Claim No. 7518

DECISION

A. Introduction

[1] By way of Application dated June 27, 2001,[1] the Claimant, a Manitoba resident who was then 45 years of age, applied for compensation as a Primarily-Infected Person pursuant to the Transfused 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] There is no dispute that the Claimant has been diagnosed with HCV infection, and is shown at Disease Level 1. There is also no dispute that the Claimant received a Blood transfusion in Canada during the Class Period.

[4] In his application, the Claimant advised that he had been transfused twice in his lifetime in Canada, first in 1986 and next in 1998.[2] It appears that the Claimant was in error in asserting that he had been transfused in 1986. However, a traceback was done on the two units of blood received in 1988 at Concordia General Hospital, Winnipeg. The first unit was negative and the second unit was not confirmed as the donor had deceased and the unit therefore could not be the subject of a traceback. Accordingly, there was no confirmation that he received positive units of blood. Therefore, while no positive traceback could be proved, at the same time the traceback was deemed by the Administrator to be "inconclusive".

[5] However, the application was denied, not on the basis of failure to prove an HCV positive transfusion, but rather, on the basis of the Claimant's admitted non-prescription intravenous (IV) drug use. The first Tran 2 (Treating Physician's Form) completed by Dr. Hamm, dated August 27, 2001,[3] checked off other risk factors including non-prescription intravenous drug use, tattoos and significant surgeries. Dr. Hamm also queried whether there had been transfusions outside the class period. Later in the same form, Dr. Hamm stated "No" in answer to the question: 'Is there anything in the ... medical history or clinical presentation that indicates he used non-prescription IV drugs at any

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[1] Claim Centre File for the Claimant, pp. 1-495 was marked as Ex. 1. See pp. 32-35. The medical records not forwarded to the Medical Expert, pp. 496-866 were marked as Ex. 2. The Medical Expert File, materials sent to Dr. Garber, pp. 1-324, were marked as Exhibit 3.

[2] p. 33

[3] pp. 36-40

time?' Thereafter, upon request by the Administrator, the Claimant completed an "Other Risk Factor (ORF) Inquiry Form"[4], in which he indicated that he had 5 tattoos done in the late '70s and early '80s, in a shop in which he owned all the equipment. Further, he asserted that he never used equipment or needles used by anyone else. He also indicated that he had used cocaine intra-nasally using a straw ("personal only then discarded for new one") from 1988 to 1992 more than X25, and intravenously, more than X30. However, he asserted that he "NEVER" shared needles, "not even once".

[6] Pursuant to the Plan and the Court Approved Protocol (CAP) for Non-prescription IV Drug Use, the burden to prove eligibility is on the claimant once there has been an admission of non-prescription IV drug use. In this case, in an effort the meet this burden, the Claimant provided the ORF statement and certain medical records.

[7] The medical history and pertinent records were provided to Dr. Gary Garber, Professor and Head of Infectious Disease at the University of Ottawa, with a view to determining whether he could find any indication that the Claimant was first infected as a result of a blood transfusion and not as a result of his IV drug use. Dr. Garber made the following statements:[5]

- Interestingly, his liver biopsy in 2001 indicated only a 0 to 1 grade of fibrosis which is fairly minimal level disease for an individual potentially infected 13 to 14 years ago and who has a significant alcohol intake.

- His injection drug use is noted in the medical charts as of 1991 with the possibility of a seizure from withdrawal from cocaine and the use of injection drugs for pain control.

- Dr. Kaita indicates first drug use at the age of 13 which the patient says is incorrect.

- In 1990 his MCV and MCH were elevated. He had normal folic acid at that time and his AST was a bit elevated. This could be related to liver disease or alcoholism. Certainly, once he was diagnosed around 2000-2001 his liver tests have been persistently elevated.

[8] Dr. Garber also notes that the risk of receiving Hepatitis C from a single unit of blood is quite small (one unit having been found to be negative and

[4] pp. 59, 60
[5] pp. 490, 491

the other not confirmed). Dr. Garber feels that the drug use is far more likely the explanation as to the cause of HCV infection, concluding his findings his way[6]:

> Therefore, on the balance of probabilities and based on the minimal damage to the liver seen despite an extensive alcohol intake history suggests that his exposure to hepatitis C would most likely have been after 1988 and therefore most likely in the period when he was actively using injection drugs. On this basis, I think it's more likely on the balance of probabilities that he was exposed to Hepatitis C through injection drug use rather than a single unit of blood that has not been traceable.

