Claim No. 5

DECISION

A. Introduction

[1] The Claimant, a Manitoba resident and 49 years of age, applied for compensation as a Primarily-Infected Person pursuant to the Hemophiliac HCV Plan ("the Plan"), which is Schedule B to the 1986-1990 Hepatitis C Settlement Agreement ("the Settlement Agreement").

[2] Pursuant to the terms of the Settlement Agreement and the Plan, the "Class Period" (January 1 1986 to and including July 1, 1990) is the only period of time in respect of which compensation may be available. Further, while there are many possible sources of infection with respect to the Hepatitis C Virus ("HCV"), the Plan only provides compensation for individuals who received transfusions during the Class period of defined blood products, generally, but with an exception, where the donors have been tested and found to be infected with the HCV.

[3] However, by letter dated October 16, 2003,[1] the Administrator denied the claim, having carefully reviewed the material provided in support of the claim, for the following reasons:

> … You have not provided sufficient evidence to support your claim that you received blood during the Class Period.
>
> In your original application you indicated you were having difficulty retrieving documents to support receipt of a blood product between January 1, 1986 and July 1, 1990. You stated you received transfusion of cryoprecipitate at the Health Sciences Centre in 1989. In claims such as yours where the claimant is having difficulty obtaining evidence of a transfusion, the Administrator contacts Canadian Blood Services to request contact (sic) the hospital directly to see if they can verify if you received a blood product. The results of this investigation were received June 25, 2003 and the hospital confirmed they have evidence of you receiving blood products from 1973 to 1982, however, there is no evidence to support you received blood after that date. Therefore, you do not meet the Criteria for compensation, based on Article 3.01(1a) of the … Settlement Agreement, because there is no medical evidence to support you had a transfusion of "blood" between January 1, 1986 and July 1, 1990.

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[1] The initial Claims Centre File, consisting of 88 pages, was entered as Exhibit 1 at the hearing. The October 16, 2003 letter is found at pages 45 and 26.

[4] The Claimant maintains that a received units of Cryoprecipitate ("Cryo"), which is included in the definition of "blood" found in the Plan text, from the Health Sciences Centre (HSC) in Winnipeg in August, 1989. While there are health records that document his attendances at this facility on both July 19 and August 17, 1989, he maintains that there was a third attendance, on or about August 3, 1989, on which he received Cryo, but which was not documented either in the hospital health record or the Blood Bank records. Canadian Blood Services (CBS) Traceback reports[2] state that hospital records show numerous transfusions from 1973-1982 but no blood products having been administered during the Class Period. With the reasons supporting his Request for Review, the Claimant stated "the record of my treatment with Cryo in 1989 has been misfiled, lost, destroyed or never documented when I was treated…" The hearing was delayed many times while the Claimant continued his search for further documents. Once the hearing was scheduled, it was adjourned once at the request of Fund Counsel. Prior to the hearing, in several teleconferences, it became evident that the Claimant was continuing to experience difficulty accessing his health records. In order to address the Claimant's concerns in that regard to the extent possible, I wrote to the HSC on March 22, 2005, enclosing a Summons prepared with the assistance of Fund Counsel, compelling the production of "the complete medical records of [Claimant] for the entire year of 1989". A reply was received, dated April 22, 2005, including Emergency Room (E.R.) records for the Claimant's attendances on July 24, 1989 (which had been supplied previously) and August 17, 1989[3] (for the first time).

[5] Fund Counsel's written submissions, dated April 27, 2005, set out the position of the Administrator. Counsel relies on Section 3.01 (1) (a) of the Plan text:

> **ARTICLE THREE**
> **REQUIRED PROOF FOR COMPENSATION**
> **3.01 Claim by Primarily-Infected Hemophiliac**
>
> (1) A person claiming to be a Primarily Infected Hemophiliac must deliver to the Administrator…
>
> (a) medical, clinical, laboratory, hospital, The Canadian Red Cross Society, Canadian Blood Services or Hema-Quebec records demonstrating that (i) the claimant has or had a congenital clotting factor defect or deficiency and (ii) the claimant received or took Blood during the Class Period:

[6] Fund Counsel acknowledges that the Claimant has met the requirements of s. 3.01 (1) (a) (i) but takes the position that the Claimant has failed to establish that he "received or took Blood during the Class Period", as required by 3.01 (1) (a) (ii).

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[2] Exhibit 1, pages 75 and 76, dated June 24, 2003 and Exhibit 2, dated March 24, 2005.
[3] This letter from the HSC and attached records were entered collectively into evidence as Exhibit 3.

[7] Both parties agree that the case turns on the issue of whether or not the Claimant has met the "notwithstanding" provisions of Section 3.01:

> 3.01 (2) Notwithstanding the provisions of Section 3.01 (1) (a), if a claimant cannot comply with the provisions of Section 3.01(1)(a) (i) or (ii), the claimant must deliver to the Administrator corroborating evidence independent of the personal recollection of the claimant or any person who is a Family Member of the claimant establishing on a balance of probabilities that he or she has or had a congenital clotting factor defect or deficiency[4] and received or took Blood during the Class Period.

