CLAIM # 70124

Province of Infection: (Province)
Province of Residence:(Province)

IN THE MATTER OF A REFERENCE
TO REVIEW THE DECISION OF THE ADMINISTRATOR

BEFORE: Tatiana Wacyk

SUBMISSIONS: Claimant
John Callaghan for the Fund

Decision

1. The Estate of the Deceased, (the "Estate"), represented by the Deceased's son, submitted an application for compensation under the 1986-1990 Hepatitis C Settlement Agreement (the "8690 Program").

2. The Deceased was born in 19XX and died 20XX. The Medical certificate of death states the immediate cause of death was cardiac arrest, with terminal hepatic failure as the antecedent cause.

3. The Deceased was diagnosed in 19XX as infected with Hepatitis C.

4. As the application missed the deadline to apply for such compensation, the Estate was required to obtain an order to permit a late claim. On April 17, 2018, Referee Devins permitted the claim to proceed. In her order she stated:

> I have only decided that an application form to file a Late Claim should be issued Claimant 70124: . I have not considered whether the Estate is eligible to receive compensation, that decision will be made by the Administrator upon receiving and reviewing the Late Claim Application Form with the required supporting documents.

5. By letter dated August 20, 2019, the Administrator denied the claim on the basis there was insufficient evidence to support the claim that the Deceased "received Blood (Transfused) during the Class Period." i.e. between January 1, 1986 and July 1, 1990.

6. The Estate requested that a Referee review the Decision of the Administrator.

7. On agreement of the parties, their submissions were made in writing. The Estate was represented by counsel for its Reply Submission.

8. In addition, viva voce evidence was heard from Dr. X, the Decease's Family Physician, and Dr. G Specialist in Internal Medicine and Infectious Diseases.

BACKGROUND:

Ontario Hepatitis C Assistance Plan (OHCAP) – Application by Deceased

9. OHCAP provides compensation for persons who contracted Hepatitis C through the blood system in Ontario prior to January 1, 1986, or between July 2, 1990 and September 28, 1998 i.e. outside of the class period at issue in this Reference.

10. The Deceased made a claim to the OHCAP program on December 16, 19XX.

11. The Deceased's OHCAP file, requested and received by the Administrator, reveals the following.

12. In his OHCAP application the Deceased was asked:

> Did you receive a transfusion in Ontario during any of the following time period(s)". The choices are:
>
> "on or before December 31, 1985"; "January 1, 1986 – July 1, 1990" or "July 2, 1990 – September 28, 1998" and "all".

The Deceased placed an "x" only in the box indicating "*on or before December 31, 1985*".

13. The "Physician Form" for OHCAP, also dated December 16, 1998, and bearing the signature of Dr.X, the Deceased's Family Physician, expressly asks:

> Did applicant receive a transfusion in Ontario during any or all of the following time period(s)". It offers options "on or before December 31, 1985"; "January 1, 1986 – July 1, 1990" or "July 2, 1990 - September 28, 1998" and "all".

The only option selected is "on or before December 31, 1985".

14. An additional entry on the Physician Form indicates the Deceased was transfused at the X General Hospital due to "Surgery Post M.I. (anemia)". Presumably, the M.I. refers to a myocardial infarction, i.e. heart attack.

15. The following was entered under "Other Comments":

> Routine Blood Work picked up [elevated] Liver Enzymes Further Testing > Dx of Hep. "C".

16. In May 1999, as part of the OHCAP process, the Deceased provided a written statement asserting "the only time" he received a blood transfusion "of any kind", was at the X General Hospital in 195X, after a 70 foot fall. He also describes the surgery he underwent to save his leg.

17. An OHCAP Investigating Nurse interviewed the Deceased on February 5, 199X. During that interview the Deceased again indicated that his transfusion occurred in 195X at the X General Hospital. During that interview it was also noted "both claimant & wife remember the need to find friends to donate blood to replace the blood that that the claimant received from Red Cross".

18. This interview was followed by a letter to OHCAP from the Deceased's wife, in which she stated: "I know [the Deceased] received blood because I had to find blood donors to replace the blood used on the blood transfusion he had".

19. The Deceased was again interviewed, by an OHCAP Investigating Nurse on May 18, 199X. Notes from that interview indicate the Deceased again confirmed he was transfused in 195X at The X General Hospital, and that the need for a transfusion resulted from surgery following a work-related 70 foot fall. The Deceased again referred to the need to find friends to donate blood.

20. In response to an OHCAP "Request for Records Search", the Ministry of Health indicated that while documentation of the Deceased's hospital admission to the X General Hospital in 198X existed, but there was no record of a transfusion during that admission, or any other time.

21. OHCAP also requested a search of the X General Hospital records. The X General Hospital responded that there was no record of the 195X incident but there was

a record of the 198X stay. However, there was no record of a transfusion during this admission. It also indicated there was no other documentation of transfusion.

22. In May 199X, OHCAP granted benefits to the Deceased, on the basis the information regarding the extent of his 195X surgery was "consistent with likelihood of transfusion".

Ontario Hepatitis C Assistance Plan (OHCAP) – Application By Estate

23. A subsequent application for OHCAP benefits was brought by the Estate in 200X.

24. That claim was rejected in correspondence dated January 6, 201X, because the stated transfusion date in that instance i.e. 198X, fell outside the OHCAP period. Specifically, the rejection letter stated:

> When you completed the Form 5 — Transfusion History Form you indicated the Primarily-Infected Person was transfused at the X General Hospital in 198X. As noted previously if transfusions were received between January 1, 1986 and July 1, 1990 the Estate is not eligible for compensation under this plan and the claim must be rejected as it does not meet the Criteria for The Pre 1986/ Post 1990 Hepatitis C Program. It is recommended that you contact The 1986-1990 Hepatitis C Settlement Plan regarding applying for compensation under that Agreement.
> (1-877-434-0944).

Application for Compensation Pursuant to the 8690 Program

Application and Accompanying Documents

25. The Estate, in its Application to the 8690 Program, asserts the Deceased was transfused within the Class Period of January 1, 1986 – July 1, 1990. Specifically, it asserts he was transfused at the X General Hospital in 198X.

26. Two Forms accompanied the application filed under the 8690 Program. Neither Form is used by the 8690 Program. Rather, it appears these forms are used by OHCAP as they refer to "the Class period" being "before January 1, 1986 or between July 2, 1990 and September 28, 1998, which is consistent with the OHCAP period.

27. Indeed, it appears these documents were submitted as part of the Estate's OHCAP application in 2009, referred to above.