[9] The IV Drug Use Committee reviewed the materials including Dr. Garber's report and concluded on a balance of probabilities that they had insufficient evidence to establish that the Claimant was first infected as a result of the transfusions in 1988[7]. By way of letter dated December 5, 2005[8] the Administrator denied the claim for the following reasons:

> **Reasons for Decision**
>
> The Settlement Agreement requires the Administrator to determine a person's eligibility for class membership. The Court Approved Protocol ("CAP") for non-prescription IV drug use provides that the Administrator shall weigh the totality of evidence obtained from the additional investigations required by the provisions of the CAP and determine whether, on a balance of probabilities, the HCV Infected Person meets the eligibility criteria.
>
> The Administrator carefully reviewed all the material you provided to support your claim. A Committee reviewed your claim and concluded as follows:
>
> Dr. Hamm, the family doctor who completed the Treating Physician Form indicated that you had used non-prescription IV drugs. You confirmed this information in your Tran 3... and your ORF form.
>
> On March 26, 2004, the Administrator notified you in writing that your claim would be rejected unless you returned the Further

[6] p. 491
[7] pp. 492-495
[8] pp. 3-5

> Evidence of First Infection Form in which you indicate whether you want to provide further evidence which establishes on the balance of probabilities that you were infected for the first time with HCV by a Blood Transfusion received in Canada between January 1, 1986 and July 1, 1990. You submitted an Affidavit dated March 30, 2005 and complete medical records.
>
> In accordance with the CAP, the Administrator has considered all of the evidence submitted, including the opinion of a medical expert experienced in treating and diagnosing HCV and has determined that, on the balance of probabilities, you do not meet the eligibility criteria. The Administrator cannot conclude that you were infected by HCV for the first time by a blood transfusion received in Canada in the Class Period: therefore, and your claim is denied.

[10] An "in-person" hearing was held in Winnipeg on May 5, 2006. At that time, the Claimant confirmed that, although he had initially asked for a review by an "Arbitrator", he preferred to proceed by way of a Reference and the matter went forward on that basis. Carol Miller, RN, Appeal Co-ordinator, who was absent due to illness, testified by speakerphone and the Claimant testified in person. At the conclusion of the hearing, I undertook to request records in respect of the Claimant from two facilities of the Addictions Foundation of Manitoba (AFM) where he testified that he had attended in the 1990s. The matter was adjourned pending receipt of replies and any further submissions that may be required. Ultimately, both facilities advised that they had no records in respect of the Claimant.[9] The Winnipeg office advised that although the AFM computer records go back to 1985, they only contain the client's name and in some instances what program they were in, and that their paper files are shredded after 7 years. They further advised that the Claimant missed 2 scheduled assessment appointments with the Impaired Drivers Program in 1992 and 1993 (although it is not clear why they considered this to be relevant). A subsequent teleconference was held, during which the Claimant expressed his displeasure and frustration with the AFM, as he clearly recalled attending their facilities and even the name of the cook at the Brandon facility. The Claimant requested additional time to attempt to pursue such records and was granted until June 26, 2006 (or further time if he requested it), to provide same. The Claimant telephoned the Referee's office on or about June 26, 2006, leaving a message to the effect that he was unable to produce any further materials regarding his attendances at AFM facilities and was not requesting additional time to continue his efforts in that regard. In the result, the matter will be adjudicated upon based on the documents and testimony provided.

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[9] My letter to the AFM Winnipeg office dated May 6, 2006 and the AFM reply of May 10, 2006, have been marked collectively as Ex. 4, as if they had been tendered at the hearing. My letter to the AFM Brandon office and the AFM reply of May 17, 2006 have been marked collectively as Ex. 5, as if they had been tendered at the hearing.

B. Document Summary

[11] The Claimant was diagnosed as being infected with HCV in May, 2001. Blood bank records from Concordia Hospital in Winnipeg[10] show that on May 25, 1988, the Claimant, then 32 years old, received 2 units of concentrated red cells as a result of back surgery. The CBS Traceback Summary[11] confirms one unit as negative and the other as "donor deceased".