B. Facts, Summary of Evidence

[8] An "in-person" hearing was held in Manitoba on May 31, 2005. The Claimant testified on his own behalf, as did his sister. Three other individuals testified for the Claimant by speakerphone. Carol Miller, Appeals Coordinator of the Hepatitis C January 1, 1986 - July 1, 1990 Claims Centre (the "Claims Centre"), testified on behalf of the Administrator.

[9] The matter will be adjudicated upon based on the written materials and testimony tendered by the parties, together with one document obtained post-hearing, about which more will be said shortly.

(a) Documentary Evidence

[10] The following documentary evidence was tendered at the hearing:

Exhibit 1 - Initial Claims Centre File (pages 1 – 88)

Exhibit 2 - Letter from CBS to Traceback Coordinator, March 24, 2005, with attached Hospital Record Confirmation Form, stating, "Results of Search – Patient record available – not transfused between the years 1986-1990." It is noted that the entire patient medical record and Blood Bank records were searched and that the patient received numerous transfusions from 1973 -1982.

Exhibit 3 - Letter from the Medical Information Department of HSC to Ms. Bain dated April 22, 2005 (in response to letter and Summons supplied by Referee), with attached Emergency Documentation Forms and Emergency Triage Notes from the HSC for the Claimant for his attendances on July 24, 1989 and August 17, 1989. There is no reference to any transfusion or blood products in these notes.

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[4] The Administrator concedes that the Claimant has established this criterion.

Exhibit 4: Fax cover sheet from the Claimant to Ms. Bain dated May 10, 2005, attaching:

1. An e-mail from Betty Caron, Postgraduate Medical Education, University of Manitoba, dated September 30, 2004, stating:

> "…during the 1989-1990 academic year (July 1, 1989 - June 30, 1990) we had only two female residents (no male residents) enrolled in Hematology/Oncology. *There may have been others rotating through Hematology, however, we do not have that information*." [emphasis added]

2. A letter from Loret MacDonald, Director, Medical Information, HSC, dated March 10, 2005, stating:

> The undersigned has been asked to provide a letter to explain why some documentation of blood products given to the above named individual during the period 1987-1989 is not available.
>
> During that time, there were no standards on where to record the administration of blood products, and the information may or may not have been documented on a number of different forms.
>
> HSC patient records are microfilmed four years after information is collected but not all documents are filmed. Therefore it is possible that the notes regarding the administration of blood products were not filmed and the original documents have been destroyed….

3. Doctors' Progress Notes from the Oral Surgery Department of HSC including notes dated October 14, 1983 which state:

> "Cryo given pre-Op" for Oral and Maxillo Facial Surgery. The Claimant argues that this is significant because although the Traceback report shows that the Claimant received numerous transfusions between 1973 and 1982, it did not record the administration of Cryo in 1983. The Claimant submits this as another example of records of Cryo he had received from HSC not being recorded either in the Blood Bank Records or elsewhere in the hospital records. He points to this is another reason why the CBS traceback reports are not reliable in this case.

4. Admission/Separation Abstracts, HSC, for the Claimant from three different dates in 1979 and 1980; one shows the number of bags of Cryo administered to the Claimant on that occasion, together with the bag #s on each. The other two show the number of units of Cryo the Claimant received on those occasions, but do not record the unit #s. The Claimant produced these to show the lack of standard practices as the recording of the administration of Cryo at the HSC.

(b) V*iva voce* testimony

Administrator's Evidence

1. Carol Miller, RN

[11] Ms. Miller testified as to her broad background in most areas of hospital nursing as well as her experience with the Claims Centre since May 2000, including her current position as Appeals Coordinator. She is very familiar with practices of recording blood in Blood Bank, hospital and ER records throughout the period from the 1970s to the 1990s. Hospital records are kept specifically on each patient, including transfusion records. Although Cryo does not need to be cross-matched, signatures are required. If Cryo is given in an ER, it would be recorded in the ER records. If blood is stored in any Blood Bank, a blood products requisition is completed by any nurse or hospital employee. Blood Bank records are kept separately from the patient chart.

[12] In this case records[5] show that when he attended at ER at the HSC on July 24,1989, the Claimant received DDAVP, which is not a blood product but rather a drug that control bleeds by causing blood vessels to clamp down. At that time, he presented with a sore shin, evidently caused by playing baseball. The shin was becoming more painful when he walked. The ER form noted that the Claimant was a known responder to DDAVP. She also commented on the next available records, covering the Claimant's ER attendance on August 17, 1989, when he attended for calf muscle spasm and complaining of flu-like symptoms for which he had taken antibiotics. Ms. Miller testified that if Cryo had been administered, she would expect to see it on the instructions/orders on these forms which were completed when the Claimant attended ER on August 17, 1989. Further, if Cryo had been administered at any time during the three week interval between July 24, 1989 and August 17, 1989, normally that would have been indicated in the patient history notes on August 17, 1989. There was no reference to Cryo in the August 17, 1989 Emergency Documentation Form, although these notes do mention that the Claimant received DDAVP when he attended three weeks earlier. Further, the Emergency Triage notes record the bleed from three weeks earlier, and treatment with DDAVP, but say nothing about Cryo. Had Cryo being recently administered, she would have expected this important and recent history to be recorded in the triage nurse's notes, where the nurse normally records what the patient reports. Although other parts of the ER chart may have

