IN THE MATTER OF A REFERENCE TO REVIEW

THE DECISION OF THE ADMINISTRATOR UNDER THE HCV 1986-1990

TRANSFUSED SETTLEMENT AGREEMENT

Province of Infection: British Columbia

Province of Residence: British Columbia

Claim No.: 57141

Before: Vincent R.K. Orchard, Q.C., Referee

Heard: November 9, 2005 at Vancouver, British Columbia

DECISION

Claim ID:57141

I. INTRODUCTION

1. This reference concerns a request for review of a denial by the Administrator of a Claim for compensation under the Transfused HCV Plan ("Plan") made by the Claimant as an HCV Personal Representative pertaining to her father ("Deceased") who died on February 28, 2001 due to a drug overdose. The Deceased was born outside Canada on June 14, 1934. The Deceased lived his adult life in British Columbia. During much of his adult life he was a non-prescription intravenous drug user ("IV Drug User").

2. The Administrator denied the Claim for reasons set forth in a letter dated June 14, 2005 (pp. 3-5, Claim file, Tab 4, Exhibit 1), namely that the Claim did not meet the criteria established under Article 3.01(3) of the Plan which requires a Primarily-Infected Person who used non-prescription intravenous drugs ("IV Drugs") to establish on a balance of probabilities that he was infected for the first time with HCV by a Blood transfusion in Canada during the Class Period. The Administrator's decision turned on an analysis of evidence concerning the Deceased's medical history, various sections of the Plan and the Court Approved Protocol for Non-Prescription Intravenous Drug Use ("CAP").

3. The Claimant requested an in-person hearing which was held in Vancouver, British Columbia, on November 9, 2005. The Claimant was represented by counsel, Ms. Lori Ziebart. The Claimant appeared and gave evidence. Mr. William Ferguson, Fund Counsel for British Columbia, appeared on behalf of the Administrator. Ms. Carol Miller of the Administrator's office also attended and gave evidence.

4. In order to determine eligibility for compensation under the Plan, the threshold question in this reference is whether the Claimant has, on a balance of probabilities, met the onus that the Deceased was infected with HCV for the first time by a Blood transfusion in the Class Period.

5. As a referee and trier of fact, I am required to give reasons for my decision. I am indebted to counsel for their able submissions which were made in writing and orally at the hearing on November 9, 2005. Reasons for decision are not intended to be a recitation of all the evidence and submissions tendered during the conduct of the reference. I have carefully

considered all the evidence and submissions at arriving at my decision. That I choose to refer to only some of the evidence and submissions does not mean that I have not considered all evidence elicited and submissions made.

6. I extended the time for release of this Decision to invite further submissions from counsel on standards of review. No further submissions were made except a concession by Mr. Ferguson that the standard for review of the Administrator's decision in this context is "correctness".

7. As noted, the Claimant was born outside Canada, specifically in Europe, in 1934. He came to Canada shortly after the Second World War. It is common ground that he was diagnosed with HCV in 1997. Furthermore, it is common ground that the deceased had a Blood transfusion within the Class Period.

8. The Deceased had a history of non-prescription intravenous drug use ("IV Drug Use"). In response to a question I put to counsel at the hearing, it was agreed that if the Deceased had not been an IV Drug User he would have been entitled to compensation under the Plan because of three factors: (i) a diagnosis of HCV, (ii) a Blood transfusion in the Class Period, and (iii) an inconclusive Traceback.

9. The drafters of the Plan, which has received court approval under the terms of the 1986 – 1990 Hepatitis C Settlement Agreement ("Settlement Agreement") have drafted special rules for claims made by or on behalf of IV Drug Users requiring a stricter burden of proof than the burden of proof required of claimants who are not IV Drug Users. The CAP gives further guidance to the Administrator in interpreting and applying the provisions of the Plan.