[12] The Claimant's written descriptions of his non-prescription IV drug use, or as attributed to him by others, are summarized below:

(a) In Dr. Hamm's first Tran2[12] (Treating Physician's Form), dated August 27, 2001, non-prescription IV drug use is checked off, again with the contradictory notation later in the form that there was nothing in the Claimant's medical history ... that indicates he has used non-prescription IV drugs at any time.

(b) In his Tran3,[13] sworn January 30, 2002, the Claimant checked off "false" after "4. I declare that .... The HCV Infected Person has never at any time used non-prescription intravenous drugs" (although he did not disclose details of the time, details were not requested in this form);

(c) A report from Dr. Kelly Kaita, a Winnipeg Hepatologist, to Dr. Hamm, dated March 13, 2002[14] states: "Viral Risk Factors: IVDA (age 13 to 1990), snorting cocaine, freebasing cocaine, tattoo (age 18), and blood transfusion recipient (June 1985, May 1988) as a result of back surgery." There is also a reference to alcohol exposure, whereby the Claimant freely admits to being a heavy alcohol user for the previous 20 years, drinking predominantly on weekends. Dr. Kaita did not recommend Rebrotron for the Claimant due in part to excess alcohol use and seizures;

(d) In the ORF Inquiry Form[15] dated March 18, 2002, the Claimant acknowledged non-prescription IV drug use between 1988-1992, "Cocaine", "more than x 30", "NEVER shared needles – not even once";

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[10] pp. 49, 50
[11] pp. 86, 87
[12] pp. 36-40,
[13] pp. 41, 42
[14] pp. 249-250
[15] pp. 59, 60

(e) Dr. Hamm's second Tran2,[16] dated December 23, 2004, states; "Remote history of IV drug use prior to his blood transfusion in 1988;"

(f) In a letter dated February 12, 2005, Dr. Hamm, a specialist in Family Medicine, stated: "At that time (on August 27, 2001, when he completed the first Tran2) I had no knowledge of any past history of non-prescription IVDU. It is only over the following months and years of subsequent care that I provided (Claimant) that I became aware of his past non-prescription IVDU and also his complete addictions treatment and full recovery prior to the time I first met him. Certainly when I first got to know (Claimant) there was nothing in the clinical presentation that made me suspicious of any concurrent prescription or non-prescription drug use or abuse or a lifestyle of risky behaviours. ***It is my opinion that the weight of evidence supports that (Claimant) acquired Hepatitis C from the blood transfusion at Concordia Hospital in May of 1988***. [emphasis added]

(g) In his Affidavit sworn April 1, 2005,[17] the Claimant deposed that he had not used non-prescription IV drugs before his surgery and transfusion of May 25, 1988. He further deposed:

> "I realistically cannot state by calendar when the first time that I used non-prescription intravenous drugs, but I can state to the best of my knowledge that I used between the fall of 1989 and spring of 1994 (when I entered a treatment facility). I started occasionally, then progressed to a weekly basis and then to daily use. All drug paraphernalia was purchased at various pharmacies and all equipment was new and sterile... I have never on any occasion shared any paraphernalia (which includes spoons, filters, water and syringes) with other IV users". There is also reference to a criminal record including 4 impaired driving charges, one charge of cultivation of marijuana and one driving while disqualified, over a 20 year period ending in 2002. [18]
>
> ... I would like to clarify a portion of conversation with Dr. K. Kaita, where we discussed past alcohol and drug use ... it

[16] pp. 102-108
[17] pp. 119-120
[18] In fairness to the Claimant, there was no reference to incarceration, which can be considered a risk factor, especially in federal prisons, where sharing of razors and sharp objects is known to occur.

appears to say that I used alcohol and cocaine from the time I was 13 years old up to 1994, when in fact we were discussing first time use of the above mentioned. Yes I tried alcohol, bud didn't use drugs till much later in my life.... I hope this will clear up the confusion on the time periods.

I would also like to comment on the time periods of IV drug use. As I have stated, it is very difficult to give a specific start date although I am positive that my estimated times are accurate."

(h) Emergency Report Form, Victoria General Hospital, March 28, 1991[19] – following left eye lacerations: the following notation appears: "Admits to previous IV Drug Use (cocaine). Now snorts it."