[5] Exhibit 3

been based on health professionals' review of past records, triage records are normally based on what the patient told the nurse at that time. She also commented on the August 17, 1989 ER notes that reported flu-like symptoms for approximately 10 days. In her view, if a patient had received HCV-infected blood, most people would have jaundice within three months and a rise in liver function tests. Fever would not normally be an indicator of blood being infected with HCV. [In fairness to the Claimant, he indicated that he raised the issue of flu as a reference point for when he received the Cryo treatment, as he distinctly remembered the serious fever blisters he had on his lips at the time, not because he was in any way linking the flu to HCV]. In short, it was her view that the health records produced for the July and August 1989 attendances do no support the administration of Cryo. Further, the Blood Bank records contain no reference to Cryo either, which she would have expected to see had it been administered.

Claimant's witnesses: [witnesses testified out of order in order to accommodate their schedules]

(b) Claimant

[13] The Claimant's first Cryo treatment was in 1973. Some years he had no injuries and some years he would be treated up to four times a year. He estimates that it was an average of two or three times per year until the early 1980s, when DDAVP trials were done on all hemophiliacs. His DDAVP results were good. Therefore, from that point forward, DDAVP was the treatment of choice. He usually feels better with DDAVP, which has been very effective for him, in dealing with bleeds caused by such injuries as being hit with a hockey stick. Unless it was a life or death situation, DDAVP would be used first to treat all bleeds caused by injury, before blood products would be used. In those situations, the Claimant and other hemophiliacs did not always have to go to ER to get Cryo. Cryo treatments also tended to be surgery-related or due to spontaneous bleeds. He often went directly to the E2 Ward where a nurse or orderly could get Cryo and where Cryo could be administered. From his research, he has learned that before 1982 Blood Bank records were not available. Some were kept, some were destroyed, and in general a variety of things happened to them.

[14] The Claimant had a history of leg bleeds and shin splints. These were ongoing issues for him that he is very familiar with, as they were caused by jogging, running and floor hockey. In 1993, when he first learned that he had contracted HCV, the Claimant thought it was in 1987 that he received the Cryo, and this was the date he initially mistakenly reported to the Centre as the date of infection. He ultimately realized it was 1989 as he remembered the flu he was suffering from, the antibiotic that he took for this flu and house-sitting for his sister. The house-sitting over summer holidays occurred only once and the Claimant's sister told him that this occurred in 1989, not 1987 as he had first thought. The house-sitting occurred between July 26 and August 9,1989. This caused him to conclude that he received the Cryo on or about August 3, 1989.

[15] On July 24, 1989, when he attended at the HSC, the Claimant knew that he had shin splints which he recalled as having a couple of days before his sister went on

holidays. He received DDAVP that date and moved to his sister's home, which he was house-sitting. He put his leg up on ice in the evenings. Although he did not miss work, the problem did not go away and he remembers his skin getting hot. Because he was not getting better, on or about August 3, 1989, he returned to the HSC. He believes that this time, he did not go to ER but instead went directly to the E2 Ward. He did not see Nora Schwetz, the Bleeding Disorders Nurse Co-ordinator, but is clear that he saw a male physician who was a Hematology Resident. This physician looked at the Claimant's 1979 to 1980 chart on shin splints and told the Claimant that he needed to get the bleeding under control right away because: (a) the DDAVP was not working; (b) Cryo had been successful before; (c) this was a large muscle in the leg that was affected, that was therefore subject to more extensive bleeding; and (d) of the history of shin splints. He tried years later to find out the name of the Resident, but the Post-Graduate Office confirmed that they only kept records of Residents registered in Hematology. That office did not keep records of Residents who were rotating through Hematology as part of another residency.[6] The Claimant also checked with the Manitoba Medical Care Insurance Plan, which keeps records of physician services, but was advised that they did no keep records going back to 1989. In short, the Claimant was unable to produce the physician that ordered the Cryo in early August, 1989. The Claimant testified that he probably did not get the Cryo out of the freezer or thaw it on this occasion, although he had done so in the past in E2. In fact an entry in his August 24, 1980 HSC record that he produced[7] stated, "8 units Cryo given per self. In August 1989, someone else, likely the nurse that was helping patients with chemotherapy, removed Cryo from the freezer, likely 12-16 units, thawed and administered it. Many hemophiliacs are much more severe than is the Claimant, and would therefore self-inject, so they were not prepared to wait hours for injections and were therefore much more experienced than he was. The tags from the Cryo are supposed to be bagged and sent out of E2 to the Blood Bank. However, many times when he was getting Cryo he would see some tags in his in-box – others were not. As this was such a busy ward, often such matters simply did not get attended to.