10. Counsel for the Claimant concedes that the Deceased used IV Drugs, specifically cocaine, for ten years prior to his death. That would mean that IV Drug Use by the Deceased did not commence until after the Class Period and supports an argument that IV Drug Use could not have been the source of infection. The evidence of the Claimant is that her father told her about his IV Drug Use in 1998 but assured her that he did not share needles and he always used a needle exchange. Before her father's admission in 1998, the Claimant had no indication that her father was using IV Drugs. She knew he had a history of alcohol abuse; but he was a big burly man who looked healthy and rode a bicycle as a mode of conveyance. The Claimant stated that her father told her he began IV Drug Use in 1998 because he always felt tired from having HCV

and had chronic lower back pain as he had been hit by automobiles several times while riding his bicycle.

11. The Deceased had a girlfriend who lived with him periodically for 15-20 years prior to his death. The former girlfriend continues to live in Vancouver, but was not called as a witness.

12. Counsel for the Claimant submits that there is no objective evidence of IV Drug Use before the Deceased had a Blood transfusion in 1989 during the Class Period. She further submits that the only reliable evidence of IV Drug Use was after July 1, 1990.

II. THE PLAN AND THE CAP

13. Article 3.01 of the Plan sets out the required proof for compensation. Article 3.01 reads in part as follows:

> **3.01 Claim by Primarily-Infected Person**
>
> (1) A person claiming to be a Primarily-Infected Person must deliver to the Administrator an application form prescribed by the Administrator together with:
>
> (a) medical, clinical, laboratory, hospital... records demonstrating that the claimant received a Blood transfusion in Canada during the Class Period;
>
> (b) An HCV Antibody Test Report, PCR Test, or similar test report pertaining to the claimant;
>
> (c) a statutory declaration of the claimant including a declaration **(i) that he or she has never used non-prescription intravenous drugs,** (ii) to the best of his or her knowledge, information and belief, that he or she was not infected with Hepatitis Non-A Non-B or HCV prior to 1 January 1986, (iii) as to where the claimant first received a Blood transfusion in Canada during the Class Period, and (iv) as to the place of residence of the claimant, both when he or she first received a Blood transfusion in Canada during the Class Period, and at the time of delivery of the application hereunder. [Emphasis added]
>
> ...
>
> **(3) Notwithstanding the provisions of Section 3.01(1)(c), if a claimant cannot comply with the provisions of Section 3.01(1)(c) because the claimant used non-prescription intravenous drugs, then he or she must 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 a Blood transfusion in Canada during the Class Period. [Emphasis added]

14. As noted above it is common ground that the Deceased was a recipient of blood transfusions in Canada in March 1989. A Traceback was conducted to determine if any of the Blood received from a donor was determined to be HCV anti-body positive. The results of the Traceback were inconclusive as one of the donors was not found.

15. As the Deceased had an admitted history of IV Drug Use, the Claimant, as conceded by counsel, has the burden of providing further evidence to the Administrator in support of her Claim in accordance with the Plan and the CAP.

16. Almost the entirety of the CAP is relevant. For convenience, the CAP is attached as Appendix A to this Decision. I summarize its relevance as follows:

(i) The CAP applies because of an admission that the Deceased used IV Drugs;

(ii) The effect of sections 2 and 3 of the CAP is to put the burden of proof on the Claimant to satisfy the Administrator, on the balance of probabilities, that the HCV Infected Person [the Deceased] was infected by a Blood transfusion received in Canada within the Class Period;

(iii) Under Section 4 of the CAP, the Administrator must conduct a Traceback unless certain circumstances apply. None apply in this case, therefore the Administrator conducted a Traceback;

(iv) Under paragraphs 8 – 13 of the CAP, the Administrator must perform additional investigations where the claim is not rejected under the Traceback. In this case, the Claim was not rejected under the Traceback. For example, under Section 8(b), the Administrator shall obtain the opinion of a medical specialist experienced in treating and diagnosing HCV as to whether the HCV infection and the disease history of the HCV Infected Person is more consistent with infection at the time of receiving the Blood, the Class Period blood transfusion(s) … or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence.

17. There are a number of references in the CAP to the Administrator's responsibility to weigh the evidence and to consider the totality of the evidence and reasonably reliable evidence.