(i) Emergency Report Form, Victoria General Hospital, Feb. 17, 1994[20] – reviewed for chest pain and seizures - March 28, 1991 – "Admits to occasional IV drug use – last time ~ 5 days ago... track marks to both arms."

[13] Having received and reviewed the foregoing documents, by letter dated September 23, 2005,[21] the Administrator wrote to Dr. Gary Garber, of the Ottawa General Hospital, requesting that he review relevant medical documentation to determine if in his opinion, and on a balance of probabilities, the Claimant meets the eligibility criteria. Dr. Garber's opinion is summarized at paragraphs [7] and [8], *supra*.

C. *VIVA VOCE* EVIDENCE

(a) Evidence of Carol Miller, RN

[14] It was not until early 2004 that the CAP was enacted, so the Centre was unable to take steps to conclude its deliberations before then. Once IVDU has been flagged, which engages the CAP, the Claimant is invited to supply an ORF Form, health records going back over 10 years, a medical history form and an Affidavit Once received, the pertinent records are organized and reviewed for information relevant to HCV, including tests that occurred before HCV was diagnosed. In this case a summary of documents[22] was provided to Garber, as well as the documents themselves. Ms. Miller is part of the IDU Committee at the

[19] Ex. 1, p. 182
[20] Ex. 1, p. 185
[21] Ex. 1, p. 488
[22] Ex. 1, pp. 484-487

Centre (which includes Josee Lynch RN, Director of the Centre, Nancy Killam, RN, Director of Claims and Antonin Fortier (former Armed Forces Medic, Senior Claims Processor). The Committee reviewed the entire file both before and after Dr. Garber's report was received. After receiving Dr. Garber's report, the Committee completed a document dated November 11, 2005[23] that incorporates the criteria of the CAP that require the weighing of factors that are both supportive and non-supportive of the Claimant's position that he was first infected by a blood transfusion. In this case, the only supportive aspect indicated on this form was a "Hep C Surface antibody positive in 2001 unknown year of contact". After undertaking this analysis, the Committee concluded that a review of the evidence did not establish, on a balance of probabilities, that the Claimant was first infected by a Blood transfusion during the Class period.

[15] Responding to questions from the Referee, Ms. Miller indicated that the risk factor associated with intranasal drug use relates to nose bleeds that are particularly associated with irritation and dryness caused by cocaine snorting. Sharing straws can result in the mixing of the blood of one person with that of another. In this case, the Committee was mainly relying on the IVDU issue, not tattoos. If the tattoos were the only risk factor, it is unlikely that the claim would have been denied. The criminal record supplied by the Claimant in his Affidavit was not considered relevant in the sense that there was no incarceration shown. However, the marijuana conviction is a factor that was considered, simply because it was a drug-related offence and therefore peripherally relevant to the Claimant's drug history. Although the CAP allows the Administrator to conduct interviews of anyone with knowledge of a claimant's drug history, where the claimant is alive, typically the information is gathered from the Claimant, in the form or records and an Affidavit. If further information is needed, normally the Centre requests the claimant to provide it. There are circumstances where the Administrator concludes that notwithstanding IVDU before a transfusion, a claimant can be brought within the Plan, for example where the evidence of disease progression supports a claimant's position. However, in this case, Dr. Garber's opinion, particularly on the subject of disease progression, did not support the Claimant's submission.

(b) Claimant's Evidence

[16] In terms of surgical history, there was a spinal fusion in July, 1985 and a further spinal fusion in May, 1988, during which he received blood. The Claimant has also undergone Myelograms (involving the injection of a special dye into the subarachnoid space) in 1980, 1981, 1985 and 1992. He had both an appendectomy and a Discase injection in 1982. He quit smoking marijuana when he was 15, although he cultivated it for profit later in life. He has enjoyed