28. The Form titled "Blood Transfusion History" is dated November 1, 2009 and is signed by Dr.X. For the period "Between January 1, 1986 and July 1, 1990" the date of "Oct'8X" is entered, with an indication that 4 units of blood were transfused at the X General Hospital. The medical condition which led to the Blood Transfusion is identified as: "Surgery – Post Op Bleed".

29. Despite the direction on the Blood Transfusion History to include information concerning all blood transfusions received in Canada at any time, there is no entry for the period "Before January 1, 1986", the transfusion to which Dr. X had attested in the Physician Form he completed in 199X, referred to above.

30. The Form titled "Schedule B (and/or Section D – Declarations" depending on the version) is also dated November 1, 200X, and is also signed by Dr. X.

31. Schedule B asks that the signatory confirm whether the following is True or False:

> 2. I declare that to the best of my knowledge, information and belief that the Primary-infected Class Member was infected with HCV during the Class period (***before January 1, 1986 or between July 2, 1990 and September 28, 1998***). [Emphasis added]

The answer "True" is selected.

32. In addition, the underlined information was added, in the following paragraphs:

> 4. I declare that to the best of my knowledge, information and belief the place of residence of the Primarily-Infected Class Member at the time when he or she first received Blood in Canada during the Class Period (***before January 1, 1986 or between July 2, 1990 and September 28, 1998***) was: [Emphasis added]

> 5. I declare that to the best of my knowledge, information and belief the place the Primary-infected Class Member first received Blood in Canada during the Class period (***before January 1, 1986 or between July 2, 1990 and September 28, 1998***)

was: [Emphasis added]

City X GEN'L HOSP

33. Despite the instruction on the Form that the Declarant is to sign the Declaration "ONLY" in the presence of a Commissioner of Oaths, Dr. X has signed in the area reserved for a Commissioner of Oaths, and affixed his stamp. It appears the document was never sworn before a Commissioner of Oaths as required.

34. In accordance with the applicable traceback protocols, the Administrator conducted a traceback with Canadian Blood Services ("CBS") for any transfusion received by the Deceased at the X General Hospital during the 1986-1990 period. The X General Hospital site of the United Health Network responded that it searched its blood bank and hospital records for that period, and confirmed it had records for the Deceased. It included a reference to the Deceased by both his legal name as well as with his middle name transposed with his first. However, while there was a record of an admission in 199X, there was no record of a blood transfusion on that or any other date.

35. Specifically, UNH - XGH stated:

> Comments: Admission 199X – No transfusion, all results previously reported to OHCAP from 1999 Traceback request. [see paragraphs 19 & 20 above]
>
> …
>
> **Results of Search: Patient record is available – patient was Not Transfused.**
>
> **Comments: Patient Name listed as [Deceased]** [emphasis in original]

36. Also on file was correspondence dated June 13, 199X, from Dr. C who appears to be a surgeon practicing in (City), to Dr.X

> This sixty year old man apparently has been found to have hepatitis C and has an enlarged liver. He has not felt sick in anyway however and is quite active in terms of work around the house and he manages an apartment building. His appetite has always been quite good and he has no jaundice. **He apparently had hepatitis thirty years ago** and two months later after getting active too soon had a relapse so that he was probably sick for six months altogether at that time. He recovered however and has been well ever since. … [emphasis added]

Dr. C then indicates he will arrange for a liver biopsy.

37. In December 200X, the Deceased executed his Will before a lawyer. The relevance of this detail will be addressed below.

38. On August 20, 2019 the Administrator for the Compensation Fund of the 8690 Program denied the application as follows:

> You submitted a Transfusion History Form where you indicated the HCV infected person was transfused at the X General Hospital in October of 198X. Canadian Blood services conducted a records search for UHN — X General Site 1985 to 1989. Records were available for the 1997 admission and the HCV infected person was not transfused. Based on this information your claim must be denied based on Article 3.01 (1a) of the1986-1990 Hepatitis C Settlement Agreement, Transfused Plan; because there is no evidence to support that the HCV infected person received a Blood transfusion between January 1, 1986 and July 1, 1990.

ADDITIONAL DOCUMENTS FILED ON APPEAL:

39. For this appeal, the Executor submitted the following new documents.

Affidavit of Dr.X, dated September 18, 2019

40. In this Affidavit, Dr. X indicates he practiced in (City)for many years but retired in 201X.

41. He indicates he was the Decease's doctor from 1981 until his death.

42. Dr.X also states the Deceased was admitted to hospital in October 198X for an unknown emergency surgery and received 3 units of blood.

43. In addition, he indicates the Deceased had an unexpected illness that led to a liver biopsy in 199X at which time he was diagnosed with Hepatitis C.

44. Dr. X goes indicates he transferred his practice and records in 201X to a new Doctor.

Correspondence from Dr. Ashley X-3, dated September 12, 2019

45. Dr. Co took over Dr. X's practice when he retired in 2015. In her correspondence, she confirmed Dr. X's records for the Deceased had been destroyed.

Affidavit of Dr. X, dated January 6, 2020

46. In this Affidavit, Dr.X confirmed the contents of his prior Affidavit, dated September 18, 2019 (referenced above), and indicated he was responding to issues raised by Fund Counsel in the context of this Reference.

47. Dr. X states the Deceased was never diagnosed with Non-Hepatitis A or B in the years prior to his diagnosis in 199X.

48. Dr. X also states the Decease advised him in various medical checkups, that the blood transfusion resulting from the Deceased's workplace accident occurred in 195X not 195X, and he believes this to be the case.

49. Dr. X also states the Deceased indicated he received blood donations in association with the 195X surgery from family members, and that he has been advised by the Deceased's son and Executor of the Estate, that all died subsequent to the Deceased. Further Dr. X indicates he has been advised and believes none of the family blood donors died of any form of liver illness, and specifically did not die of Non-Hepatitis A or B, otherwise and later known as Hepatitis C.

50. Dr. X further indicates the Deceased suffered from dementia, which resulted in the cancellation of his Driver's License in the summer of 199X.

[A copy of the Deceased's Driver's License was also filed and appears to carry a sticker notation stating: "Valid Photo Card Only"].

51. Dr. X goes on to state the Deceased's son and Executor of the Estate has advised him, and he believes, the handwriting on the "OHCAP form" is that of the Deceased.[This appears to refer to the OHCAP Physician Form dated December 16, 199X, referenced in paragraphs 13 - 15]

52. Accordingly, Dr. X indicates the selection of the timeline for his blood transfusion as "on or before December 31, 1985" was made on the Form by the Deceased. Dr. X concedes, however, that response is correct, in that the Deceased had a blood transfusion in 195X resulting from his workplace injury.