18. In this case, the Administrator obtained the opinion of Dr. Gary E Garber, Professor and Head of the Division of Infectious Diseases, University of Ottawa/The Ottawa Hospital. Dr. Garber provided his opinion in his letter dated May 26, 2005. Dr. Garber concluded that **"it is more likely that [the Deceased] acquired Hepatitis C from his injection drug use over a prolonged period of time than from the risk of one unit of blood that has not been able to be tested."**[Emphasis added]. The reference to the one unit of Blood that has not been tested is a reference to the transfusion in 1989 when the Deceased required 15 units of packed red blood cells. Fourteen units had been tested and found to be Hepatitis C negative. The fifteenth unit has not been traceable; the donor of the fifteenth unit could not be located.

III. THE EVIDENCE

19. The documents reveal that the Administrator's office conducted a thorough review and investigation before denying the Claim on June 14, 2005. The Administrator had voluminous medical records of the Deceased, the Coroner's Judgment of Inquiry, affidavit evidence from the Claimant and the opinion of Dr. Garber. The Administrator also conducted a review by committee, specifically the IDU (Intravenous Drug User) Committee, which consisted of two managers and two claims examiners. The decision of the Committee was reached on June 9, 2005 and during its review, the Committee reviewed both supportive and non-supportive factors related to the Claim and made those findings in writing in a four-page document (pp. 468 – 471, Claim file, Tab 4, Exhibit 1).

20. The Committee, relying upon its experience, Dr. Garber's opinion and weighing all the evidence available before it concluded that the Claimant had not satisfied the onus of proof. It appears to me that the Committee carried out its mandate under the Plan and the CAP with diligence and thoroughness. The Administrator also carefully reviewed and summarized the Deceased's past medical history (pp. 463 – 465, Claim file, Tab 4, Exhibit 1). At the hearing, Ms. Carol Miller, a senior manager and appeals officer with the Administrator's office and a former practicing nurse of considerable experience, reviewed the operation of the IDU Committee's review and, in particular, reviewed relevant references to the Deceased's medical history.

21. Dr. Garber was provided 339 pages of medical records and documentation supporting the application for compensation under the Plan. As noted, Dr. Garber concluded that the source of the Deceased's infection with HCV was from his IV Drug Use over an unspecified but prolonged period of time, rather than the transfusion in March 1989. Dr. Garber did not testify before me. His opinion stands untested by cross-examination.

22. The question of standard of review for a referee considering the Administrator's decision in this particular context was not argued by counsel. Mr. Ferguson concedes that the standard of review is correctness and approaches a rehearing or trial *de novo*. The Plan and the CAP clearly requir the Administrator to determine the rights of claimants by applying a civil standard of proof.

23. For comparison sake I note the nature of the review of a referee's decision by the courts. I refer to the judgment of Mr. Justice Pitfield in HCV Settlement Claim No. 11910, 2004 BCSC 1421. The learned judge adverted to the standard of review described by Winkler J. in Confirmed Referee Decision No. 2, November 27, 2001, at para. 6 as follows:

> [T]he reviewing court "ought not to intervene unless there has been some error in principle, some absence or excess of jurisdiction, or some patent misapprehension of the evidence".

But Mr. Ferguson says the standard of review in this context is much more favourable to the Claimant.

24. I have also considered the principles of standard of review of administrative decisions as set out recently by the Supreme Court of Canada in cases such as *Dr. Q v. College of Physicians & Surgeons, British Columbia*, [2003] 1 S.C.R 226 and *Law Society of New Brunswick v. Ryan*, [2003] 1 S.C.R. 247. The Supreme Court of Canada requires a "pragmatic and functional approach" to the standard of review. The Supreme Court has discussed four contextual factors which should be considered in a pragmatic and functional approach. In the context of this appeal, I note a broad right of appeal to an Arbitrator or Referee; a degree of expertise of the IDU Committee; the purpose of the Settlement Agreement, the Plan and the CAP; and a question of mixed law and fact. I also note that the Administrator's office is not delegated a task of specifically making findings of the credibility of witnesses but the Administrator's office is entrusted with weighing on a balance of probabilities the totality of the evidence. Applying the law, as established by the Supreme Court of Canada, I conclude that the standard of review of the Administrator's decision to deny the Claim is indeed correctness.

