donated by the HCV Infected Person available from Canadian Blood Services and/or Hema-Quebec;

(d) an affidavit from the HCV Infected Person and a person who knew the HCV Infected Person at the time he/she used non-prescription intravenous drugs describing:

i. whether the drug paraphernalia used was sterile;

ii. whether the HCV Infected Person shared needles; and

iii. the best estimate of the number occasions and time period during which the HCV Infected Person used non-prescription intravenous drugs;

[(e) and (f) omitted]

12. 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:

(a) identification of a Class Period Blood transfusion from an HCV antibody positive donor;

(b) the HCV Infected Person was under the age of 18 at the time of the receipt of Blood ... for the Class Period transfusions

(c) reliable evidence establishes that the non-prescription intravenous rug use took place after July 1, 1990;

(d) an HCV disease history which is more consistent with the timing of:

[i. omitted]

ii. 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; or

[iii. omitted]

(e) reasonably reliable evidence that the non-prescription intravenous drug use history is subsequent to ... the date of Class Period Blood transfusion(s) ...

(f) 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

(g) no medical history of unspecified Hepatitis, Hepatitis B or Non-A, Non-B Hepatitis prior to the date of the ... Class Period Blood transfusion(s) ...

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

(a) failure to identify a Class Period Blood transfusion from an HCV antibody positive donor;

(b) an HCV disease history which is more consistent with infection at the time of non-prescription intravenous drug use than with the timing of:

[i. omitted]

ii. 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; or

[iii. omitted]

(c) reasonably reliable evidence that the non-prescription intravenous drug use took place on more than one occasion or was done with non-sterile or shared equipment;

(d) a medical history of unspecified Hepatitis, Hepatitis B or Non-A Non-B Hepatitis prior to the ... Class Period Blood transfusion(s) ...

(e) a refusal to permit the Administrator to interview any person the Administrator believes may have knowledge about the non-prescription intravenous drug use or disease history of the HCV Infected Person;

(f) a CBS or Hema-Quebec donor file which indicates that the HCV Infected Person:

(i) tested positive for the antibodies to Hepatitis B; or;

(ii) had donated blood prior to the Class Period and the pre-Class blood donations have subsequently tested positive for HCV antibodies; and

(g) the file is in any other way consistent with infection with HCV by non-prescription intravenous drug use prior to the receipt of Blood for the Hemophiliac, or the Class Period Blood transfusion(s), or the date of alleged secondary infection.

The Claimant's Statements and Evidence

6. At the beginning of the claims process, on September 23, 2004, before the Administrator had obtained any medical documentation, the Claimant completed an Affidavit entitled "Other Risk Factor Inquiry Form". This form asked her to describe her use of non-prescription intravenous drugs. She indicated that between 1977 and 1988, when she was between the ages of 16 and 27, she used Dilaudid and Heroin more than 30 times. The form did not provide a tick box for a higher numbers of uses. The form also asked her: "Did you share needles?" She

answered "no".[1] A second form completed by her treating physician, also on September 23, stated: "patient admits use".[2]

7. Two years later, on August 22, 2006, the Claimant completed another Affidavit that was not a form document with prepared questions or suggested answers. Through this Affidavit, the Claimant made the following sworn statements. In July 1987, at the age of 25, she received a transfusion of four units of blood. She was diagnosed with Hepatitis C in 1993. She had used non prescription IV drugs prior to that transfusion as follows: sporadically, from 1980 to 1983, when she used Dilaudid approximately ten times; followed by two years when she was travelling and did not use IV drugs; sporadically again, between 1985 and 1987, when she used Dilaudid, Heroin and Cocaine with no indication of the number of times; followed by a period of abstinence of a few months; followed by weekend use from 1987 until July 1989 when she stopped using both drugs and alcohol. Her affidavit further stated that her mother was a nurse who kept supplies at home and that she was able to help herself to these. She stated that she also bought supplies from dealers and later on from pharmacies. She maintained that she was a closet user and did not share her drugs with anyone and that she used her own spoon, her own cigarette filters and her own needles, using a small amount of javex mixed with water to clean them. She again denied sharing needles with other non-prescription IV drug users.[3]

8. Under oath at the hearing, the Claimant stated that by 1987, she had injected non-prescription drugs between 10 and 15 times but that she was not dependent. She stated that she injected drugs between 1987 and 1992 but without indicating the number of times. She stated that by 1992, when she was diagnosed with Hepatitis C, she was dependent. She stated that she injected Dilaudid and Heroin into her arms. She stated that she paid $200 a gram for these drugs and that she did not share them or any injection equipment with any other person. She stated that prior

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1 Exhibit 1, p. 60.
2 Exhibit 1, p. 45.
3 Exhibit 1, p. 280.

to 1987, she would inject herself mostly at her mother's house, in the bathroom. She would crush the drug into water, heat it up in a spoon using a lighter and then put it in a syringe. She stated that she knew the syringes were sterile because she either took them from her mother, who was a nurse, or bought them from her drug dealer. She stated that she knew from her mother and from other people that it was important to be clean. She stated that when she was high, she would stay alone, in her room, partly because she did not want her family to know, partly because she preferred to enjoy the high alone and partly because she did not want others judging or stigmatizing her. She denied that she ever had septicaemia, commonly known as cotton fever, that she has ever been diagnosed as suffering from an endocarditic condition, that she ever had any abscesses at her injection sites or that she ever overdosed. Then, contrary to some of the evidence she had just given, the Claimant stated that she abstained from IV drug use between 1989 and 1999 but had a relapse in 1999 that continued until 2001 when she entered a rapid opiate detoxification program. She denied that she had track marks or scarring on her arms from drug injections but, as I understood her evidence, she was only saying that she no longer has such marks, not that she never had such marks. On cross-examination, she acknowledged having a vague recollection of a medical report written in 1989 that noted "marked scarring of the forearm veins".[4] She denied that she was ever a heavy user, that she was ever homeless or that she ever suffered from malnutrition.