53. However, Dr. X maintains that by December 199X, the Deceased was in the advanced stages of dementia and not mentally capable of understanding the context of the questions.

54. Dr. X then goes on to indicate he has no recollection "of this form", and asserts that his written submission of November 1, 200X, (which I understand to be a reference to the Schedule B/and or the Transfusion Record of the same date) and his Affidavit of September 10, 2019 [sic] [September 18] remain as his evidence that the source of the Deceased's Hepatitis C was a surgical procedure in October 198X.
[However, it should be noted that while Dr. X indicates the Deceased received a transfusion in 198X in his earlier Affidavit, he does not expressly identify it as the source of his Hepatitis C. Further, Schedule B, which Dr. X signed, indicates the Deceased was infected with Hepatitis C from a transfusion which occurred "before January 1, 1986 or between July 2, 1990 and September 28, 1998" – not during the class period for the 8690 Program]

55. Dr. X indicates the October 198X blood transfusion was confirmed to him by way of transfer of copies of the Deceased's medical records identifying that he had received two units of blood for a medical procedure at the X General Hospital.

56. Dr. X indicates the Deceased remained in his care up to the time of his death on June X, 200X, and that he had full knowledge of the Deceased's medical condition.

Communication from University Health Network ("UHN") Health Records Services

57. The UHN, in a communication dated August 2, 201**X,** responded to the Executor's request for health records regarding the Deceased.

58. The following appears at the end of the list of requirements to initiate a records search:

> As allowed under the Public Hospitals Act, patient records can be destroyed, because more than ten years has elapsed since the patient was discharged.

59. This is followed by:

> **Additional Notes:**
>
> We have been unable to locate any record of the above patient being seen in the 1950's nor the 1980's.

60. Further, in an e-mail dated March 21, 2019 the "Release of Information Specialist for Health Records Services" for the UHN, stated:

> We do not have any records for [the Deceased] from 198X. As per the Public Hospitals Act we are only required to keep records for 10 years.

61. During the course of this Appeal, additional summons were issued to UHN, as well as the XX General Hospital.

62. The disclosure from the XX General Hospital, indicated the Deceased was admitted on November 13, 198X following an "episode of collapse". He was assessed on November 14, 198X by Dr. Sa who noted under "Past History: He also had hepatitis with jaundice 20 years ago".

63. The record also describes the Deceased’s 70 foot fall in the 1950s.

64. The Deceased then attended at the X General Hospital on November 24, 198X for further consultation with neurology and remained two days for observation.

65. The X General Hospital records state, under “History”:

His past health revealed that he had jaundice and **hepatitis** 20 years ago and an appendectomy and hernia repair. [emphasis added].

66. Under the Heading “History Sheet”, the X General Hospital records also state: Hepatitis & Jaundice – 20 yrs ago.

67. The X General Hospital records also showed the Deceased was tested for Hepatitis B with a negative result.

68. There were further records from a 199X visit to the X General Hospital, at which time the Deceased was seen by Dr. S, a Hepatologist. In correspondence dated April 23, 199, Dr. S references the Deceased’s Hepatitis C and indicates "The likely etiology was blood transfusions associated with surgery after trauma 42 years ago".

69. Dr. S notes as well, that the Deceased had a history of hepatitis and suggests this was likely Hepatitis A with which his son was infected at the time (about 30 years earlier). Dr. S makes no mention of any transfusion in 198X.

70. The XX General Hospital records include attendances in 200X-200X. By this time, the Deceased was suffering from renal failure, and Dr. X requested a consultation.

71. In his consultation request of May 23, 200X, Dr. X described the reason for the consultation as “terminal hep failure [indecipherable] Hep C of 30 – 40 yrs”.

72. Another hospital note, dated May 23, 200X, stated: "Hep C contracted from blood transfusions received after sustained a fall many years ago".

73. Yet another, undated, document indicates the Deceased contracted Hepatitis C as a result of "Accident fall 70 ft-45 yrs ago...had blood transfusion".

74. Still another, also undated document, in the category of "Previous Blood Transfusions" only indicates "45 yrs ago [with] fall and 1 year previous with TIA?[Stroke] Confused ? Under "Adverse reactions describe" is noted: Believes he contracted Hep C from this.

75. Finally, Dr.X' Discharge Summary from the XX General Hospital, following the Deceased's death in 200X, refers to the Deceased contracting Hepatitis C "during routine surgery" at the XGH "many years ago" for which he was receiving compensation from the Provincial Government's Compensation Program for the victims of Hepatitis C.

VIVA VOCE TESTIMONY:

Dr. X' Testimony

76. During the course of this Appeal, at the request of Counsel for the Fund, Dr. X testified via videoconference on October 16, 2020. His testimony is set out below.

77. Dr. X had a general practice in X from 198X until 201X, during which he had a roster of 1800 patients. In addition to his medical practice, Dr. X was the Medical Director of a (City) nursing home.

78. Dr. X was the Deceased's family physician from 1981 until his death in 200X.

79. In support of his Affidavits indicating the Deceased had a blood transfusion in 198X, Dr. X testified while all of his records were destroyed and he was relying on his

memory, he recalled "very vividly" that in 198X/8X, he referred the Deceased to the X General Hospital, and the Hospital documents Dr. X subsequently received indicated the Deceased had had a laparotomy to explore abdominal pain.

80. However, the Deceased bled as a result of a resectioning of his bowel and received a transfusion inter-operatively. Dr. X indicated the Deceased had been unaware of the transfusion, until advised of it by Dr. X.

81. Dr. X conceded that Dr. C, in his report dated June 13, 199X, referenced above reported the Deceased "apparently had hepatitis thirty years ago." (see paragraph 36)

82. Dr. X also acknowledged that Dr. S, a Hepatologist, had also concluded that the Deceased's Hepatitis C was likely contracted from his blood transfusions approximately 42 years ago i.e. in the 50s, (see paragraph 69).

83. However, Dr. X maintained there was nothing in the literature indicating anyone could survive 40 plus years after contracting Hepatitis C.

84. When confronted with a document issued by the Centers for Disease Control and Prevention ("CDC") titled "Hepatitis C Questions and Answers for Health Professionals", which indicated the 10 – 20% of every 100 people infected with HCV will go on to develop cirrhosis over a period of 20 - 30 years, Dr. X responded that was only the case if an individual lived that long.

