IN THE MATTER OF HEPATITIS C – CLASS ACTION SETTLEMENT 1986-1990

CLAIM FILE NO. 17773

REFEREE

Gerald J. Charney, Q.C.

APPEARANCES FOR THE ADMINISTRATOR

Carol Miller – Hep C Claims Centre
Belinda Blain - Counsel

APPEARANCES FOR THE CLAIMANT

Claimant

DECISION

The claimant has filed a claim for compensation under the HCV Transfused Plan (the "Plan") as a Primarily-Infected Person. His claim was denied on the basis that he did not receive a blood transfusion within the Class Period. The Class Period is January 1, 1986 to July 1990.

On August 13, 1988 the claimant was admitted to the McKellar General Hospital, now known as the Thunder Bay Regional Hospital, for treatment in connection with lacerations to his arms. The claimant said in his evidence that the doctor told him that he had received seven units of blood. He never saw the blood or the transfusion that he said he received.

Hospitals have merged since then and a number of his records have been thrown out however, no blood services chart was destroyed and the blood bank records are intact. Those records have been provided. In addition, there was a pre-operations report, and a post-operations report by Dr. Sewell the surgeon. The clinic that he attended has also thrown out his records since it is more than ten years. There are no other records.

The claimant testified that some glass cut his left arm when he smashed a window and the arm was stuck and he had a big gash. He said he lost a lot of blood and they put a restraint on him in the ambulance. He said it was a tourniquet. He thought his arm would come off but Dr. Sewell came in the next morning and said he could save the arm. He left the tourniquet on and he got very cold.

He woke up the next day and Dr. Sewell talked to him and he said he told him that he had seven units of blood transfused. He had 300 stitches in the hospital and he was there for 12 days.

The claimant was 27 when it happened and he started getting sick when he was 43 years old. He has level 3 Hep C. He started using drugs, morphine for pain. He was injecting for one year prior to going on methadone. He also used cocaine and morphine. He started methadone in 2007.

His evidence is that his pain started in 2003 and describes to some extent the nature of his illness.

It should be pointed out that there is no issue that the claimant has Hepatitis C or that his level is level 3.

The information he has from Dr. Sewell about his transfusion is that he said Dr. Sewell in casual conversation, told him about this. There is a letter saying that he had in fact prepared six units of blood.

The hearing in this matter had been scheduled for November 21, 2011 and it was adjourned in an attempt to determine if additional medical records might exist from any of the McKellar General Hospital, the Spence Clinic (where Dr. Sewell practiced), Dr. John Michael Hargadon and the Ministry of Community and Social Services. Summonses were delivered seeking any additional records which might exist. By way of letter dated March 26, 2012, John Callaghan, Fund Counsel, confirmed that each of these parties had advised that no further records existed.

Carol Miller, the nurse who is involved in all of these Hepatitis C cases, gave evidence that the hospital records are his patient records and blood bank records is

blood that is used. Their procedure is as follows, step 1 they test the blood and put it aside, they match it and two staff members deal with it. Her evidence is that records are available that would show if he had received a transfusion. It is not unusual to put blood aside and not use it. She also stated that his consultation with Dr. Sewell was at 10:40 a.m. and the accident happened at 8 p.m. the night before, they could not have had a tourniquet on for all that period, though it could have been a pressure bandage.

On May 7, 2010 Janet Sharun of Thunder Bay Regional Health Science Centre completed a hospital record confirmation form confirming that blood bank records were available from McKellar Hospital starting in 1986 and that these records had been searched and there was no record of a transfusion or blood work done to the claimant. The patient chart relating to the claimant is no longer available.

There are records now available from the Ministry of Community and Social Services relating to the claimant. There is a one page typewritten consultation record from Dr. Sewell, dated August 13, 1988, also patient record notes that the claimant was admitted on August 13, 1988 in the emergency department having cut both cubital fossas (inside his elbows) on a glass window. It was suspected that he had lacerated his radial nerve. Dr. Sewell indicated that the claimant should be seen in the operating room to address his wounds, and stated, in the last paragraph of his Consultation Record, "I suggested that we type him for six units of blood and he should get polio, and 1 gram of Ancet IV stat". (emphasis added)

Carol Miller stated a "type and crossmatch" is a procedure in which blood of the same blood type as the patient is requested and saved in the hospital blood bank, in the event that it may be needed for a transfusion. However, not all blood that is typed and

crossmatched is in fact transfused. It is not uncommon for blood which has been typed and crossmatched never to be transfused. As a result, the notation within Dr. Sewell's Consultation Record suggesting that the claimant be "typed for six units of blood" does not establish that the claimant was in fact transfused with six units of blood. It simply demonstrates that, at the time he prepared the Consultation Record, Dr. Sewell believed it wise to have blood available, in the event it should become necessary in connection with the upcoming surgery.

The MCSS file also contains a two page type-written Operation and Operative Findings in Detail report (MCSS File, pages 105 and 106) concerning the surgery conducted by Dr. Sewell on August 13, 1988. There is no mention in this report of any significant blood loss during surgery, or of any blood being ordered for or transfused to the claimant.

Dr. Sewell is now deceased.

There is no mention of any of the medical records available of the claimant receiving a blood transfusion within the class period.

The claimant is entitled to compensation if he can fit within the settlement agreement reached in the Hep C Class Action.

Section 3.01 of the Settlement Agreement provides 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, 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 or she has never used non-prescription intravenous drugs,
(ii) to the best of his or her knowledge, information and belief, t 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.

2. Notwithstanding the provisions of Section 3.01(1)(a), **if a claimant cannot comply with the provisions of Section 3.01(1)(a), 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 received a Blood transfusion in Canada during the Class Period.** (emphasis mine)

The only evidence that the claimant received any blood was a purported conversation he had off hand with Dr. Sewell. He never saw any blood being delivered to him. The blood bank records show that blood was in fact prepared and I accept the evidence of Carol Miller that preparation of blood is not an indication that blood was finally transfused to the patient. Secondly, blood bank records would show, in these circumstances it seems to me, if blood was actually delivered to the patient. There is no such record.

There is neither direct evidence of any blood being transfused to the patient, nor, in any event, is there any corroboration as required by the Settlement.

In result then, the claim is dismissed and the administrator's decision is upheld.

DATED at Toronto, this 12th day of September, 2013.

G. Charney

Gerald J. Charney, Referee