9. The Claimant then gave evidence about the car accident in July 1987 which resulted in her hospitalization and her receipt, for the first and only time in her life, of a blood transfusion. She also gave evidence about her exposure to another potential source of Hepatitis C infection by denying that she has ever been tattooed. Finally, she acknowledged that the hospital records from that time indicated that she had been exposed to Hepatitis B.[5] Since such exposure is a relevant consideration under paragraphs 12(g) and 13(d) of the CAP, the Claimant

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4 Exhibit 1, p. 184.
5 Exhibit 1, p. 101.

attempted to explain this exposure by testifying about her travels prior to 1987. She stated that in 1983, she went to Morocco for a month and a half and then to the Canary Islands for four months. She stated that she was also in the Bahamas and in Mexico in 1986 and 1987.

10. On cross-examination, the Claimant expressed some uncertainty about whether she was diagnosed with Hepatitis C in 1992 or 1993. However, she insisted that she did not use IV drugs for a short period in 1987 and then between July 1989 and 1999. She also stated that she could not see how her relapse in 1999 had any bearing on her appeal. She was then asked to explain the discrepancy between her evidence and the information contained in a medical report in May 2004 which indicated that she started using IV drugs when she was 16, that she suffered a relapse in 1991, not 1999, and that she continued to use IV drugs from 1991 to 2001.[6] The Claimant admitted that the doctor in question would have obtained this information from her but nonetheless denied its accuracy, asserting both that her relapse was from 1999 to 2001, not 1991 to 2001, and that she first used IV drugs in 1980, when she was 18 years old. It was pointed out to her that according to her first Affidavit in 2004, she started to use IV drugs in 1977, when she was 16. She then acknowledged that perhaps she started to use in 1978, when she was 17. Referred again to this Affidavit, which did not provide a tick box for a higher numbers of uses than 30, she acknowledged that by July 1989 she had used IV drugs up to 50 or 100 times. She maintained that this was not inconsistent with her earlier evidence, to the effect that by 1987 she had only used IV drugs between 10 and 15 times, because these latter numbers did not include her uses after her 1987 accident. On re-examination, she stated that her use of IV drugs increased after her 1987 accident as a way of controlling the pain she experienced as a result of the accident. She maintained that before the accident, she was not dependent.

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6 Exhibit 1, p. 215.

11. The Claimant was cross-examined about her alleged practice of not sharing needles. It was suggested to her that this precaution conflicted with her apparent willingness to take other risks with her health, in particular, by engaging in unprotected sex with new partners as documented in her doctor's notes.[7] The Claimant did not dispute the accuracy of the doctor's notes and stated, on re-examination, that her main fear of unprotected sex was pregnancy. On cross-examination, she did not agree that her sexual behaviour could be tied to her drug habits. Her attention was then drawn to evidence that she herself combined sex and drug use. A 1992 note of her doctor described a recent sexual encounter and then stated: "1st time she ever had sex without drugs or alcohol."[8] The Claimant denied that she *never* had sex without taking drugs and stated that when she did have sex with drugs, the drugs in question were not always IV drugs. She maintained that because of the heavy "stone" they produced, she mostly used IV drugs alone, either at her mother's house or her own place. Still, she acknowledged that she did sometimes combine sex and IV drug use and that her sexual partners might also, on those occasions, use IV drugs. She nevertheless maintained that this only happened the odd time and that, on those occasions, she never shared needles or the IV drugs themselves, as the drugs were expensive. She denied that she might not remember having shared needles or drugs because she was high or because she was also drinking alcohol. She said that she never combined IV drugs with alcohol. She testified that she kept her drugs and equipment to herself in a purse which she hid. She stated that she used syringes that came out of individual wrappers though she acknowledged that she sometimes reused her own syringes.

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7 Exhibit 1, pp. 159, 161, 162.

8 Exhibit 1, p. 157.

Expert Evidence presented by the Claimant

12. **Dr. Margaret (Peggy) Millson** gave expert evidence at the hearing. I was given copies of both Dr. Millson's 30-page, single-spaced, Curriculum Vitae[9] and a shortened version[10] which reads as follows.

> Dr. Millson is an Associate Professor in the Department of Public Health Sciences (HIV Social, Behavioural & Epidemiological Studies Unit) at the University of Toronto, with particular focus on bloodborne and sexually transmitted infectious diseases. From 2000-2005, she was a Research Scientist funded by the Ontario HIV Treatment Network, where she is now a Senior Scientist. She is a physician with an MHSc in Community Health and Epidemiology, and an FRCPC in Community Medicine. In 1991, she completed a postdoctoral fellowship in HIV/AIDS research. In the mid-1980s, Dr. Millson worked as a public health physician with the sexually transmitted disease (STD) and HIV/AIDS program at the City of Toronto Health Department. Since 1987, she has been principal investigator or co-investigator for 38 research studies related to HIV and more recently HCV, including studies of prevention, harm reduction, HIV in prisons, partner notification, psychological aspects of living with HIV for women, HIV care for marginalized populations, and costs of HIV in Ontario. She has evaluated harm reduction programs including conducting the first evaluation of Toronto Public Health's needle exchange program and an evaluation of harm reduction of methadone maintenance programs based at the needle exchanges in Kingston and Toronto. She has published over 160 peer-reviewed journal articles, book chapters and abstracts in the fields of HIV/AIDS and of harm reduction. She teaches a graduate course on prevention and control of infectious diseases for the Dept. of Public Health Sciences, Faculty of Medicine, University of Toronto, and teaches

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9 Exhibit 3.
10 Exhibit 3a.

about harm reduction in the Program in Addiction Studies at the University of Toronto. She is currently Ontario principal investigator for the Public Health Agency of Canada's (PHAC) national I-track behavioural surveillance study of HIV/HVC risk in injection drug users. She was lead author for a report entitled 'Injection Drug Use, HIV and HCV Infection in Ontario: The Evidence 1992-2004', written by a team of researches from the University of Toronto, the University of Ottawa, and the Centre for Addiction and Mental Health. She is also a member of the team who wrote the 'Best Practices for Needle Exchanges in Ontario' document which won the Kaiser award for national leadership in harm reduction in 2006.