85. Dr. X conceded that while the Deceased was diagnosed with Hepatitis C in 199X, he would have had to develop it sometime before that, but maintained he could not have had cirrhosis for 40 years, and that the cirrhosis would usually show "outside of 20 years".

86. Dr. X was also confronted with the consultation request he had completed in May 200X, referenced above. In that request, he referred to the Deceased's "terminal hep

failure [indecipherable] Hep C of 30 – 40 yrs". However, he explained that at the time, he didn't realize the duration was much shorter.

87. Dr.X was also questioned regarding his Discharge Summary, following the Deceased's death in June 200X. In that summary, Dr. X described the Deceased as having; "**A long-standing history** of progressive hepatic failure secondary to Hepatitis "C" (emphasis added). Dr. X indicted that by "A long-standing history" he meant several years, not 20 years or more. He subsequently indicated by "A long-standing history" he meant two or more years.

88. When confronted with the November 15, 1982 report from the XX General Hospital, and the records from the X General Hospital, related to the Deceased's admission dated November 24, 198X, both of which indicate the Deceased had hepatitis with jaundice 20 years prior, Dr. X pointed out he was not the Deceased's physician at the time, but that it would have been very unusual for the Deceased to have developed hepatitis "so quickly" after the transfusion he received in the 1950s as it takes "a long time" to develop. He pointed out the Deceased had no liver disfunction until the 1990's.

89. It was also Dr. X' evidence that Hepatitis C was only first identified in the late 70s or early 80s, and there was no way the Deceased could have caught it in the 195X. Rather, he suggested that the Deceased might have contracted Hepatitis D.

90. Dr. X also recalled discussing his OHCAP claim with the Deceased, and conceded he had signed the "Physician Form" for OHCAP, dated, December 16, 1998.(see paragraphs 13 – 15)

91. When asked about the entry on the Form that indicated the Deceased was transfused at the X General Hospital due to "Surgery Post M.I. (anemia)", Dr. X testified that was not correct, as myocardial infarctions are not treated with blood

transfusions. He subsequently indicated the Deceased's M.I. occurred after the abdominal surgery.

92. Regarding the selection of "on or before December 31, 198X" in answer to the question of when the transfusion occurred, Dr. X indicated this was incorrect and that the transfusion occurred in 198X.

93. Dr. X indicated that at the time he signed the form, he understood the eligible period was between 1986-1990, and did not appreciate it was limited only to those transfused before 1986.

94. On further questioning by the Executor, Dr. X indicated that such applications for compensation were usually filled out by the patient, and brought to him by his nurse to sign.

95. When asked by the Executor if he would be surprised if told it was the Deceased's handwriting on the form, he indicated he would not. He also agreed with the Executor that it could also be assumed it was the Deceased who checked the boxes indicating the transfusion occurred on or before December 31, 1985.
[This is curious as the writing bears a remarkable similarity to Dr. X's signature and contains medical language that arguably would not be that of a lay-person with dementia i.e. "Routine Blood Work picked up [elevated] Liver Enzymes Further Testing > Dx of Hep. "C".]

96. Regarding the Deceased's application for OHCAP, which also indicated his only transfusion was in 195X, Dr. X testified the Deceased was "demented" at the time, and had no short term memory. He testified the Deceased would have found the forms "mindboggling" as they contained language which was difficult to comprehend for a lot of people.

97. When asked about the Letter from the Deceased's wife, also filed in support of the OHCAP Application, Dr. X indicted she had "limited comprehension" and didn't understand "many things".

98. Dr. X testified both the Deceased and his wife were "simple – of limited intelligence" and he would have been surprised if they were able to independently compose the letters they submitted in support of the Deceased's OHCAP application.

99. Dr. X also indicated that the Deceased's signature on the letter did not look like his signature, as the Deceased used to sign "things" for Dr. X. He also suggested this was the case with regard to the signature of the Deceased's wife. Apparently, he was making this assessment on the basis of his memory of their signatures.

100. Dr. X was also questioned regarding his answer of "True" to the following question on the Schedule B, which he signed on November 1, 2009:

> 2. I declare that to the best of my knowledge, information and belief that the Primary-infected Class Member [not named on the Form] was infected with HCV during the Class period (***before January 1, 1986 or between July 2, 1990 and September 28, 1998***). [Emphasis added]

101. When Dr. X was asked if he had read the document when he signed it, he indicated he had.

102. However, he subsequently indicated the writing in the body of that form was not his. When asked by the Executor if he would be surprised if the writing on the form was that of the Executor, Dr. X indicated he would not.
[Again, this is curious as the writing bears a remarkable similarity to Dr. X's signature as well as the writing on the OHCAP Physician Form", dated, December 16, 1998]

103. As indicated earlier, on November 1, 2009, Dr. X also filled out a "Blood Transfusion History" in which he indicated the Deceased received 4 units of blood at the X General Hospital in October 198X.

104. Dr. X indicated that as these documents were filled out 8 years after the Deceased's death, he relied on the information contained in the Deceased's medical records.

105. Dr. X conceded that in his September 18, 2019 Affidavit, he testified the Deceased had received 3 units of blood after emergency surgery in 198X, and that in his January 6, 2020 Affidavit, he indicated the Deceased received two units of blood for a medical procedure. However, he maintained both were done from his memory and an error, and that the correct number was indeed 4 units.

106. Dr. X conceded he made the odd error in filling out forms, and was not infallible. He noted that his 1800 patient roster resulted in his having to keep track of a lot of information.

107. When asked who requested that he fill out the various documents he signed, Dr. X indicted no one did – to his recollection. He conceded, however, that he did appreciate the purpose of filling out the documents was to claim monetary benefits.

108. Dr. X conceded that as the Deceased's physician, he had signed forms which assisted him in receiving compensation on the basis of his having only received a transfusion on or before December 31, 1985.

109. However, Dr. X also indicated he was not aware the Decease had already been awarded benefits under the OHCAP when he filled out the forms requested by the Executor. Rather, he indicated the Executor had simply indicated this was a new application.

110. It was also Dr. X' evidence that the Deceased was tested for Hepatitis A and Hepatitis B, but was only positive for Hepatitis C.

Dr. G 's Testimony

111. Subsequent to hearing Dr. X evidence, Counsel for the Fund submitted correspondence from Dr G, dated October 23, 2020.

112. Dr. G is certified by the Royal College of Physicians and Surgeons of Canada in Internal Medicine and Infectious Diseases. His clinical practice is at the Ottawa Hospital where he has worked in the area of viral hepatitis and specifically the management of patients with Hepatitis C for over 20 years.