25. I will now refer to some of the evidence before the Administrator and before me as Referee.

26. There is little objective evidence of the history of the Deceased's drug use, its length, degree and nature. The Treating Physician Form, called a TRAN 2 form, completed December 12, 2001 by Dr. Anthony Otto indicates that Dr. Otto knew the Deceased four years prior to his death in February 2001 and noted an admitted history of intermittent IV Drug Use for a number of years. Dr. Otto also noted that the history of intermittent IV Drug Use was 'not documented' in the patient's file. (pp. 5-9, Claim file, Volume 2 of 4, Exhibit 2).

27. The evidence of the Claimant does not shed any penetrating light on the subject of the Deceased's Drug Use. In an affidavit sworn November 19, 2004 the Claimant indicated that the Deceased informed her he first used IV Drugs on or about January 19, 1998 and he used cocaine until 2001 when he passed away. He informed her that he used cocaine about 2-3 times per week. He further informed the Claimant that he always obtained the needles he used from a needle exchange and she had, on numerous occasions, driven the Deceased to a needle exchange on Pender Street in Vancouver, British Columbia. The Deceased informed her that he always used sterile drug paraphernalia and did not share needles.

28. In the Request for Review document completed by the Claimant on June 14, 2005 (pp. 472-475, Claim file, Tab 4, Exhibit 1), the Claimant stated that "I always knew that my father had a history of non-prescription IV drug use. It's in the initial application. I don't know, however, when he commenced his use. My father told me he used drugs to deal with the pain and depression associated with the disease". She also indicated that the "historical medical records have been destroyed, as a result, I cannot provide pre-86 evidence".

29. I was referred to the Judgment of Inquiry by the Coroner of June 13, 2001 (pp. 84-86, Claim file, Tab 4, Exhibit 1). The immediate cause of death was found to be "cocaine, heroin and alcohol poisoning". The coroner reported the following:

> [the Deceased] was found collapsed on his stomach at the foot of his bed. There was a black belt across his chest at approximately the nipple line. Drug paraphernalia was found in the room: syringes, small water bottles, and a teaspoon contained light powder. **The daughter [the Claimant] related that [the Deceased] became addicted to drugs when he was 20 years old.** [Emphasis added]

30. At the hearing, the Claimant said that she was referring to alcohol use going back to age 20 not drug use when she spoke to the Coroner.

31. Ms. Carol Miller reviewed some of the voluminous medical records during her testimony at the oral hearing. The earliest records reviewed were clinical notes by a general practioner dating back to December 23, 1983. Ms. Miller reviewed a number of entries in the records between March 9, 1987 and admission to St. Paul's Hospital in March 1989, many relating to liver function tests. I gather that these liver function tests were equivocal: some were normal and some tests were elevated. Ms. Miller also reviewed medical testing during 1997 to 1999 concerning Hepatitis B and C. The Deceased was negative for Hepatitis B but positive for Hepatitis C as of September 18, 1997. The various medical tests were considered by the IDU Committee as supportive and non-supportive considerations.

32. Ms. Miller also gave evidence concerning liver function tests between 1997 and 1999. She referred to tests on June 17, 1999 that showed certain liver function tests, ALT and AST, as being within normal values versus earlier elevated ALT tests in 1997.

33. From the clinical records of March 23, 1998 there is an entry of a general practitioner that the Deceased suffered anxiety/depression, secondary to chronic drug abuse. In a consultation report from St. Paul's Hospital dated June 22, 1999, completed by Dr. Tindall of the Division of Infectious Diseases, the doctor notes that the Deceased is "a rather poor historian. Apparently, he lives alone in the downtown Eastside and has been using IV cocaine for 8-9 years." (pp. 299-300, Claim file, Vol. 2 of 4, Exhibit 2).

34. There were also entries in the St. Paul's Hospital records in June 1999 to the effect that the Deceased had indicated he had a transfusion in 1989 and he contacted Hepatitis C. He used cocaine to get energy.