13. In a letter to the Claimant, entered into evidence,[11] Dr. Millson set out some of the findings of her co-authored report entitled "Injection Drug Use, HIV and HCV Infection in Ontario: The Evidence 1992-2004". Dr. Millson's letter made some comments about how she thought issues of entitlement should be approached. The relevant parts of the letter read as follows:

> Prevalence of Hepatitis C from studies on injection drug users in Ontario has ranged from 76% in Ottawa to 54% in Toronto; in your original home of _____, the prevalence reported in a 2003 study funded by the Public Health Agency of Canada was [approximately 60%; I have not indicated the exact figure because that might permit the reader to identify the Claimant's home town]; this study has been repeated in 2004 and 2005, with the Hepatitis C prevalence reported being [approximately 69% and 58%].
>
> Most participants in these studies are relatively long-term injectors attending needle exchange programs. Even in these relatively high risk populations, as many as 40% or more of participants are Hepatitis C

[11] Exhibit 4. The letter was undated but Dr. Millson stated that it was written sometime in late 2007.

negative. Given your history of injecting at a relatively young age and not sharing equipment, your risk would be expected to be significantly lower than this. In fact, … without sharing of any materials of equipment, the risk should be zero or close to it.

I have spoken to other injection drug users who report never sharing equipment but have received transfusions and are Hepatitis C positive. In my opinion, likely source of infection should be assessed on specific history of injection use risks. I consider it inappropriate to assume that all former injection drug users, regardless of their risk behaviours, became infected through this means.

14. Dr. Millson provided additional evidence through her oral testimony at the hearing. I would summarize her most significant evidence and opinions as follows.

15. On examination-in-chief, Dr. Millson was asked whether she could estimate the risk of infection with Hepatitis C from a blood transfusion in 1987. She responded that she understood her colleague and co-author, Dr. Robert Remis, to estimate that risk at somewhere between 1.25 % and 1.3% per transfusion, with an average transfusion consisting of between 4 and 5 units of blood.[12] Accordingly, the risk of infection per unit of blood transfused could, she thought, be estimated at approximately ¼ of 1% or .25%. She explained, however, that if a unit of transfused blood was, in fact, infected with the Hepatitis C virus, the recipient would definitely be infected as a result. That is because the "viral load" of a unit of blood would be sufficiently large to ensure transmission of the virus. Dr. Millson went further on cross-examination to explain that while the virus is highly infectious, the viral load of a drop of blood might not be sufficiently large to

[12] She wondered whether the risk of infection would be higher than that for units of blood that could not be traced back, suggesting perhaps that some of those donors might, indeed, have been infected with Hepatitis C and subsequently become ill or died as a result, thus explaining the failed traceback. However, her estimates did not take that possibility into consideration and neither have I.

ensure its transmission, especially if the blood was diluted in water. In that regard, she stated that she understood the risk of infection from a Hepatitis C infected needle stick injury to be about 1%. She stated that she would estimate the risk of infection from the sharing of a Hepatitis C infected needle or water to be about the same. But she also acknowledged, in accordance with her own study showing high rates of Hepatitis C infection among injection drug users, that the statistical risk that a needle or water shared by injection drug users would be infected with Hepatitis C would have to be estimated at a minimum of 50%. To summarize, her evidence was that while the risk that a unit of transfused blood was infected with Hepatitis C was low, .25%, the risk of transmission of the virus through the transfusion of a unit of infected blood was 100%. On the other hand, while the statistical risk that a needle or water shared by injection drug users was infected with Hepatitis C was high, at least 50%, the risk of transmission of the virus through the sharing of that needle or water was only 1%. With the assistance of counsel for the Administrator, these comparative risks were expressed mathematically at the hearing as follows: the first risk is .0025 times 1 = .0025 or 1 over 400; the second risk is .5 times .01 = .005 or 1 over 200. Accordingly, while Dr. Millson's evidence was admittedly only based on statistical averages and estimates, it suggested that the risk of infection through the sharing a needle or water by injection drug users only once was at least twice as large as the risk of infection for the recipient of a single unit of transfused blood.

16. Dr. Millson also explained some of the similarities and differences between Hepatitis A, B and C.

17. She stated that while Hepatitis A is commonly contracted while travelling in Third World countries, Hepatitis B is less commonly contracted in this way.

18. She explained that Hepatitis B and Hepatitis C are similar in that both are bloodborne viruses that can be transmitted by needle sharing. However, she pointed to two differences between Hepatitis B and C.

19. First, the risk of contracting Hepatitis B through needle sharing was known to at least some injection drug users in the late 70's and early 80's, several years before the Hepatitis C virus was identified in 1989. Still, Dr. Millson agreed that probably only a minority of that population knew about the risk of Hepatitis B in the late 70's and early 80's. She also agreed that knowledge of the risks of needle sharing increased sharply when the second cluster of HIV/AIDS cases in 1983/4 demonstrated the connection between that disease and injection drug use. As a result, she agreed that it is unlikely that the prevalence of Hepatitis C infection amongst injection drug users was, if anything, higher prior to 1987 than shown in her report covering the period 1992 to 2004. It would not likely have been lower.

20. The second difference between Hepatitis B and C that Dr. Millson referred to was this: while sexual contact, not needle sharing, is the most common mode of transmission of Hepatitis B, sexual contact is not the most common mode of transmission of Hepatitis C. In fact, sexual transmission of Hepatitis C, if it happens at all, is extremely rare. In other words, the fact that an injection drug user has Hepatitis B may be explained by sexual contact, not by needle sharing. As a result, Dr. Millson thought that even if an injection drug user is ultimately found to have both Hepatitis B and Hepatitis C antibodies, that fact should only be regarded as raising "slightly" the chance that he/she acquired Hepatitis C from needle sharing.

21. Finally, Dr. Millson did not agree that an injection drug user necessarily takes the same attitude towards issues of safe sex as towards issues of safe drug use. She stated that studies in the HIV/AIDS field show no clear correlation between the two; that is, the same individual might engage in unsafe sex but still have safe drug habits. On the other hand, there was, she believed, a correlation between unsafe drug habits and lack of access to safe equipment and secure locations. She stated that supervised injection sites are intended to provide that access to users who might not otherwise have it, particularly homeless and marginalized users.

22. The Claimant also presented expert evidence from **Dr. Kumar Gupta**. He also provided both his Curriculum Vitae[13] and a shorter version.[14] I set out the shortened version below, supplemented with relevant information obtained form the longer version, as indicated in square brackets.