[23] Ex. 1, pp. 492-495

drinking beer. He did not use Cocaine when he was growing up in Thompson, where it was not available. He left Thompson at age 32. Cocaine became the drug of choice largely due to back pain he experienced as a result of his work as a long distance trucker. He started with inhalation, then progressed to injection and ultimately freebasing.[24] He had money from trucking and cash from accident claims, so was able to afford cocaine. When he did start using cocaine intravenously, he was taught how to inject safely by someone with a medical background. She stayed with him on that occasion. He used rubbing alcohol, Dettol and sterile insulin syringes from a pharmacist. He never used the needle exchange program as he always had money to buy them from pharmacists. Paraphernalia included spoons for mixing, a water glass, a medium to filter impurities from water, straws or a piece of a pen, or a rolled up bill for snorting. There were times where someone passed bills around and he saw blood on the ends of these and did not want to use them. He only inhaled over a short period. He was more of a closet addict. People did not know he was in trouble because he was usually alone when he used it. When there were other people there, they were not IV drug users, but they did snort or freebase. Once one starts freebasing, ones usually does not go back to the other forms of ingestion, as freebasing gives the most intense high. Friends stopped coming over as they did not want to see him when he was a user. He only stopped using cocaine after he started having seizures, when he knew he had to quit. He did not start either drinking or snorting when he was 13, as Dr. Kaita reported, although he may have had a beer. On his ORF Form[25] he states 1988 as the year he starting cocaine use, both intra-nasally and IV and 1992 as the end date. He was 32 at the time he started. He can pinpoint 1988 as the start date because he moved from Thompson to Winnipeg in May, 1988, just before his surgery. He is not confident on the end date, which he listed as 1992, as he believes this may have continued until as late as 1994, when he thinks he attended the AFM treatment facility in Brandon. He also attended shortly before Brandon at an AFM treatment facility in Winnipeg. He began drinking beer heavily when he was 15 or 16 and this has remained an issue for him throughout his life since, and he is "a raging alcoholic", despite attempts to quit. His drinking has escalated considerably since he gave up cocaine. He can easily drink 24 beers on a summer day.

[17] In cross-examination, the Claimant acknowledged:

- Dr. Hamm moved in 2004 or 2005 and stopped being the Claimant's physician at that time.
- In the ORF form he said the cocaine use was from 1988-1992 whereas in his Affidavit he stated that he started in 1989. Dr.

[24] Freebasing is a heating process with baking soda that reduces impurities, leaving an absolutely pure chunk of product that is not injected but is smoked. This is particularly dangerous.
[25] pp. 60

Hamm's second Tran2 showed the Claimant's verbal report of first drug use prior to 1988, but the Claimant says this was in error.

- Dr. Hamm's letter of February 12, 2005,[26] in which he opined that the Claimant acquired HCV from the 1988 transfusion, was based on the Claimant having told him that he always used sterile needles and paraphernalia and did not share.
- Dr. Kaita was also in error when he wrote that the Claimant reported IVDA from age 13 to 1990[27]. He was wrong on both dates. The Claimant tried to get this confusion sorted out, but it was next to impossible to get through to Dr. Kaita. The Claimant thinks Dr. Kaita probably confused age 13 as the time the Claimant first tried beer or marijuana, not cocaine.
- The Claimant told Dr. Kaita that he also had a transfusion in 1985, which the Claimant later learned was incorrect. The only transfusion he received was in 1988.
- While he thought he stopped using IV cocaine in 1992, having reviewed the ER record from February 1994,[28] it is now absolutely clear to him that he was continuing to use at that time, to the point of causing track marks to both arms. He thought he was having a heart attack and shortly after that stopped IV usage.
- When he was using Cocaine IV, this was usually daily. He used the same syringe a maximum of twice, as he has thick skin and the needles became dull after that.
- The Claimant lived alone from 1988-1994.
- Other than spending the odd night in the drunk tank, he has never been incarcerated.
- The last time he stopped using IV cocaine, he quit without the assistance of rehab, and simply had to disassociate himself from his supplier.

D. ANALYSIS

[18] The Claimant is understandably concerned that the second unit of blood could not be tested and is unquestionably convinced that he contracted HCV from the unit that could not be tested. However, the Plan and CAP require more than a Claimant's honest conviction to meet the burden upon him. in this case, even if the Claimant had clear evidence that this unit had been traced back to a donor who had tested HCV positive, his history of non-prescription IV drug use changes the way his claim is dealt with and necessarily takes the Administrator down a certain path. In other words, a proven transfusion coupled with a positive traceback in these

[26] p. 121
[27] Ex. 1, p. 250
[28] Ex. 1, p. 185

circumstances would only be one factor in the Claimant's favour, to be weighed against the totality of the evidence, bearing in mind that given the circumstances, the Claimant now bears the burden of proof in this respect.