35. The St. Paul's records noted that when the Deceased was admitted to St. Paul's hospital in 1999 he presented with a heart infection known as *S. aureus right side endocarditis with septic emboli and empyema*. This infection was specifically noted by Dr. Garber in his report of May 26, 2005. Ms. Miller testified that endocarditis would be secondary to IV Drug Use from a dirty needle. As Dr. Garber reports the admission in 1999 to St. Paul's Hospital with endocarditis occurred two days after a recent injection of cocaine.

36. It will never be known with precision when the Deceased began IV Drug Use. Claimant's counsel does not dispute the truth of the contents of the references in the medical evidence to IV Drug Use going back to 1990/1991. The Claimant gave evidence that the Deceased told her that the IV Drug Use began in January 1998; however, I conclude that the Deceased was not particularly forthcoming about his IV Drug Use. As Dr. Tindall has noted, the Deceased was "a poor historian". Indeed the Claimant did indicate in her appeal (pp. 472-475, Claim file, July 11, 2005) that she actually did not know when her father commenced his IV drug use. That comment has the ring of truth. The Deceased told her his IV Drug Use began in 1998; the records which remain extant indicate 1990 – 1991. It is obvious that the Deceased was not particularly accurate in the information he provided about something he may not have wished to discuss. Although the Deceased claimed that he always used clean needles and paraphernalia and a needle exchange; he did present in June 1999 with a heart infection that is related to using unclean needles. In addition, there is the statement in the Coroner's Judgment of Inquiry attributed to the Claimant that the Deceased's drug addiction began when he was 20 years of age. That would have been approximately in 1954, well before the Blood transfusion in 1989. Moreover, the records indicate that the only IV Drug Use was with cocaine, yet the Coroner concluded that he died from a combination of alcohol, cocaine and heroin. The inconsistencies in the evidence about the Deceased's IV Drug Use affect the weight of the totality of the evidence and no doubt did not assist the Claimant in satisfying the onus of proof.

IV. CONCLUSION

37. The drafters of the Settlement Agreement, the Plan and the CAP intended that IV Drug Users would be presented with a more difficult burden in proving that a Blood transfusion in the Class Period is the source of their HCV infection.

38. It is clear that the Administrator followed carefully the CAP and conducted the investigation meticulously as required. The Administrator obtained an independent medical opinion from Dr. Garber. The Administrator reviewed all available medical and clinical records. There was no identification of a Class Period Blood transfusion from an HCV anti-body positive donor. One of the donors could not be located. Therefore the Traceback was inconclusive. The evidence of whether IV Drug Use took place only after the Blood transfusion in March, 1989 was equivocal: there was clear evidence that IV Drug Use took place as early as 1990/1991, and there was some evidence that IV Drug Use may have taken place before then and before the Blood transfusion in the Class Period. There was no reasonably reliable evidence that IV Drug Use was

limited to a single occasion with unshared sterile equipment (s. 12f of the CAP). In favour of the Claimant, there was no medical history of Hepatitis B before the Class Period (s. 12g of the CAP). There is reasonably reliable evidence that IV Drug Use took place over a long period of time one more than one occasion or was done with non-sterile or shared equipment (s. 13c of the CAP). There was uncontradicted medical evidence before the Administrator that the Deceased's HCV infection was more consistent with IV Drug Use than the Class Period Blood transfusion (s. 13b of the CAP).

39. I am satisfied that the Administrator carefully considered the totality of the evidence in accordance with paragraphs 8-13 of the CAP. There was evidence that IV Drug Use took place on more than one occasion and may have been done with non-sterile or shared equipment. The Committee concluded that the Deceased's HCV history was more consistent with infection by IV Drug Use than infection by Class Period Blood transfusion. In coming to its decision the Administrator relied upon Dr. Garber's letter and of course would have had regard to the evidence I referred to in paragraphs 26 to 36 of my Decision.