> [MD obtained 1994 University of Manitoba, Addiction Medicine Clinical Fellowship 1997-1998, Centre for Addiction and Mental Health] I have been practising medicine for 10 years with specialty in Addiction Medicine. [Full time Clinical Activity in Addiction Medicine/Methadone Maintenance]. I am board certified in Addiction Medicine [2000] and chair of the Methadone Committee at the College of Physicians and Surgeons. A majority of my patients have Hep C and I treat and monitor them. [I am a member of the Canadian Society of Addiction Medicine] I am also a Coroner and work the Chief Coroner's Office.

I would summarize Dr. Gupta's most significant evidence and opinions as follows.

23. He has about 200 patients who are injection drug users. In this patient population, there is a close correlation between needle sharing and Hepatitis C status. Those who are Hepatitis C positive, about half, have shared needles and will even claim to know the particular incidents of needle sharing that caused their Hepatitis C infections. The other half, those who are Hepatitis C negative, have not shared needles. Which half a particular patient falls into depends largely on his/her socio-economic status: needle sharing is not something done by users with the resources to buy clean needles; it is something done homeless, poor, street users who are desperate for a fix.

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13 Exhibit 8.
14 Exhibit 6.

24. On cross-examination, Dr. Gupta was asked whether he could estimate the risk of Hepatitis C infection through the sharing of infected needles by injection drug users. He answered that he was not aware of any way to quantify that risk but that he was familiar with the 1% estimate mentioned by Dr. Millson and that it sounded right. It was then pointed out to him that this estimate would be contrary to his own evidence that his Hepatitis C positive patients claim to know the *particular* incidents of needle sharing that caused their Hepatitis C infections, something they could not do if the risk was only 1%. Dr. Gupta responded that he was only testifying about his patients' beliefs, as reported to him in a clinical setting. He stated that in addition to the other known risks of exposure, in particular, tattoos and blood transfusions, the cause of Hepatitis C remains unknown in 20% of the infected population. Still, he acknowledged that it is "axiomatic" that the risk of transmission through needle sharing is high because infection can result from a single incident of needle sharing.

25. Dr. Gupta testified that his patients were not reluctant to tell him about their behaviour, "they tell me anything", and that he believed that they were honest with him. He stated he had never heard of any cases of IV drug users combining sex with IV drugs though there might be "rare instances" of this behaviour. He noted that the opiates drugs, like heroin, reduce libido in both men and women and can produce impotence in men. As a result, users of these drugs often stop having sex. Dr. Gupta also did not agree that unprotected sexual relations could be analogized or equated with a willingness to share needles.

26. Dr. Gupta testified that while track marks are commonly observed on the arms of injection drug users, such marks can heal and disappear.

Expert Evidence presented by the Administrator

27. Paragraph 8(b) of the CAP required the Administrator to "obtain the opinion of a medical specialist experienced in treating and diagnosing HCV as to whether the

HCV infection and the disease history of HCV Infected Person is more consistent with infection at the time of ... the Class Period transfusion(s) or ... the non-prescription intravenous drug use as indicated by the totality of the medical evidence." The medical specialist from whom the Administrator obtained an opinion was **Dr. Gary E. Garber**.

28. A letter stating Dr. Garber's opinion was included in the materials forwarded to me and the parties prior to the hearing.[15] At the hearing, Dr. Garber also provided a copy of his Curriculum Vitae, 37-pages in length, single-spaced.[16] No shortened version was provided but most of the following information was elicited from Dr. Garber through questions by the Administrator's counsel. Dr. Garber obtained his MD in Calgary in 1980. He became a specialist in Internal Medicine in 1984 in Toronto and pursued a fellowship in the Division of Infectious Diseases at the Vancouver General Hospital between 1983 and 1986. From 1986 to 1990, he was Assistant Professor of Medicine with a cross appointment to the Department of Microbiology & Immunology at the University of Ottawa. In 1990, he became the Head of the Division of Infectious Diseases in the Department of Medicine at the University of Ottawa. In 1985, he received a Certificate of Special Competence in Infectious Diseases, issued by the Royal College of Physicians of Canada. In 1998, he became a Fellow of the Infectious Disease Society of America. Since 2004, he has been a member of the Provincial Infectious Diseases Advisory Committee created by the Ontario Ministry of Health and Long-Term Care. Dr. Garber stated that he has more than twenty years experience working with over 1600 Hepatitis C patients - or what were formerly referred to as Hepatitis non-A, non-B patients. He also stated that he had direct treatment experience with approximately 1,000 Hepatitis C patients at the Ottawa Hospital Viral Hepatitis Program.

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15 Exhibit 1, pp. 286-7.
16 Exhibit 10.

29. Dr. Garber provided a written opinion to the Administrator by letter dated November 20, 2006. The most significant part of this letter reads as follows:

> The key question is where did this individual acquire hepatitis C infection[?] On the one hand, we have one unit of transfused blood that cannot be traced. On the other hand, it is well documented extensive drug injection drug use intermittently and over a prolonged period of time. The evidence of prior natural infection to hepatitis B does also indicate at risk behaviour for transmission of blood and body fluids whether this was from injection drug use or sexual transmission cannot be determined definitively.
>
> ... Although one cannot dismiss categorically the small but real risk from a single unit of blood that cannot be traced, it is far more likely that injection drug use over a prolonged period of time would enable multiple potential exposure points whether through needle sharing or contamination of supplies. That risk would also be validated with evidence of other exposure to blood borne pathogens (hepatitis B).
>
> In summary, on the balance of probability it is more likely that this individual was exposed to hepatitis C through injection drug use than through a single untraceable unit of blood. Based on the information I have seen, I am unable to pinpoint with any accuracy when the infection likely occurred.

30. Dr. Garber's additional oral evidence and opinions can be summarized as follows.

31. He explained further why there was nothing in the Claimant's HCV disease history that permitted him to draw a conclusion about when the infection occurred. His letter had described the Claimant's HCV disease history as follows:

> In 1992 screening for hepatitis showed that she had antibodies to hepatitis C and had significant jump in her liver function tests in 1993 when the SGOT climbed to 328. Subsequently she was seen by a Viral Hepatitis Clinic [in 1993] in Toronto and repeat liver function tests at the time had normalized and there had been some waxing and waning of these liver functions tests with slight elevation determined on a number of occasions in the mid-90s. More recently in 2003-2004 her liver function have remained normal and testing for hepatitis C has shown she has genotype 1 with low viral load at $9x10^3$. She then underwent a liver biopsy which has actually shown minimal damage with grade 0-1 fibrosis and grade 2 inflammation.