[19] Fund Counsel relies on Section 3.01 (1) (a) of the Plan text:

> **ARTICLE THREE**
> **REQUIRED PROOF FOR COMPENSATION**
>
> **3.01 Claim by Primarily-Infected Person**
>
> (1) A person claiming to be a Primarily-Infected Person must deliver to the Administrator…
>
> (a) medical, clinical, laboratory, hospital, The Canadian Red Cross Society, Canadian Blood Services or Hema-Quebec records demonstrating that the claimant received a Blood transfusion in Canada during the Class Period:
>
> (b) an HCV Antibody Test report, PCR Test report or similar test report pertaining to the claimant;
>
> (c) ***a statutory declaration of the claimant including a declaration* (i) *that he… has never used non-prescription intravenous drugs***, (ii) to the best of his… knowledge, information and belief, that he …was not infected with Hepatitis Non-A Non-B or HCV prior to 1 January, 1986, (iii) as to where the claimant first received the blood transfusion in Canada during the Class Period, and (iv) as to the place of residence of the claimant, both when he…first received a Blood transfusion in Canada during the Class Period and at the time of delivery of the application hereunder…. [emphasis added]

[20] In light of the Claimant's admitted non-prescription IV drug use, this case substantially turns on the issue of whether or not the Claimant has met the burden imposed upon him by the "notwithstanding" provisions of Section 3.01 (3) of the Plan, which states:

> 3.01(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… must deliver to the Administrator other evidence establishing 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.*.** [emphasis added]

[21] 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 and Section 3.01(3) of the Plan text, *supra*.

[22] The CAP dealing with Non-Prescription IV Drug Use sets out the mechanics as to how Section 3.01(3) of the Plan is in practice to be applied. This CAP is in conformity with the Plan, although in fairness to the Claimant, did not exist at that time his application was filed. Portions that are of particular relevance to this case provide:

> **Applicability of CAP**
>
> 1. This CAP applies where:
> a. there is an admission that the HCV Infected Person used non prescription intravenous drugs;...
>
> **Eligibility Criteria Where this Cap Applies**
>
> 2. The Administrator must be satisfied on the balance of probabilities: ...
>
> 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...
>
> 3. The burden to prove eligibility (where this CAP applies) 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**
>
> ...
>
> 5. If the Traceback CAP does not apply, the Administrator shall perform the additional investigations required by paragraph 8 below....
>
> 7. The Administrator may not accept a claim based on the results of the traceback investigation without performing the additional investigations required by ... 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 the 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 ... 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.

9. The Administrator shall weigh the totality of evidence obtained including the evidence obtained from the additional investigations required by ... 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 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. ...medical and clinical records ....

c. The donation history, transmissible disease information ...

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 of occasions and time period during which the HCV Infected Person used non-prescription intravenous drugs;

e. a consent to conduct a criminal records search ...

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. [Here the CAP sets out a list of criteria to be considered, which is mirrored in the IDU Committee Review form]

[23] Here the Administrator did what it was directed to do by the terms of the CAP. The IDU Committee appears to have carefully followed the provisions of the CAP. It did not simply make a mathematical calculation, but rather conducted a careful balancing of the totality of the available evidence. Clearly the Committee was concerned with the inconsistencies in the Claimant's various reports as to the timetable and extent of his IV drug use. Further, the Committee appears to have placed considerable reliance on Dr. Garber's report, which it was entitled to do under the terms of the Plan and the CAP.

[24] Even if the one unit in question could have been traced back to a positive donor, while this would have been one factor to consider, it would still have been necessary to also consider the other factors. In this case the medical evidence tends to suggest an alternative source of infection other than transfusion. The timing of the disease progression, as identified by Dr. Garber, was clearly an important factor that informed the Administrator's decision. The Administrator can be guided by disease progression in determining both the source and timing of infection. Because the diagnosis of HCV was only made in 2001, the only certainty is that the Claimant was infected at some point before 2001. This therefore reduces the issue to a consideration of possibilities and probabilities.

[25] There is no question that it is ***possible*** that the Claimant's infection originated from the single unit of blood transfused in 1998. However, that is not the test under the Plan or the CAP.