113. Previously Dr. G chaired the Clinical Issues Subcommittee which reported to the Ontario Ministry of Health, Hepatitis C Secretariat.

114. In his correspondence, Dr. G responded to a series of questions put to him by Counsel for the Fund. As most are self-evident in his responses, most questions are not reproduced.

115. When asked, in his professional experience, how common it would be for a patient to exhibit cirrhosis with the bridging of fibrosis 30, 40 or more years after exposure to Hepatitis C, Dr. G indicated the literature is clear that the average presentation of cirrhosis after infection with hepatitis C is 20-30 years, and in many cases the patients have no symptoms. He indicated he had personal experience of a patient who was diagnosed with Hepatitis C viral infection at the age of 60, and was also found to have cirrhosis. His only risk factor stemmed from exposure around the age of 18.

116. Dr. G also indicated that it is estimated that 20-30% of patients infected with Hepatitis C virus will develop cirrhosis at 20 years after infection. Most patients have few or no symptoms and if they do not progress to cirrhosis, can live a full life. Thus a patient can live 40-50 years after exposure to hepatitis C. Dr. G also pointed out there is literature documenting cirrhosis 50 years after exposure. (Lancet 1997; 349: 825–832 - Natural history of liver fibrosis progression in chronic hepatitis C.)

117. In addition, Dr. G indicated it would be distinctly unusual for an individual to develop cirrhosis as early as 7 years after exposure to Hepatitis C infection. While some of the literature has identified early cirrhosis after 9 years of infection, this was in specific circumstance such as co-infection with HIV/AIDS and advanced immunodeficiency, a condition not found in the Deceased.

118. Finally, Dr. G stated that Hepatitis D is cause by the delta hepatitis virus, and can only occur if a patient is also infected with Hepatitis B. He further indicated that as the Deceased did not have evidence of infection with Hepatitis B, Hepatitis D would not be a factor in his condition.

119. At the request of the Estate, Dr. G also testified during the course of this Appeal.

120. In his viva voce evidence, Dr. G testified that Hepatitis C was not identified until sometime around 1990. Previous to that time, it was only referred to as Non-A and Non-B Hepatitis.

121. He reiterated that it would be highly unusual for a person infected with Hepatitis C to develop cirrhosis of the liver within 7 years of infection.

122. While the Executor of the Estate suggested the Deceased's co-morbidities of obesity and heart disease, with Hepatitis C infection, may have accelerate the deterioration of his liver, Dr. G testified that neither would have such a significant impact. Rather, he indicated it was co-morbidity such as HIV which could result in significant acceleration of liver damage.

123. Dr. G made a similar observation regarding the Deceased's occasional use of Tylenol, which he testified is not a not a well-known cause of liver disease. Further, if damage resulted from the overuse of Tylenol, the individuals usually recovered unless they had experienced a massive overdose.

124. Dr. G also reiterated that the literature suggests cirrhosis would not be present in a Hepatitis C patient until 15 years after infection, even in the instance of a person over 50, and that in his experience patients may not exhibit cirrhosis for as many as 50 years after infection.

125. Dr. G was also asked whether he could imagine any situation which might result in someone like Dr. X "lying" on his Affidavit. This question was objected to by Counsel for the Fund, and I upheld that objection on the basis it was entirely speculative. However, Dr. G did offer that he would never rely solely on memory to indicate what had happened many years prior with regard to a specific patient.

126. Dr. G indicate that in review of the Deceased's file, he noted the Decease had been seen by Dr. S , with whom Dr. G had worked, and whom he described as a "pre-eminent" physician in the area. Indeed, Dr.X-1 referred to Dr. S as the "cream of the crop" in terms of expertise in the area of Hepatitis C infection. Dr. G further indicated he would have no reason to question Dr. S 's 1997 notes, which indicated the likely source of the Deceased's Hepatitis C infection was the blood transfusion associated with his surgery following his leg trauma 42 years earlier.

127. Finally, Dr. G stated that to "cut to the chase" it was not likely the Deceased had developed cirrhosis of the liver in a 7 year period as suggested by the Estate. However, it was "absolutely" possible he could have had Hepatitis C for 40 years with no other symptoms.

RELEVANT PROVISIONS OF THE 1986-1990 HEPATITIS C SETTLEMENT AGREEMENT:

128. In order to qualify for compensation under the terms of the Transfused HCV Plan (the "Plan") a Claimant, or in this instance the Estate, must satisfy the criteria set out in that Plan. In other words, the Estate bears the onus of demonstrating the Administrator erred in denying its application.

129. Article 3.01(1)(a) of the Plan provides that a person claiming to be a Primarily-Infected Person must provide the Administrator with, amongst other things, "…records demonstrating that the Claimant received a blood transfusion in Canada during the Class Period." As noted above, the Settlement Agreement establishes the "Class Period" to be "the period from and including 1 January 1986 to and including 1 July 1990."

130. Article 3.01(1)(c)(ii) requires a person claiming to be a Primarily-Infected Person to deliver, with their application form, a statutory declaration that to the best of their knowledge, information and belief, they were not infected with Hepatitis Non-A Non-B or HCV prior to 1 January, 1986.

131. If a person claiming to be a Primarily-Infected Person cannot comply with Article 3.01(1)(a), Article 3.01(2) provides that that individual 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.

132. In addition, Article 3.04(2) of the Transfused Plan requires that where there is no positive trace back, the claimant must establish that the relevant Primarily-Infected Person … was infected, for the first time, with Hepatitis C by a Blood transfusion received in Canada during the Class Period.

133. The operation of S.3.01(2) of Transfused HCV Plan section is covered by Standard Operating Procedure ("SOP") 3.01.(2) which states:

> **Evidence Of The Unavailability of Hospital Records**
>
> 1. In every case where it is asserted that the hospital records of a person claimed to be a Primarily-Infected Person have been destroyed or are otherwise unavailable, the claimant must provide, or the Administrator must obtain, documentation from the hospital(s) at which the person claimed to be a Primarily-Infected Person is said to have been transfused confirming that the records have been destroyed or are otherwise unavailable, together with a consent form signed by or on behalf of the person claimed to be a Primarily-Infected Person authorizing the Administrator to communicate with the hospital(s) and make further inquiries about the availability of records.
>
> …
>
> **Evidence Where There Are No Hospital Records Or The Hospital Records Do Not Confirm Transfusion And The Person Claimed To Be A Primarily-Infected Person Did Not Receive Notification As Part Of A Blood Recipient Notification Program**
>
> 4. Subject to paragraphs 1 and 6 and the following constraints, the Administrator may accept any evidence it deems reliable as proof on the balance of probabilities of a transfusion during the Class Period in satisfaction of s.3.01(2) of the Transfused HCV Plan:
>   A. evidence of the person claimed to be a Primarily-Infected Person or a Family Member of the person claimed to be a Primarily-Infected Person may not be considered unless there is corroborating evidence independent of the recollection of the person claimed to be a Primarily-Infected Person or any person who is the Family Member of a person claimed to be a Primarily-Infected Person; and
>   B. any evidence which is in the nature of personal recollection must be in affidavit form and must provide the following particulars:
>
>   i. the month and year of the hospitalization(s);
>   ii. the reason for the hospitalization(s); and
>   iii. the basis of the affiant's personal recollection that the person claimed to be a Primarily-Infected Person was transfused during the hospitalization(s);
>
> 5. Subject to paragraph 4, the following are examples of the type of evidence which the Administrator may consider:

A. an affidavit of a medical practitioner or hospital employee involved in the care of the person claimed to be a Primarily-Infected Person at the time of the alleged transfusions(s) who recalls the transfusion(s);

…

134. The SOP is not intended to override the terms of the 1986-1990 Hepatitis C Settlement Agreement.

THE ESTATE'S SUBMISSION:

Abuse of Process, Estoppel and Res Judicata

135. The Estate submits the fundamental issue in this appeal is Dr. X' indication on the Blood Transfusion History that the Deceased was transfused in October 198X.

136. The Estate submits that having relied on Dr. X' assertion to deny its OHCAP claim, the Administrator cannot subsequently change its mind with respect to the veracity of Dr. X "certification", particular in light of his testimony and two Affidavits indicating the Deceased was transfused in 198X.

137. The Estate submits to do so is an abuse of process. It maintains the Fund is precluded from making any submissions regarding the veracity of that evidence by the "doctrines of estoppel and res judicata".

138. In any event, the Estate further submits it has met all the requirements to establish its claim.

Existence of Medical Records

139. The Estate submits that, as required by the S.3.01.(2) 1. of the SOP for theTransfused HCV Plan, set out above, it has demonstrated the Deceased's records have been destroyed or are otherwise unavailable.

140. In that respect the Estate relies on the March 2019 e-mail communication from Ms. S, set out above. That e-mail states, essentially, that the XHN does not have any records for [the Deceased] from 198X, and that as per the *Public Hospitals Act* they are only required to keep records for 10 years.

141. The Executor adds that during their telephone conversation, Ms. S indicated physical records from the 1950s, 1980s and 1990s were destroyed on the basis that there was not a continuum over the subsequent years of information that warranted retention of patient files. As such those "one time" records were destroyed.

142. The Executor also relies on the September 12, 2019 correspondence from Dr. Co confirming the destruction of Dr. X' records for the Deceased.

143. The Executor submits it is specious that records of the Deceased's 198X X General Hospital visit were somehow retained, as revealed in OHCAP's record, and in the records received in the context of this Appeal, but the Deceased's attendance in 198X at the X General Hospital was not.

144. The Estate further points out that S.3.01.(2) 5 of the SOP specifically refers to a medical practitioner's affidavit as providing proof of a transfusion during the Class Period.

145. In that respect, the Estate relies on Dr. X' Affidavits of September 18, 2019 and January 6, 2020, stating the Deceased received a blood transfusion in October 198X.

146. The Estate suggests these Affidavits, in isolation from all of the other evidence, ought to be determinative, and that the Administrator's position that they must be weighed with all the evidence is incorrect, as the SOP makes no reference to such weighing.

147. Finally, the Estate relies on the November 1, 2009 Blood Transfusion History, in which Dr. Phillips indicated the Deceased received 4 units of blood at the X General Hospital in October 198X.

148. The Estate maintains the 1998 Physician Form, although signed by Dr. X, and indicating the Deceased had a transfusion "before January 1, 1986 or between July 2, 1990 and September 28, 1998" at the Toronto General Hospital, was completed by the Deceased when he was mentally incompetent. It concedes, however, that it was correct with regard to the Deceased's blood transfusion in 195X.

149. The Estate further submits the documents submitted to OHCAP by the Deceased and his wife cannot be relied on, as the Deceased was mentally incompetent at the time, and his wife would not have been physically or mentally capable or competent to prepare or consider any documents as she was recovering from a major stroke.

150. The Estate further indicates there was no typewriter or word processor in the home, and that the purported signature of the Deceased is not his. The same is suggested of the signature of the Deceased's wife. Rather, the Estate submits that the letters were contrived by other, unidentified, parties other than the Deceased and his wife.

151. The Estate also submits contracting Hepatitis C in 195X was not possible as the disease had not been introduced to Canada nor identified.

152. Further, the Estate maintains the Deceased's blood transfusions came from family members, none of whom died of any form of liver disease.

153. The Estate asserts that in addition, there has never been any evidence of Non-A/Non-B Hepatitis in the Deceased's medical history. Rather, the Estate maintains the Decease's health began to deteriorate only after his transfusion in 198X.

154. Also included in the Estate's submissions were references to the historic shortcomings in the retention of Hospital Records, which are not in dispute.

155. Finally, the Estate points to alleged errors in the processing of this claim and appeal, and in hospital records.

156. None of the alleged errors, to the extent they may or may not exist, are relevant to the issues that must be determined in this Appeal. Rather, these allegations appear to be intended to demonstrate incompetence, and to undermine the credibility of the source of the information.

157. As these allegations do not assist me in determining the issue in this matter i.e. whether the Deceased was transfused within the Class Period of January 1, 1986 – July 1, 1990, and for the sake of brevity, I have not set them out.

THE FUND'S SUBMISSION:

158. The Fund points out the onus is on the Estate to prove the Deceased received a transfusion and was first infected during the class period.

Existence of Medical Records

159. The Fund disputes the Estate's position that the X General Hospital destroyed the Deceased's medical records, or that Blood Bank records have been destroyed.

160. Specifically, the Fund disputes the Estate's position that Ms. S's email of March 2019, indicates records from 198X were destroyed. Rather, the Fund submits that when asked about records for 198X by the Executor, Ms. Svec only indicates there were no records of an attendance in 198X, and adds they are only required to keep hospital records for 10 years.

161. The Fund points out the X General Hospital reported the Deceased's patient records were available at UHN but he was not transfused, while the CBS traceback for

UHN expressly stated: “Patient record is available - patient was Not Transfused”. It also mentions there were records from a 199X admission but there was no blood transfusion at that time.