32. Dr. Garber stated that a jump in the Claimant's SGOT might indicate a possible point of infection within the previous six months and that such a jump was observed in 1993. He also noted that there was no evidence of such a jump taking place within six months of the Claimant's 1987 blood transfusion. He was nevertheless not prepared to draw any conclusion from this evidence, or lack of evidence, about the point of infection. He explained that this is because an undefined percentage of patients develop no noticeable symptoms within six months of exposure to Hepatitis C and, therefore, provide their doctors with no reason to investigate their Hepatitis C status at that time. In this regard, I note that the Claimant's case demonstrates how such a SGOT jump might come and go without the patient's Hepatitis C status ever being investigated. In a letter to the Claimant's family doctor in 1993,[17] the doctor at the Clinic for Viral Hepatitis in Toronto observed:

> Just a follow up note on this 31 year old lady who was incidentally found to be Hepatitis C+ve and had an abnormal AST [SGOT] of 328 [that is, she was not tested due to symptomology]. As I mentioned in my last letter, [the Claimant] was perfectly asymptomatic at the time I saw her [on July

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17 Exhibit 1, p. 197.

16, 1993] and indeed liver function tests done on that day were perfectly normal apart from a slightly elevated total bilirubin of 27 umol/L. This most likely represents Gilbert's disease. It is certain that [the Claimant] had a flare of her Hepatitis C at the time you saw her and she has recovered from this. [The Claimant] feels perfectly well at the moment and wanted to withdraw from the Hepatitis Clinic. I explained to her that Hepatitis C is a chronic disease and she needs follow up. ...

33. Dr. Garber also explained why the fact that the Claimant has remained asymptomatic does not assist in determining her time of infection. Not all patients who have been exposed to Hepatitis C, and test positive for the antibody, go on to develop Hepatitis C and, for those that do, it normally takes 15 years for the symptoms to appear. The Claimant's being asymptomatic would, therefore, be consistent with her having been infected after her blood transfusion and the infection simply having not yet had enough time to progress into Hepatitis C. But it would also be consistent with her having been infected at any time, before, during or after her blood transfusion, and her infection never developing into Hepatitis C.

34. On the other hand, Dr. Garber thought that Dr. Millson over-estimated the risk of infection through the transfusion of a single unit of blood during the Class Period. In his view, the risk was not 1 over 400, or .25%, but rather 1 over 1000, or .01%. He also reiterated that whereas we know that the Claimant was only exposed to this risk on one occasion, she may have been exposed to the risks of sharing Hepatitis C infected needles or water on many occasions. He stated that the greater the number of times a person uses IV drugs, the greater the chances for breaches or compromises in the precautions taken. He also stated that drug addiction and related illnesses can affect memory and that he has spoken to some IV drug users who could not even recall where or when they injected. He also suggested that some IV drug users might deny sharing needles in the past because

they now know "the rules of the game". Nevertheless, he acknowledged that some IV drug users do use alone.

35. Dr. Garber also disagreed with Dr. Millson's estimate that the risk of infection from a single sharing of a Hepatitis C infected needle or water was only 1%. He maintained that such an estimate could not be reliably based on Hepatitis C infected needle stick injuries. The difference between the two was, he stated, that while IV drug users intend to introduce substances into their veins, victims of accidental needle stick injuries do not. He acknowledged that trial studies could never be conducted to better ascertain the risks of sharing needles or water but stated that, in his view, the risk of infection from the sharing of Hepatitis C infected needles or water was extremely high. Moreover, he testified that whereas the risks of needle sharing were better known after 1984, due to the HIV/AIDS scare, the risks of sharing water while taking IV drugs was not widely known until the last ten years.

36. The Administrator's counsel drew Dr. Garber's to the fact that when the Claimant was admitted to hospital in July 1987 as a result of her motor vehicle accident, one of the doctors stated in a report: "She is a prostitute."[18] This was the only time in any of the oral evidence that this issue was addressed but I note that there was other documentary evidence suggesting that the Claimant may have worked as a prostitute.[19] The Claimant was given this documentary evidence before the hearing but made no attempt to deny its accuracy in her own evidence and did not give any evidence in reply to Dr. Garber's evidence. In Dr. Garber's view, an IV drug user who sells sex for money in order to buy drugs is less likely to exercise caution in the use of IV drugs.

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[18] Exhibit 1, p. 263 but also found in Exhibit 2, p. 58. Exhibit 2 is the set of documents the Administrator supplied to Dr. Garber. It does not contain all the documents contained in Exhibit 1. In particular, Exhibit 2 does not contain the summary provided to Dr. Garber, his letter in response or the Administrator's subsequent analysis of the claim. Those documents are only found in Exhibit 1. Exhibit 1 and 2 also have different pagination.

[19] There are references in the family doctor's 1992 notes to the Claimant's temptation to "turn tricks", either for money or as part of "acting out". Exhibit 1, pp. 159-161.

Other witnesses

37. Two other persons testified at the hearing on behalf of the Claimant: **Ms. Lori Naylor** and **Mr. Raffi Balian**. Both testified about their work with IV drugs users and their knowledge of the behaviour of IV drug users. However, since neither was able to testify about the Claimant's behaviour while she was an IV drug user, their evidence was of little assistance to me.

38. **Ms. Carol Miller**, a registered nurse and the Administrator's Appeal Coordinator, testified about the process used to reach the decision to deny the claim. She stated that the four-member "IDU Committee" used a chart that identifies the seven factors outlined under paragraph 12 of the CPA - those that would support the Claimant's entitlement - and the seven factors outlined under paragraph 13 of the CPA - those that would not support the Claimant's entitlement. The chart was entered into evidence.[20] Like paragraphs 12 and 13 of the CPA, the chart states: "... none of these factors may prove conclusive in any individual case because the Administrator must consider the totality of the evidence ..." Ms. Miller testified that the IDU Committee found that none of the first set of seven factors would support the claim and three of the second set of seven factors would not support the claim. Accordingly, Ms. Miller stated, the IDU Committee decided to reject the claim.