[16] On the occasions when he did need Cryo, he often needed 8 units. E2 is a very busy ward, with children with hair loss and people getting IVs for chemo. He would not have had any of his own Cryo at that time because he had not use it for six years before then. This August, 1989 situation was the absolute last time he had Cryo as now they use Factor VIII recombinant blood products. He has had no blood products of any kind since 1989 and had none between 1983 and the first week of August 1989. He pointed out that in a November 21, 2000 memo from Lee Grabner (Co-ordinator, Blood Transfusion Service, HSC) to CBS,[8] the author listed the number of units of Cryo administered to the Claimant between July 1973 and May ***1982***. Further, she also reported that there were no records of transfusion of Cryo in July, 1987, the year that the Claimant had first reported, either in the health records or the Blood Bank records. The Claimant says it is significant that this memo fails to record the units of Cryo given to the Claimant with his oral surgery in ***1983***, which he says is supportive of the lack of reliability

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[6] Exhibit 4, attachment 1 (email from Betty Caron)
[7] Exhibit 4, attachment 4
[8] Exhibit 1, page 64

of both the HSC and Blood Bank records during this period insofar as the administration of Cryo was concerned. This is important because although he has proven that he received Cryo on that occasion in 1983, there is no record of it in ER, E2 or the Blood Bank. Moreover, the memo also states:

> Very few donors unit numbers were recorded in the medical record. Blood Bank records for the above time frames are unavailable.

[17] When he returned to the HCS on August 17,1989, the Claimant did not go to E2 because he knew he needed physiotherapy, which was not available, even if Nora Schwetz or the Resident recommended it. For that reason, he went to ER on August 17, 1989. He was asked by Ms. Bain whether some of the notes from that attendance came from a personal history and responded that often the health professionals did not fill in the chart during the interview. He doubts he even mentioned DDAVP from 3 weeks previous on August 17,1989, because there was no doubt in his mind that he did not have a bleed on August 17th. He therefore concludes that the notation regarding DDAVP was made as a result of a review of the recent chart, not as a result of anything he told the interviewer.

[18] In the early 1990s, the Claimant applied to increase his life insurance through work because he and his wife wanted to have a child. He was told to contact this physician for a blood test, which he did in 1991. In the early winter of 1993, just weeks before their first child was born, blood tests showed that he had tested positive for the HCV, which was known by his physician since 1991. However, the physician failed to communicate this to the Claimant until 1993. Fortunately, neither the Claimant's spouse nor either of his children are infected with the virus. The Claimant had intensive screening, for among other things risk factors (such as tattoos, i.v. drug use, body piercing, sexual practices), before it was determined that he was a suitable candidate for a one year regimen of early Interferon therapy, which has fortunately proved to have been effective. The Claimant is of the view that the HCV with which he was infected must only have been one strain as if there are multiple strains, it is very difficult to clear all of the virus. Hemophiliacs cannot safely have liver biopsies done because it is life-threatening to do so. Sadly, most hemophiliacs with HCV that the Claimant has known or is aware of are dead.

[19] In cross-examination, the Claimant acknowledged that he mistakenly first thought he received the Cryo in 1987 not 1989. He was asked whether in view of this error it was possible that he could have also been mistaken is remembering receiving Cryo in 1989. The Claimant replied that this was not possible because he had many vivid memories surrounding the event. In addition to the other clear memories that he testified to earlier, he remembers returning from the HSC after receiving Cryo on or about August 3, 1989, at which time the shopping center that is now near his sister's home was not complete. He clearly remembers walking across this field and wondering if that would be the last time he would need Cryo. All of this assists in pinpointing the time-frame. He also remembers the Resident he consulted with on or about August 3, 1989, who had jet black hair. When he was asked how he could be so sure on the particular dates on which he was house-sitting, he stated that the actual dates came from his sister. The time before

1989 that he received cryo was from injuries he sustained in winter which was another incident he could not find records for. However, this was definitely well before 1986.

(c) Nora Schwetz, RN, BSc

[20] Ms. Schwetz has been the Bleeding Disorders Nurse Coordinator at the HSC since 1984. She wrote a letter in support of the Claimant dated December 10, 2001,[9] in which she stated:

> I am writing this letter on behalf of (Claimant) with regards to his application for compensation for the Hepatitis C infection he contracted from blood products received between 1986 and 1990….
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> I have reviewed (Claimant's) hospital chart and hospital microfilm and have found it incomplete. It is not surprising to me that he was unable to find the documentation he requires. In those years unfortunately lost documentation was commonplace due to the system used. I will describe the system for you in order for you to understand why this documentation never reached the chart.
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> The patients were seen in the emergency department, which is the largest, most acute, and busiest emergency department in … Manitoba. If the patient was assessed to be stable, but requiring treatment, they were sent to E2, which is a very inadequately staffed outpatient area (after 3 pm there were usually 2 nurses for 12-20 patients receiving a variety of treatments.) Sometimes the documentation went with the patient, or sometimes it followed dependant on what the situation was in the ER. Often when both areas were very busy, the documentation was incomplete as it never made it to E2, which is the case with (Claimant). This area also had a freezer full of Cryo and a sign in book. The patients who had been educated about the preparation of Cryo would often thaw and prepare their own treatment. This book was sent to storage about 8 years ago and unfortunately cannot now be found.
>
> I am very happy to report that the system has improved and the importance of documentation is crystal clear.
>
> (Claimant) should not be made to suffer more than he has already suffered with his Hepatitis C, which is most definitely the result of Cryo he received in the years 1986 -1990. He had no other risk factors. He is clear on the date and the circumstance that he received the Cryo. The fact that he cannot produce the