[26] In terms of ***probabilities***, it becomes necessary to consider both the 1988 transfusion and the admitted IV non-prescription drug use from at least (even if one disregards Dr. Kaita's notes about the Claimant starting IV drug use at age 13) 1988 to 1994. Over this 6 year period, the Claimant acknowledged that he quickly escalated from snorting to IV use. As IV use was often on a daily basis, it is reasonable to infer that hundreds, if not thousands of needles were used over this period. While I accept without

hesitation that the Claimant's evidence was given truthfully, I do have significant concerns as to its reliability. The Claimant firmly believes he did not share needles. However, with an addiction as prolonged and significant as this, coupled with the affects to both judgment and memory that may be associated with cocaine use, it is not difficult to see how the Claimant could be mistaken in his recollections. These concerns relate to the extent of the use, the dates of use and the circumstances surrounding the use. The same can be said about the snorting of cocaine, in terms of the Claimant's good faith recollection that there was no sharing of paraphernalia. While the Claimant was unable to obtain support for his position from the rehab facilities he attended, I do not draw any adverse inferences from this. I do not believe he would have caused me to embark upon a futile exercise in attempting to obtain these records and have no doubt that his testimony was honest in this respect and others.

[27] While there are clearly several important unexplained contradictions in the timing of the Claimant's IV drug use and rehab that are not easily reconciled, of most importance is the evidence of disease progression outlined by Dr. Garber, which points to the probability of a more recent infection. Dr. Garber would have expected to have seen a higher grade of fibrosis in 2001 in an individual who was infected 13-14 years previous. Dr. Garber's opinion in that regard may be understated, as he was not aware of the extent of the Claimant's alcohol intake, which came out in his testimony.

[28] Dr. Kaita, Hepatologist, did not provide anything to assist the Claimant and his notes of the Claimant's history only serve to exacerbate the issues related to reliability that have been summarized earlier. Unfortunately for the Claimant, the report of Dr. Hamm also does not assist, for several reasons. First, Dr. Hamm, while no doubt well qualified in the field of Family Medicine, is not an expert in HCV. Second, unlike Dr. Garber's opinion, Dr. Hamm does not offer any explanation or support for his opinion that the "weight of the evidence supports that the Claimant acquired HCV from the blood transfusion ... in May of 1988." Third, and perhaps most important, a good deal of caution is warranted in considering Dr. Hamm's report, as it appears to have been be derived completely from information imparted to him by the Claimant , who it seems, only gradually becoming more forthcoming with Dr. Hamm. In the end, there is good reason to be concerned that Dr. Hamm did not have a full grasp on the nature and extent of the Claimant's cocaine addiction and usage. In all the circumstances, Dr. Garber's opinion is entitled to considerable weight. The report of Dr. Hamm does not rise to the level of meaningfully contradicting Dr. Garber and in the final analysis, fails to assist the Claimant in meeting the burden placed upon him by the Plan and the CAP.

[29] In the circumstances, I am unable to find that the Administrator has failed to properly apply the terms of the Plan and the CAP to these facts. Further, I find that the Claimant has failed to meet the burden upon him to establish that he was probably infected with HCV for the first time as a result of a 1986 Blood transfusion.

[30] The appeal must therefore fail. The Claimant is not entitled to receive compensation. The Administrator has an obligation to assess each claim and determine whether or not the required proof for compensation exists. The Administrator has no discretion to allow compensation where the required proof does not exist. The financial sufficiency of the Fund depends upon the Administrator properly scrutinizing each claim and determining whether the Claimant qualifies. A Referee similarly has no jurisdiction to alter, enlarge or disregard the terms of the Settlement Agreement or Plan.

D. Decision

[31] Upon careful consideration of the Settlement Agreement, Plan, CAP and documentary evidence tendered, the Administrator's denial of the Claimant's application for compensation is hereby upheld.

[32] In closing, I wish to make it clear that I found the Claimant to be a most honourable and impressive witness. He did not mince words and was most forthcoming in the description of his addictions and the way he has dealt with them. He is to be commended for the positive role he now takes in this regard, as he always takes the time to try to convince anyone who is considering it, not to use cocaine. It is my sincere hope that the strength he showed in overcoming his cocaine addiction will inspire him in battling the addiction to alcohol that he is contending with.

[33] I would like to express my appreciation to Ms. Miller and Mr. Callaghan for their assistance and courtesy throughout.

Dated at Saskatoon, Saskatchewan, this 13th day of July 2006.

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

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