39. During the course of Ms. Miller's evidence, questions arose about the process used to try to locate the donor of the untraceable unit of blood received by the Claimant in July 1987. The parties agreed to adjourn the hearing so that I could order the Administrator "to request that Canadian Blood Services include in the Traceback Summary information relating to the steps taken by the Tracing Agency in locating the last donor [of the untraceable unit of blood], and whether there are further additional steps that can be taken by Canadian Blood Services to

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20 Exhibit 1, p. 288.

locate the unidentified donor." In a letter to Ms. Miller dated June 17, 2008,[21] Canadian Blood Services responded that the unit of blood in question was:

> ... subjected to our in-house Standard Operating Procedures which has a process outlined for donor identification. The process included an attempt to make a telephone call to the donor using the donor telephone number on file with CBS, but the phone number was "out of service". The donor information was then sent to the TRAX tracing agency on 2004-10-22. On 2004-11-30, they reported that they were unable to locate the donor.

The letter from CBS went on as follows:

> CBS has recently contacted the TRAX company and verified that they are unable to disclose the methods they employ in locating persons for CBS. There is a legal and binding contract of disclosure, plus detailed scripting for their specific use for CBS, when contacting people. The tracing agency agrees to abide by all legislation and laws when acting on CBS' behalf. All information gathered remains confidential. The only information that is provided to the tracing agency is the case number, person's name(s), date of birth, last known address and, possibly, telephone number. TRAX reports back within 30 days with a "not located" or information of a (new) name, current address and telephone number. If the information is verified by the CBS as correct, then CBS pays the fee agreed upon for the service. If the information is NOT correct and CBS that this is NOT the person they are looking for, the CBS informs the tracing agency and the fee is retracted.
>
> It is clearly documented that all steps were taken, following CBS' Standard Operating Procedures, to attempt to locate the donor in this case. No further action can be or will be taken.

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21 Exhibit 10.

Analysis of the Committee's decision

40. As Ms. Miller testified, the IDU Committee applied the CAP through a chart that replicated the language of paragraphs 12 and 13. In my view, the Committee's reliance on that chart was problematic for several reasons. First the chart only permitted a "yes", "no" or "not applicable" response for each factor. This generally had the effect of assigning uniform weight to all the factors though, as we shall see, it sometimes led to the doubling of the weight assigned to single factors. Second, it focused attention on the language of, and the evidence under, paragraphs 12 and 13, rather than on the language of the CAP read as a whole and the obligation it imposes to "weigh the totality of the evidence". Third, it ignored an important limitation on the Claimant's to obtain evidence in support of her claim.

41. The limitation on the Claimant's ability to obtain evidence in support of her claim relates to the first factor identified in paragraph 12(a) of the CAP: "identification of a Class Period Blood transfusion from an HCV antibody positive donor". The Claimant had to prove that she was infected for *the first time* by her blood transfusion. She could not succeed merely by proving that her transfusion included blood received from an HCV antibody positive donor. That would not establish that she was first infected by the transfusion. Nevertheless, had she been able to prove that her transfusion included blood received from an HCV antibody positive donor, the balance of her burden of proof would have definitely been lighter. She could have then argued that she would have ultimately been infected by her transfusion in any event and that she, therefore, only had to prove that her pre-transfusion use of IV drugs, or her other pre-transfusion risks, did not result in her first infection. She was not able to lighten her burden of proof in this way because she had no ability to either obtain evidence or to challenge evidence in relation to the traceback. She had to rely on the Administrator, who, in turn, relied on the Canadian Blood Services (CBS) who, in turn, relied on the employees of

the TRAX tracing agency who, in turn, were apparently not obliged "to disclose the methods they employ in locating persons for the CBS". CBS was satisfied that "all steps were taken" and perhaps they were, but, in my view, it is significant that the Claimant had no ability to either discharge her onus of proof in relation to this factor or to verify or challenge the investigation that led to an inconclusive traceback. That does not, of course, change the fact that no HCV antibody positive donor was found; nor does it render that fact irrelevant. It does, in my view, reduce the weight that should be assigned to this factor. Under the chart, this factor was given the same weight as the other six factors enumerated in paragraph 12.

42. The first factor mentioned in paragraph 13(a) of the CAP also relates to the traceback: "failure to identify a Class Period Blood transfusion from an HCV antibody positive donor". The Committee noted here, as it had under paragraph 12(a), that "no positive donor found". Applying the chart, this factor was then treated as a factor that would not to support the claim. This resulted in a doubling of the weight assigned to the negative factor that no positive donor was found, under both paragraph 12(a) and again under paragraph 13(a). In fact, this should have been treated as a neutral factor under paragraph 13(a). That is because, in this case, the reason why there was a "failure to identify a Class Period Blood transfusion from an HCV antibody positive donor" was that one of the units transfused to the Claimant could not be traced back.[22] That was, by itself, a neutral, not a negative, factor.

43. Paragraph 12(b) of the CAP indicates that it would have been a factor in the Claimant's favour if she had been under the age of 18 at the time of the transfusion. Since she was 26 years old at the time of the transfusion, she did not

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22 Of course, another reason why there might be a "failure to identify a Class Period Blood transfusion from an HCV antibody positive donor" would be that all the tracebacks were negative. However, paragraph 6 of the CAP states that the CAP does not apply "If the result of a traceback investigation is such that the Traceback CAP requires the Administrator to reject the claim of the HCV Infected Person". If the tracebacks were all negative, section 3.04 of the Plan required the Administrator to reject the claim without any further investigation.

benefit from this factor. Applying the chart, the Committee regarded this as a negative factor and assigned it the same weight as the other six factors mentioned in paragraph 12. This factor is obviously aimed at protecting minors and cannot be assigned zero weight. However, it did not require the Committee, and it does not require me, to assign this factor any specific weight when assessing the eligibility of persons 18 years of age or older.