[9] Claims Centre file, Exhibit 1, p. 61

documentation you require is because the documentation is lost. Please compensate this gentleman for his pain and suffering.

[21] Ms. Schwetz testified that the Claimant was someone with small stores of Factor VIII, which in his case could be in the range of 10 to 15%, as compared to normal, which is 100%. DDAVP makes cells squeeze out Factor VIII to almost normal levels. This drug may be tried once or twice, generally if the bleed was almost resolved. However, it does not work indefinitely due to the small stores of Factor VIII that are available to be squeezed out. Once DDAVP is no longer effective, one would have to resort to Cryo. She said she understood that the Claimant remembers being at HSC on August 5 or 6, 1989. She said the she would expect the August 17, 1989 record would only have referred to the earlier Cryo if the earlier record was there. As the situation was, it was the patient's responsibility to document Cryo taken from the freezer. Often the patient was treated before the documentation (e.g. ER record) was received. This was due to the rule of thumb for treating hemophiliacs: prompt treatment = better outcome. Health professionals might opt to treat without documentation. The holdup in the documentation is the top typewritten part of the ER record. She was not sure if at that time hemophiliacs would always go to the ER. She thought they might go directly to E2 and could recall that there was a sign-in sheet to let people know a patient was there. In theory, which was not always followed, patients would need to report either at Admitting or at ER because E2 had nobody to type these forms. Although the paperwork should have come up before Cryo was admitted, if it was very busy, patients could get to the freezer and help themselves to Cryo. It was a very loose system. She is sure that there were cases where patients administered their own Cryo. She knows of cases where Cryo "chits" were left with little or no records. In those cases, all one would know would be the lot numbers of the Cryo, not who received them. Because the Claimant was a mild hemophiliac and because he had not used this for years, he did not have his own supply of Cryo in the freezer. He could easily have used somebody else's Cryo, as Cryo can be used for everyone, because it contains no red blood cells. The E2 Ward was not used for people who were acutely ill to the point of justifying ER attendance, but was instead used for people on chemotherapy and hemophiliacs. It had a big logbook as well as a big chest freezer which contained plasma and at least 80 units of cryo at any one time. Most hemophilia patients could thaw and mix their own cryo and prepare their own needles. In such cases the nurse would assess the injury and plan. There are more than 30 hemophilia patients, who are very well-educated on the use of Cryo and active in their own treatment, particularly given the loose situation. The Blood Bank is on the 7th floor. In theory, tags from the Cryo boxes as well as the patient's name who received the Cryo would go to the Blood Bank. There are 4 different lots per box. This was not handled by computers at that time. (Now, once the Cryo as been entered, it becomes carved in stone. At that time, it was not going into any big database). On July 24, 1989, it is likely that the Claimant went to ER, Nora was likely tied up and the doctor would probably have ordered DDAVP and then transferred him to the E2 Ward. In her view, the history information on the records might come from either the patient or the chart. In her view, the probability is that the Claimant did get Cryo on August 5 or 6, 1989. The reasons she gave for this were that having worked with him for years, she

knows that the Claimant has such good recall, is aware of such details and is such a fine person. Perhaps most importantly, she does remember him getting Cryo on an occasion where DDAVP did not help, although she is not sure of the year. She can clearly remember a case where he was not getting in better and they had to go to Cryo and she feels that this was the 1989 occasion when he received Cryo. She says that unfortunately there were many cases where the (pink) ER sheet simply went missing or never did show up and she has heard complaints about this from ER doctors.