40. I agree with Fund Counsel that the Administrator followed the Plan and the CAP in conducting the required investigation and came to a conclusion on the totality of the evidence that the Claimant had not met the eligibility criteria. The Administrator was not satisfied that the Claimant had shown on a balance of probabilities that the Deceased was infected by HCV for the first time by a Blood transfusion received in Canada in the Class Period. Applying a standard of correctness, I conclude the Administrator's decision has not been shown to be incorrect in any way. No error of law or fact has been shown. No misapprehension of the evidence has been shown. Indeed, I find the Administrator was correct in applying the Plan, the CAP and in assessing the totality of the evidence on a balance of probabilities. I uphold the Administrator's denial of the Claim.

DATED at Vancouver, British Columbia, this 25th day of January, 2006.

Vincent R.K. Orchard, Q.C., Referee

Appendix "A"

Court Approved Protocol

CAP - NON-PRESCRIPTION INTRAVENOUS DRUG USE

Sections 3.01(1)(c) and (3), 3.02(1)(a) and (2) or 3.05(5) of the Transfused HCV Plan and Sections 3.01(1)(c) and (3), 3.02(1)(a) and (2) or 3.04(5) of the Hemophiliac HCV Plans)

Applicability of CAP

1. This CAP applies where:

a. there is an admission that the HCV Infected Person used non-prescription intravenous drugs;

b. there is no s.3.01(1)(c), 3.02(1)(c), 3.04(5) or 3.05(5) declaration that the HCV Infected Person has never used non-prescription intravenous drugs; or

c. despite receipt of a s. 3.01(1)(c) or 3.02(1)(c), 3.04(5) or 3.05(5) declaration, there is other evidence that the HCV Infected Person has used non-prescription intravenous drugs.

Eligibility Criteria Where This CAP Applies

2. The Administrator must be satisfied on the balance of probabilities that:

a. the HCV Infected Hemophiliac or person with Thalassemia Major was infected with HCV for the first time by Blood received in Canada; or

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. by a Spouse who is a Primarily-Infected Person/Opted-Out Primarily-Infected Person; or
iii. by a Parent who is an HCV Infected Person/Opted-Out HCV Infected Person;
as the case may be.

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

TRACEBACK

4. The Administrator shall conduct a Traceback under the Traceback CAP, unless:

a. in the case of a Hemophiliac or person with Thalassemia Major, the HCV Infected Person was a regular recipient of Blood prior to his/her attaining the age of 18; or

b. in the case of a person claimed to be a Secondarily-Infected Person, the person has no history of blood transfusion.

5. If the Traceback CAP does not apply, the Administrator shall perform the additional investigations required by paragraph 8 below.

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.

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

Additional Investigations

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; and

b. obtain the opinion of a medical specialist experienced in treating and diagnosing HCV as to whether the HCV infection and the disease history of the HCV Infected Person is more consistent with infection at the time of the receipt of Blood, the Class Period Blood transfusion(s) or the secondary infection or with infection at the time of the non-prescription intravenous drug use as indicated by the totality of the medical evidence.

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.

Examples of Additional Investigations

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

a. an independent medical examination with a physician of the Administrator's choice, to obtain opinion evidence on any medical issues which the Administrator believes will assist in making its decision;

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. a consent to conduct a criminal records search of HCV Infected Person; and

f. an affidavit or interview of any person the Administrator believes may have knowledge about the non-prescription intravenous drug use or disease history of the HCV Infected Person.

Results of the Investigations

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 Hemophiliac or the Class Period Blood transfusions;

c. reliable evidence establishes that the non-prescription intravenous drug use took place after July 1, 1990;

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

i. the receipt of Blood for the Hemophiliac;
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. the alleged secondary infection;

than with the time of non-prescription intravenous drug use;

e. reasonably reliable evidence that the non-prescription intravenous drug use history is subsequent to the receipt of Blood for the Hemophiliac, or the date of Class Period Blood transfusion(s), or the date of alleged secondary infection;

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 receipt of Blood for the Hemophiliac, the Class Period Blood transfusion(s) or the date of alleged secondary infection.

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. the receipt of Blood for the Hemophiliac;
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. the alleged secondary infection;

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 date of the receipt of Blood for the Hemophiliac, or the Class Period Blood transfusion(s) or the date of alleged secondary infection;

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;
had donated blood prior to the Class Period and the pre-Class Period blood donations or
ii. recipients of the pre-Class Period 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.

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