44. The factors identified in paragraphs 12(c) and 12(e) of the CAP both relate to the period of IV drug use. Paragraph 12(c) stipulates that it would have been a factor in the Claimant's favour if "reliable evidence establishes that the non-prescription intravenous drug use took place after July 1, 1990". Likewise, paragraph 12(e) stipulates that it would have been a factor in the Claimant's favour if there was "reasonably reliable evidence that the non -prescription intravenous drug use history is subsequent to ... the Class Period transfusion(s) ..." Since the Claimant started her use of IV drugs many years before both her blood transfusion in 1987 and July 1, 1990, she did not benefit from either of these factors. But these factors are only significant in cases in which it is possible to determine from the disease history that the infection probably took place prior to or during the Class Period, 1986 to 1990, thus pointing away from the IV drug use as the likely cause of first infection. When, as in the Claimant's case, the infection may have taken place before or after 1990, the *period* of drug use is, by itself, of no assistance in determining the likely cause of first infection. Under the chart, these factors were nevertheless given the same weight as the other five factors enumerated in paragraph 12.

45. Paragraphs 12(d) and 13(b) of the CAP both specifically address the factor of disease history. In this case, the disease history was as consistent with the Claimant having been infected by her 1987 blood transfusion and as it was with her having been infected by her IV drug use. It was, therefore, a neutral factor. Applying the chart, the Committee recognized the neutrality of this factor by answering "no" to the factor identified in paragraph 12(d) and "yes" to the factor

identified in paragraph 13(b), noting in both cases Dr. Garber's inability to identify the time of the infection. These self-cancelling answers produced the correct result but demonstrate the Committee's focus on the factors enumerated under paragraphs 12 and 13 and its determination to apply the chart.

46. The factors identified in paragraphs 12(f) and 13(c) of the CAP both relate to the number of occasions IV drug use took place and to whether non-sterile or shared equipment was used. Paragraph 12(f) states that the factor can only be regarded as positive if there is "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." (my emphasis) Likewise, 13(c) states the factor can only be regarded as negative if 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 or shared equipment". In other words, read in isolation, these two paragraphs appear to state that if it is established that the claimant used IV drugs on more than one occasion, it is immaterial that he/she also claims or presents evidence that, on each occasion, he/she used sterile equipment that was not shared. That appears to be how the Committee understood these paragraphs. It duly noted in both parts of the chart that the Claimant "states never shared" but made no attempt to weigh or assess the reliability of this assertion. Instead, it concluded that both factors should be regarded as negative, apparently solely because of the multiple occasions the Claimant used IV drugs.

47. I cannot agree that no weight can be assigned to a claimant's testimony that he/she never shared needles or drugs merely because he/she admitted using IV drugs on many occasions. In my view, this restricted reading of paragraphs 12(f) and 13(c) conflicts with paragraph 9 of the CAP which states that the "Administrator shall weigh the totality of evidence". That requirement is then repeated at the beginning of paragraphs 12 and 13 of the CAP, together with a statement that "none of these factors [as listed in those paragraphs] may prove

conclusive in any individual case".[23] Furthermore, paragraph 11(d) of the CAP allows a claimant to produce affidavit evidence dealing with any of the following issues: "whether the drug paraphernalia used was sterile; whether the HCV Infected Person shared needles; the best estimate of the number occasions and time period during which the HCV Infected Person used non-prescription intravenous drugs". I acknowledge that paragraph 11(d) appears to require that such affidavit evidence come from both the claimant "*and* a person who know the HCV Infected Person at the time he/she used non-prescription intravenous drugs" (my emphasis). However, in view of the CAP's clear direction to weigh the totality of the evidence, I am satisfied that the Committee was, and I am also, entitled to consider the Claimant's evidence that she never shared needles or drugs even though she used IV drugs on many occasions and even though her evidence is not supported by the evidence of other persons who knew her at the various times she used IV drugs.

48. Paragraphs 12(g) and 13(d) of the CAP both address the issue of exposure to Hepatitis B prior to her blood transfusion. Since the Claimant had been exposed to Hepatitis B prior to her blood transfusion, this was another negative factor in her case. But by providing negative answers under both parts of its chart, the Committee once again doubled the weight of what was really only one negative factor. In my view, paragraphs 12(g) and 13(d) required the Committee, and require me, to assign some weight to the Claimant's exposure to Hepatitis B prior to her blood transfusion. However, they did not require the Committee, and they do not require me, to assign any specific weight to this factor.

49. Paragraph 13(e) of the CAP raises the issue of whether the Claimant refused "to permit the Administrator to interview any person the Administrator believes may have knowledge about the non-prescription intravenous drug use or disease history of the HCV Infected Person". There was no evidence that the Claimant

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[23] This language is also set out in the chart used by the IDU Committee but, as already explained, it would not appear that in applying paragraphs 12(f) and 13(c) of the CAP, the Committee considered anything other than the fact that the Claimant used IV drugs on many occasions.

ever refused to permit such enquires. The Committee nevertheless chose the "N/A", not applicable, response in completing its chart. The accurate response would have been "no", there had never been such a refusal. Since the Committee regarded "no" answers to factors identified under paragraph 12 as negative factors, it might have then regarded a "no" response to a factor identified under paragraph 13 as a positive factor. The "N/A" response did not allow this approach. Nor did it allow the Committee to consider this factor in assessing the Claimant's credibility though, again, there is no indication that the Committee made any attempt to assess the Claimant's credibility.

50. Paragraph 13(e) deals with the information that might be obtained from the testing of a claimant's blood *donations*. The Committee noted that the Claimant in the case was "never a blood" donor and answered "N/A", not applicable, in response to this factor.

51. Paragraph 13(g) asks whether there is information which "is in any *other way* consistent with infection with HCV by non-prescription intravenous drug use *prior to* ... the Class Period Blood transfusion(s)" (my emphasis). The Committee answered "no" to this factor, noting only that the Claimant had a positive Hepatitis B prior to her blood transfusion, a factor which had already been taken into consideration under paragraphs 12(g) and 13(d). In fact, the opinion the Committee had obtained from Dr. Garber would have allowed it to answer "yes" to this question. He had said: "Although one cannot dismiss categorically the small but real risk from a single unit of blood that cannot be traced, it is far more likely that injection drug use over a prolonged period of time would enable multiple potential exposure points whether through needle sharing or contamination of supplies." This statement did more than repeat the Claimant's history of IV drug use, a factor already considered by the Committee. It also expressed an opinion about comparative risk which pointed towards IV drug use, not the blood tranfusion, as the likely cause of first infection.