(d) Loret MacDonald

[22] Ms. MacDonald is the Director, Medical Information for the HSC. She started with the Department in 1993 and has been Director for 1.5 years. She was asked to clarify what she meant when she stated in her letter of March 10, 2005[10]: "During that time (1987 -1989) there were no standards on where to record the administration of blood products, and the information may or may not have been documented on a number of different forms." She testified that there was nothing specifically stated in any hospital protocol or policy as to when, how or where to record the administration of blood on any specific form. It could be on an ER sheet, a medication record, an in-patient or out-patient sheet, progress notes, or finally, not documented at all. There were also serious issues in connection with microfilming health records over a brief, but in this case critical period of time. In this case it is possible the notes regarding the administration of blood products were not filmed and the original records have been destroyed. They were microfilming at the HSC since the 1940s. However, there is a 4 to 5 year lag time between the making of the record and the microfilming of it. Therefore, 1989 records would not have been filmed until roughly 1994 at which point a decision had been made to not film all records. The Medical Information Committee, which she sits on, reviews all documents and determines their value in terms of being filmed at any given point in time. In 1993 it was decided that only 60% of the chart would be filmed. Examples of records not being filmed between 1993 and 1996 (covering records generated during at least 1989) included fluid balance records (which could have recorded the administration of Cryo), records of out-patient/ambulatory care clinic visits, activities of daily living sheets and other documents that did not contain much clinical information. Legislative changes in 1996 dictated that the originals of all documents that had not been filmed must be retained. The records generated in this case were created during the short window during which 40% of all health records were neither filmed nor retained. In short, she stood by her original statement that it is possible that during the period 1987-1989, notes regarding the administration of blood products were not filmed and the original documents have been destroyed.

(e) Claimant's Sister

[23] The Claimant's sister was asked by Fund Counsel how she was able to say with such certainty that she was away on holidays in 1989 between July 26 and August 9. She replied that she kept the itinerary. I asked her if she still had it and she

[10] Part of Exhibit 4

replied that she had it at home. She undertook to have a copy faxed to my office following the hearing, which she did.[11] She did not go away every summer at that time in her life as she did not have enough money. She recalls being given money from friends as result of which she went to Edmonton. When she returned home to Manitoba, she knew that her brother was suffering from severe flu and leg problems. She was disappointed to learn at that time that he had needed another Cryo treatment. In reference to the flu he was suffering from, she was concerned because he had experienced reactions to Cryo a couple of times in the past, including elevated blood pressure and heart rate, once to the point that he had become weak and had to be monitored. She and her brother both wondered at that time whether he had a Cryo reaction, because the flu came on right after he had been treated.

(f) T.T.

[24] This gentleman is a hemophiliac who lives in the same city as the Claimant. Many hemophiliacs admitted to HCS for Cryo went straight to the E2 Ward. He is a severe hemophiliac and required many more treatments than did the Claimant. He never went through ER to go to E2 until E2 was moved to MS3, a room in a new building. In E2 he would take out the Cryo and then record it in the log book. Usually one of the hemo nurses on E2 would meet you there and put something on file. Often he treated on his own. On E2 he usually saw Nora. He only saw a Hematologist if he got a really bad bleed. When he self-administered, usually the only records would be lot numbers on the big ledger book. He only went through ER or Admitting after MS3, which he estimates happened in approximately 1981. [12]

C. ANALYSIS

[25] The Administrator was obligated to apply the provisions of Section 3.01 of the Plan text, *supra*. Having initially properly done so, the onus shifts to the Claimant, to meet the burden set out in the "notwithstanding" provision contained in Section 3.01(2) of the Plan text, *supra*, which provides an exception to the general rule embodied within Section 3.01(1) (a).

[26] Therefore, the sole issue is whether or not the Claimant has nevertheless succeeded in providing "evidence independent of the personal recollection of the claimant or … a family member, establishing on a balance of probabilities that … he received a blood transfusion in Canada during the Class Period." There is a heavy, though not insurmountable burden upon the Claimant to establish that he fits within the "notwithstanding" provisions of Article 3.01(2). Having carefully considered the totality of the evidence, I am satisfied that in the unique circumstances of this case, the Claimant has met this burden. In this respect, I am mindful of the numerous other

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[11] This was entered into evidence as Exhibit 5, as if it had been tendered at the hearing.
[12] Nora Schwetz was asked about this after T.T. testified, but this did not cause her to change her views as to the probability of the Claimant having received Cryo on August 3, 1989.

decisions which bear on this issue, which discuss the burden of proof upon a claimant in such circumstances and which are posted on the web-site. I do not propose to review the many cases in which the claimant was unsuccessful in meeting this burden. Rather, I will turn to three of the cases to date which have allowed a Claimant to prove that she/he was infected with HCV by a Blood transfusion received in Canada during the class period, notwithstanding the lack of the specified health records demonstrating that the claimant received such a transfusion.