162. Further, the hospital and Blood Bank records produced from the X General Hospital date back to 1982 and include consultation notes and test orders from Dr. S dated April 23, 1997. Records from the XX General Hospital are also available back to 1982.

163. The Fund points out this is consistent with the information in the OHCAP file. OHCAP summonsed X General Hospital records in 199X, only 12 years after the alleged surgery. The X General Hospital records revealed an admission and hospital stay in 198X, but no transfusion. Nor was there a record of any surgery in 198X.

164. Moreover, the blood bank records were checked from 1/1985-12/1989 and it was confirmed there were no transfusions for the Deceased, under either his legal name, or with the first and middle names transposed.

165. Accordingly, the Fund maintains it is clear hospital and Blood Bank records were not destroyed.

166. However, there exists no contemporaneous record of any procedure or transfusion in 198X.

167. The Funds points out that while the X General Hospital produced records from 198X and 199X, there were no records from 198X, and submits this is because there was no procedure at the X General Hospital in 198X.

168. Similarly, the Fund submits this is why there are no blood bank records in 198X.

Infection with Hepatitis C

169. The Fund points out that under the Hep C 86-90 Settlement, a claimant must be first infected as a result of a transfusion during the Class Period.

170. Where there are no records, the onus is on the claimant to establish that, notwithstanding the absence of records, there is evidence that would satisfy the Administrator the claimant was transfused in the class period. (see Article 3.01(2))

171. In addition, where there is no positive trace back the onus is on the claimant to establish the primary infected person was infected for the first time with HCV by a blood transfusion received in Canada during the class period (i.e. 1986-90) (see Article 3.04(2) of the Transfused Plan).

172. Further, where evidence is filed, even that of a Doctor, SOP S.3.01.(2) 4 requires the Administrator to assess the evidence and determine if the evidence is "deem[ed] reliable as proof on the balance of probabilities of a transfusion during the class".

173. The Fund points out Deceased's transfusion in the 1950s is not in doubt.

174. Further, the Fund maintains myriad medical records (referenced above), indicate the Deceased suffered from hepatitis years before the alleged 198X transfusion relied on by the Executor.

175. Specifically, the Fund relies on the November 15, 198X report from the XX General Hospital, as well as the reports from the X General Hospital, dated November 24, 198X, which indicate the Deceased had hepatitis with jaundice 20 years prior.

176. The Fund points out that neither the records from X General Hospital or the XX General Hospital provide support for a blood transfusion in 198X or even a hospital stay.

177. Rather, the Fund maintains the records continue to support and verify only one, Pre-Class transfusion, resulting from a fall in about 195X, and further verify this transfusion was the only identified source of the Deceased's Hepatitis C.

178. The Fund points out this is also all consistent with the Deceased's own claim to the OHCAP fund.

179. In addition, Dr. C's report, dated June 13, 1994, indicates the Deceased "apparently had hepatitis thirty years ago," and makes no mention of a transfusion or surgery in 198X being the source of the infection.

180. Also, as indicated above, Dr. S, a Hepatologist, in correspondence dated April 23, 1997, references the Deceased's Hepatitis C and indicates "The likely etiology was blood transfusions associated with surgery after trauma 42 years ago".

181. The Fund points out these medical notes are all consistent with a hepatitis infection being diagnosed in the early 1960s.

182. While the reports do not identify the strain of hepatitis, the Fund submits there is no dispute that Hepatitis C was not identified until the mid-1980s. The Fund points out however, it is clear the Deceased had hepatitis soon after the one agreed upon transfusion in 195X/X, and the OHCAP money was provided to the Deceased on the basis of his having been contracted Hepatitis C from that transfusion.

183. The Fund submits that in an attempt to minimize the likelihood of Hepatitis C infection from 195X, Dr. X provides evidence of what was relayed to him regarding the

early transfusions and other family members. Specifically, Dr. X indicates the donated blood in the 195X transfusion came from family members who did not have Hepatitis C.

184. The Fund points out this is not the narrative told to OHCAP. Rather, as indicated above, the OHCAP Investigating Nurse's interview notes indicate both the Deceased and his wife recalled the need to find friends to donate blood to replace the blood the Deceased received from the Red Cross. The Fund points out that in addition, this was confirmed in the subsequent letter from the Deceased's wife, indicating she had to find blood donors to replace the blood used in the blood transfusion received by the Deceased.

185. While the Estate, in its submissions, suggests the correspondence in the OHCAP file is not authentic, the Fund submits there is no plausible explanation why anyone else would file the letters on the Deceased's OHCAP claim. Indeed, that correspondence was relied upon on by the Deceased and is consistent with the OHCAP notes.

186. The Fund submits that without some explanation as to who was responsible for allegedly misrepresenting the Deceased's transfusion history, the allegation is both unpersuasive and inconsistent with the totality of the evidence.

187. Further, while the Estate suggests the Deceased suffered from dementia in 199X, the Fund points out he not only had the ability to file material in support of his claim for OHCAP, but was interviewed by its staff, and submitted correspondence resulting in the acceptance of his claim. The Fund notes there is no suggestion of dementia or diminished capacity in the notes of the OHCAP interview or the correspondence. Further, in late 2000, he had sufficient testamentary capacity to execute his Will before a lawyer.

188. Finally, Dr. G points out that cirrhosis after 7 years of exposures is "distinctly unusual".

189. The Fund further submits that even if it can be concluded there was a transfusion, the evidence is overwhelming that the Deceased had hepatitis long before 198X.

Dr. X' Evidence

190. The Fund submits Dr. X' evidence is neither credible nor sufficient to meet the onus borne by the Estate.

191. The Fund points out Dr. X concedes he signed Schedule B on November 1, 2009. In that Form he declared "that to the best of my knowledge, information and belief …the Primarily-Infected Class Member was infected with HCV during the Class period (before January 1, 1986 or between July 2, 1990 and September 28, 1998)". The Fund further points out this is consistent with the application for compensation for an infection contracted prior to the class period, and consistent with the Deceased having been transfused in 195X, and subsequently diagnosed with hepatitis.

192. While Dr. X, also on November 1, 2009, indicated on the Deceased's Blood Transfusion History, that he was transfused in 198X with 4 units, the two documents are inconsistent and indicate the Deceased was infected either before or after the 86-90 Class Period.