My Analysis and Conclusion

52. I find that the Committee failed to assess two significant factors in deciding this claim: the comparative risk of infection from IV drug use versus a blood transfusion and the Claimant's credibility. To be fair, neither of these factors is specifically referred in the CAP. Moreover, I received more evidence about comparative risk than the Committee and I also had the opportunity to assess the Claimant's credibility through the hearing process. Nonetheless, the evidence with respect to these two factors has become part of "the totality of the evidence" before me and, in my view, must be assessed in order to properly apply the CAP.

53. Dealing first with comparative risk, the evidence of both Dr. Millson and Dr. Garber suggested that from a statistical point of view, the risk of infection through a single sharing of a needle or water by IV drug users was greater than the risk of infection through a transfusion of a single unit of blood during the Class Period. Dr. Garber estimated a lower level of risk through blood transfusion, one in a thousand, than did Dr. Millson, who estimated that risk to be one in 400. I note, however, that Dr. Garber testified in another case that this risk was somewhere between one in a thousand and one in a hundred[24]. This would put his estimate closer to Dr. Millson's. Still, based on the evidence before me, the statistical risk of infection through a single sharing of a needle or water by IV drug users appeared to be at least double the risk of infection through a transfusion of a single unit of blood during the Class Period.

54. And yet, as noted by the Court at paragraph 37 of its decision in *Parsons v. Canadian Red Cross Society* 51 O.R. (3d) 261: it would be "fundamentally unfair to exclude an individual on the basis of a group statistic without regard to the individual attributes or circumstances." In this case, it would be unfair to exclude the Claimant on the basis of a statistical estimate that assumed that she shared needles or water with other IV drug users without considering her evidence that

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24 see paragraph 16, page 11 of Decision 13602, released November 28, 2007.

she never shared needles or drugs. In short, as I see it, this claim cannot be decided without assessing the Claimant's credibility. That assessment must consider both the possibility, or the probability, that she was prepared to give false evidence and the possibility, or the probability, that her evidence was inaccurate, regardless of whether she believed it to be true.

55. The Administrator's counsel submitted that the Claimant's credibility had to be assessed in light of the following evidence:

a) the numerous inconsistencies in her statements and evidence regarding the periods of use of IV drugs.
b) her probable ignorance of the risks of sharing needles or water when she started to use IV drugs in 1977 due to both her own youth at the time and to the fact the HIV/AIDS scare had not yet happened, bringing with it greater awareness of those risks.
c) her willingness to engage in unprotected sex during contemporaneous periods, demonstrating a lack of caution to protect herself from infectious diseases.
d) the evidence that she sometimes combined sex and drugs, thus establishing that she did not always prefer to be alone when using IV drugs.
e) the evidence that she worked as a prostitute and Dr. Garber's evidence that she was, at least during these periods, less likely to exercise caution in the use of IV drugs.
f) the fact that the Claimant was Hepatitis B positive prior to her blood transfusion.

56. As to sub-paragraph a), there were indeed numerous inconsistencies in the Claimant's statements and evidence regarding the periods of her IV drug use. However, I note that at the very beginning of the claims process, before any medical documents had been obtained, the Claimant admitted to both the

Administrator and to her doctor that she had used IV drugs on many occasions before her blood transfusion in 1987. She later made further, though sometimes conflicting, admissions about when she used IV drugs. This was not the behaviour of claimant who was attempting to conceal her IV drug history. In my view, the fact that she gave conflicting evidence about *when* she used IV drugs does not establish that she gave false or inaccurate evidence about *how* she used IV drugs. I accept that she could have been mistaken about the periods, which were multiple, but honest and accurate about what she described as her universal practice: she *never* shared needles or drugs.

57. There was also evidence to support each of sub-paragraphs b), c), d) and e). But even if the Claimant was ignorant of the risks of sharing needles or water, I accept that she may have *generally* preferred to use IV drugs alone, to be a "closet user", and have *never* been prepared to share them with sexual partners due to the cost of obtaining them. In my view, there was nothing inherently implausible in the Claimant's evidence in these regards. On the contrary, her evidence struck me as plausible given that she initially started using IV drugs in her mother's home and that she may have, during certain periods, paid for her drugs by working as a prostitute. On the other hand, if the Claimant was aware of the risks of sharing needles and water, I accept the evidence of Dr. Millson and Dr. Gupta that there is no necessary connection between an IV drug user's willingness to take risks in sexual matters and her willingness to take risks in using IV drugs.

58. As to sub-paragraph f), the fact that the Claimant was Hepatitis B positive prior to her blood transfusion, I acknowledge, as the CAP requires, that this fact increases the *possibility* that the Claimant contracted both Hepatitis B and C prior to her blood transfusion through IV drug use. However, whereas there is no other evidence to establish this, there is evidence, given by Dr. Millson, that sexual contact, not needle sharing, is the most common mode of transmission of Hepatitis B. I, therefore, assign little weight to this factor.

59. I also assign little weight to the fact that the Claimant was not under the age of 18 at the time of her blood transfusion. This factor may assist claimants under the age of 18 but it should not, in my view, serve to undermine claims by persons 18 years of age and older.

60. I find three reasons to assess the Claimant's credibility in her favour:

a) from the outset of her claim, she admitted to significant, pre-transfusion IV drug use.
b) she never refused to permit the Administrator to obtain documents or to interview any person who might have knowledge about her IV drug use.
a) near the very end of the hearing, she consented to my order requiring the Administrator to ask CBS to advise whether further steps could be taken to locate the donor of the "untraceable" unit of blood she received in 1987; before making this consent order, I carefully explained to the Claimant that she ran the risk that the donor would be found, that his/her blood would test negative for the HCV antibody and that her claim would then have to be rejected; she nevertheless agreed without hesitation.

61. The Claimant bore the onus of proving, on the balance of probabilities, that she was first infected with HCV by her blood transfusion in July 1987. I find that the Claimant discharged that onus by establishing, on the balance of probabilities, that while she used IV drugs, she never shared needles or IV drugs. She did not specifically testify that she never shared water but I am satisfied that she would have had no reason to do so unless she shared IV drugs. For these reasons, I reverse the Administrator's decision and allow the claim.

David Leitch, Referee

August 18, 2008
Date