[27] In *Confirmed Referee Decision # 96*, July 23, 2003, Referee Miller carefully considered whether the circumstances in that case could meet the "notwithstanding" test embodied in Section 3.01(2). It is necessary to consider the unique factual background that gave rise to the Miller decision. There, the claimant was treated in 1984 -1986 for a laceration, underwent surgery on both feet in 1986, underwent surgery to repair severe facial injuries at Vancouver General Hospital (VGH) following an MVA in 1987, was hospitalized in 1987 due to a major infection at which time her doctor told her that her white blood cells were 200 times the normal, eye surgery and head injury in 1989 (no records were located) and a craniotomy in 1990. The claimant had no recollection of any blood having been given in any of the hospitalizations. When she submitted her application for benefits, the claimant referenced her belief that there were missing records from the Canadian Red Cross and the VGH. Testing for and the diagnosis of HCV occurred in July 1997. The claimant was notified as part of the Blood Recipient Notification Project that she was a person who likely received a blood transfusion during the class period, although the BC Ministry of Health indicated that the record must have been sent in error as the traceback revealed no transfusions. The main issue in the decision revolved around the September 1987 facial smash surgery performed by a Dr. Kester, a plastic surgeon, at VGH following the MVA in which the claimant's vehicle collided with a moose. Dr. Kester testified at the hearing and submitted to cross-examination by fund counsel. In 20 years of experience as a plastic surgeon in the Vancouver area, he had personally performed surgery in several facial smash cases and he recalled 3 cases of facial smashes specifically involving moose-car accidents. While he did not specifically remember a blood transfusion occurring in the operating room under his supervision in the claimant's case, he did remember the claimant, her condition and the hospitalization under consideration. He remembered that the claimant's facial condition was such that her blood loss was severe. He reviewed all the hospital records that had been provided to him by fund counsel and noted that the absence of any reference whatsoever to the need for blood or the existence of a blood transfusion would be unusual, particularly in the anesthetist's records, but noted that he expected it would be referenced in the nursing notes, which were no longer available. His testimony was that he considered it ***highly probable*** that the claimant received a blood transfusion because it would be normal in a severe facial fracture of that type. He opined that in the Vancouver area in the context of a severe fracture and the accompanying blood loss, the infusion of one unit of blood would not be unusual and would not likely be regarded by any the surgeons or residents within the operating theatre either as a complication or as an emergency need. He found further support for his conclusion in that the hemoglobin readings recorded after the surgery went up,

which he would not expect unless the patient had received an injection of blood. He also noted that if an emergency arose in the course of surgery, a unit of O blood could be ordered from the O.R. He noted that the claimant's preoperative hemoglobin level was recorded at 117 which he interpreted as being on the low side and following surgery he would have expected the hemoglobin readings be in the range of 105 to 110 whereas her reading was 120. He felt that this rise in hemoglobin levels was probably attributable to the injection of blood. He also stated that if the doctor had given a verbal order in the operating room, he would tell the anesthetist to do so, but the anesthetist would not know that he had typed and crossed the blood. In other words, if blood had been ordered in the operating room by the anesthetist, it may not have been noted. In addition to the testimony from Dr. Kester, although it was not relied on in reaching the decision, there was also oral testimony from the claimant's former partner who testified that he witnessed the blood transfusion occurring while awaiting the claimant's return from the operating room and described the details of his discussions with the nurse in that respect. Referee Miller stated, in allowing the claim:

> 60. In my view, Dr. Kester's evidence must be treated as the best evidence before me and where there are inconsistencies between his testimony and the hospital records, ***I find his oral evidence overrides because of his familiarity with the usual practices of surgeons at VGH in facial smash surgeries of this type, and in particular by reason of his specific recollection of this particular operation***. …I must conclude that his unchallenged opinion convinces me it is likely, or probable, that the claimant received a blood transfusion on September 13, 1987 in connection with the facial surgery performed by Dr. Kester. ***Without the weight of Dr. Kester's viva voce evidence, I would have been unable to conclude that there was requisite evidence on the balance of probabilities to satisfy the requirements of the Plan.***
>
> 61. My decision in this case may put a nearly impossible burden on the Administrator to undertake a trace-back of blood apparently transfused into this claimant for which no record can ever be found. ***In light of all the foregoing, I conclude this case must very likely be confined to its own peculiar facts***. [emphasis added]

[28] The Miller case clearly turned on the specific testimony provided by Dr. Kester, which was well supported by his specific recollection of the surgery in question, and other surgeries he had performed relating to facial smashes, even more specifically relating to moose-car crashes; like the Miller case here there were no nursing notes or other records. In the present case, while the Claimant was unable to produce a physician that could support his position, he was able to give evidence as to the extensive efforts he underwent to locate the Resident who ordered the giving of Cryo. Clearly he was not reluctant to find this individual for fear of what he might say. The Post-Graduate Medical

Education Office of the University of Manitoba confirmed that it does not maintain records of Residents who rotated through Hematology but were not full-time Residents within that Department. The Manitoba Health plan does not maintain records going back to 1989. The Claimant was able to produce lay evidence that in my view supports his claim.

[29] There is a second decision in which a referee has determined that a claimant met the "notwithstanding" burden imposed by section 3.01(2). In *Confirmed Referee Decisions # 150* (Nols, Referee, June 22, 2004), the claimant alleged that he had received a blood transfusion during a brief hospitalization in 1987. The claimant admitted that he had an operation which normally does not necessitate a blood transfusion, but for reasons which he could not fully explain, alleged that he had been transfused while under general anesthetic. The hospital wrote him advising that the records concerning all blood products that were administered to him were destroyed following the closure of the hospital in January 1997. Referee Nols pointed out that this was not a case where the hospital records were silent on the issue of whether the claimant received a transfusion or not, but rather was a case where such records, including blood bank records, had been purged or destroyed. Faced with the non-availability of his hospital records, the claimant called as a witness a friend of the family who had visited him while he was hospitalized in 1987. The friend recalled a nurse coming in, hanging some blood and "plugging it in". This witness eventually graduated in nursing in 1993 and admitted that while he did not have a "trained eye" in 1987, was familiar with blood transfusions and knew how to recognize one. The Referee was clearly impressed by the testimony of this witness and accepted it. There was no evidence to suggest that the claimant had a "lifestyle or a character such as to create additional risk factors" and no more plausible explanation given for the infection than that of a 1987 blood transfusion. On the unique facts of that particular case, including the lack of any health records or blood bank records of any kind and the affidavit and *viva voce* evidence of the claimant's friend, Referee Nols found that the claimant had met the "notwithstanding" burden of Section 3.01(2) and should therefore succeed in his appeal.

[30] In another recent decision, Unconfirmed Referee Decision 185,[13] Referee Killoran allowed the Claimant's appeal in spite of the lack of medical evidence, finding that there was sufficient independent evidence to allow the claimant to meet the burden. In that case, there was evidence from a former neighbor who visited the claimant in hospital on the day of her surgery and remembers seeing a bag of blood being transfused into the claimant's arm. Also, the Referee relied on the evidence of the patient who was in the bed next to the claimant and who remembered the claimant's transfusion because her own blood bag was changed at the same time as that of the Claimant.

[31] Although dealing with the Transfused HCV Plan and not the Hemophiliac HCV Plan, the Nols and Killoran cases illustrate that while medical evidence to support the assertion of transfusion is the most clear-cut and reliable method by which to permit a claimant to meet the burden, strong and tested independent lay evidence may also be sufficient, in appropriate circumstances, to permit the claimant to succeed.

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[13] Dated May 5, 2005

[32] The Claimant is absolutely clear in his testimony and in his own mind as to the last two times that he obtained Cryo – neither of which appears in the HSC health records or Blood Bank records. One was clearly well before the Class Period. The second was the incident of on or about August 3, 1989. The flu that he suffered from in late July and early August 1989 is important as it does enable him to pinpoint the crucial date for two reasons: (1) it allows him to use his sister's holiday house-sitting as a reference point: (2) he had received Cryo so seldom in the 1980s (and not at all since 1989) that it was apt to stand out in his mind when he did receive this, particularly in view of his fear of suffering a reaction to Cryo, such as he had experienced in the past, including one particularly bad reaction. His evidence was delivered in a most candid and evenhanded manner. He was an extraordinary witness and I accept his evidence without hesitation. Likewise, the evidence of his sister, while brief, was compelling and I accept it. Having made these assessments, however, it must be remembered that Section 3.01 (2) of the Plan Text permits a claimant to establish a transfusion with the use of corroborating evidence *independent of* the personal recollection of the claimant or any person who is a "Family Member" of the Claimant. The definition of "Family Member" contained in Section 1.01 of the Plan Text includes a sibling of an Infected Person. Therefore, the evidence of the Claimant and his sister, however compelling, would not be, without more, sufficient to meet the requirements of independent corroborating evidence. However, that does not preclude a referee from considering both the Claimant's evidence as well as that of his sister in considering the totality of the evidence. In doing so, I find that the combined impact of the independent supportive evidence of Nora Schwetz and Loret MacDonald, together with the letter from Karen Timlick, HRT, Medical-Legal Correspondent for the HSC, dated April 18, 2002,[14] the Memo from Lee Grabner in which she states that the hospital and blood bank records fail to document the Cryo that the oral surgeon's records show the Claimant received in 1983, does in my view rise to the point of enabling the Claimant to meet the burden placed upon him by the "notwithstanding" section, when considered in light of the evidence of the Claimant in this case, as well as that of his sister. These were very unique circumstances and I therefore wish to make it clear that the result in this case must be confined to the specific facts before me.

[33] In conclusion, upon careful consideration of the totality of the evidence, I find that there was in this case persuasive independent contradictory evidence adduced by and on behalf of the Claimant that meets the Miller, Nols and/or Killoran criteria, in order to allow me to reasonably conclude that the Claimant has established, on a balance of probabilities, that he received or took Blood during the Class Period.

[34] The appeal is allowed. Both parties are to be commended for the collegial, courteous and capable, yet vigorous manner in which this case was presented.

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[14] Exhibit 1, page 62, which states: "Although there is no evidence present in your HSC Medical Records (which since that time has been put on microfiche), it is possible that the information has been misplaced or was not properly documented."

D. Decision

[35] Upon careful consideration of the Settlement Agreement, Plan, Court orders and the *viva voce* and documentary evidence tendered, the Administrator's denial of the Claimant's application for compensation is overturned. The Claimant is entitled to such compensation as he may otherwise qualify for under the Plan. The Claimant is entitled to recovery the reasonable costs of obtaining the evidence presented at the hearing according to a tariff that has been developed for this purpose. I reserve jurisdiction to determine the amount In the event that the parties are unable to agree.

Dated at Saskatoon, Saskatchewan, this 4th day of July 2005.

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Daniel Shapiro, Q.C., C. Arb., Referee