193. The Fund also points to another inconsistency in Dr. X' evidence – the number of units of blood allegedly received by the Deceased. As indicted above, on November 1, 2009, Dr. X indicated the Deceased received 4 units. However, in his September 18, 2019 Affidavit, he indicated the Deceased received 3 units of blood after emergency surgery in 198X, the nature of which he could not remember. In his January 6, 2020 Affidavit, he indicated the Deceased received two units of blood for a medical procedure.

194. The Fund also points out the 1998 Physician Form, which was signed by Dr. X but which the Estate asserts was completed by the Deceased, has details it is difficult to imagine a person with dementia could articulate, including the place of transfusion, Dr. X CPSO number and a short explanation of the diagnosis of Hepatitis C.

195. However, if as suggested by the Estate, the Deceased filled the document out prior to it being signed by Dr. X, the Fund submits he did so in a fashion that demonstrated he understood the questions clearly and answered clearly. The Fund suggests that undoubtedly, he did the same in the OHCAP interview, as there is no suggestion otherwise.

196. The Estate further submits Dr. X' own contemporaneous notes do not support his testimony. Rather, his vague and contradictory evidence on the reason and number of units of blood undermines his credibility, as does his apparent willingness to sign statements without reading them.

197. The Fund also points out Dr. X testified the 198X blood transfusion was related to the Deceased's emergency bowel surgery. However, there are no contemporaneous records that mention a 198X surgery, notwithstanding the availability of documents from the X General Hospital and the XX General Hospital.

198. Rather, the records disclose considerable discussion as to the origin of the Deceased's Hepatitis C, with no mention of a transfusion or bowel surgery in 198X. To the contrary, the Fund points out the origin of the Hepatitis C has consistently been dated back to the transfusion in 195X.

199. The Fund points out that the CDC reports that 10 to 20% of all people who have Hepatitis C will "go on to develop cirrhosis over a period of 20 to 30 years". Dr. S, the Deceased's Hepatologist, reported in 199X that his Hepatitis C was most likely the result of the 195X blood transfusion. Specifically, he stated "the likely etiology was blood transfusions associated with surgery after trauma 42 years ago".

200. Dr. X, however, testified he disagreed with Dr. S's assessment, and maintained that liver latency does not exceed 20 years. Accordingly, he maintained an infection from 1950/60/70s would not lead to a diagnosis of cirrhosis in 199X.

201. Further, while Dr. X' 2020 Affidavit indicates the Deceased was never diagnosed with non-A or non-B Hepatitis, the Fund points out he made no mention of the hepatitis contracted in the early 1960s, prior to the Deceased becoming his patient. However, in his testimony, he suggested it might have been Hepatitis D.

202. The Fund submitted the evidence of Dr. G demonstrates that both of Dr. X statements are inaccurate. The Fund pointed out Dr. G is a recognised expert on Hepatitis C, and submitted his evidence is to be preferred.

203. The Fund points out that like Dr. S and the CDC statement, Dr. G states that cirrhosis may take decades to be diagnosed in Hepatitis C patients, and it would be distinctly unusual for cirrhosis to develop after only 7 years from infection – as suggested by Dr. X.

204. Further, Dr. G indicates a diagnosis of Hepatitis D is accompanied by Hepatitis B, which the Deceased did not have.

205. Most telling, submits the Fund, is that Dr. X' testimony regarding a transfusion in 198X is also contrary to Dr. X' own contemporaneous records in 2001. Indeed, the Fund submits Dr. X' contemporaneous statements were all to the contrary. For example, as mentioned above, in 2001 when seeking a consultation from other doctors, where one would assume the referring doctor wishes to be accurate, Dr. X refers to the Deceased as having had Hepatitis C of 30-40 years duration. (see paragraph 71)

206. The Fund submits these contemporaneous records are supported by Dr. X' actions in assisting the Deceased to receive compensation from OHCAP. In support of that application, Dr. X specifically checked the boxes for the blood transfusion being prior to December 31, 1985.

207. In 2009 he did the same. (see paragraph 100)

208. The Fund submits that Dr. X' explanation, essentially that he did not pay attention when signing these documents, is not credible. It submits that as a professional, it is not credible that he would put his name to a document regarding a government compensation program with such reckless disregard.

209. Further, the Fund maintains Dr. X' testimony that he was not entirely clear as to what OHCAP was is also not credible, as his Discharge Summary in 2001 makes it perfectly plain he was aware the Deceased had sought compensation for having been transfused in the provincial program which covered pre/post Class period transfusions. Specifically, Dr. X' Discharge Summary indicated the Deceased contracted Hepatitis C "many years ago" and "was on the provincial government compensation program for the victims of hepatitis C".

210. The Fund also submits the 2009 forms filed for the compensation under this program are also "mysterious". Dr. X could not say who asked him to, or why he filled out those forms. Rather, he suggests someone else filled them out and he signed them. In other words, a person who Dr. X cannot identify is to have incorrectly filled out the Forms in 2009 and he simply signed it. Again, the Fund argues this is neither credible nor commendable.

211. The Fund also points out that Dr. X' evidence regarding what he was told by the Executor about the 195X/X donors does not satisfy the requirement that evidence used to

establish that a person was first infected by a blood transfusion during the class period cannot come from a claimant or Family Member.

212. Rather, the Executor relaying information to Dr. X does not change the character of the evidence as that of [the Claimant and] a Family Member, and is not admissible under Article 3.01(2) of the Transfused Plan and section 4A. of the SOP. Indeed, the Fund points out the Executor would have no first-hand knowledge in any event, given that the transfusion was in 195X/X.

213. Moreover, the evidence relayed to Dr. X by the Executor is inconsistent with the OHCAP interview notes and the letter from the Deceased's wife.

214. As such, the Fund submits Dr. X' evidence in this regard is uncorroborated and therefore inadmissible.

215. The Fund reiterates that Dr. X' evidence is not credible, and that it is contradicted by the contemporaneous documents, including his own.

216. The Fund further submits that even if the Deceased had been transfused in 198X, this does not oust the requirement in Article 3.01(1)(c)(ii) of the Plan, which requires a claimant to attest that "to the best of his or her knowledge, information and belief, that he or she was not infected with Hepatitis Non-A or Non-B prior to 1 January 1986". The Fund points out this provision ensures only those first infected in the Class Period are eligible.

217. However, it points out the Deceased never once suggested he was transfused in 198X. Rather, the Fund points out the Deceased attested to OHCAP that he was infected with Hepatitis C in 195X, and on that basis received compensation.

218. The Fund submits the suggestion of dementia does not negate the Deceased's clear intention, (and that of his wife) to filed material asserting and supporting that he was first infected in 195X.

219. The Fund submits this appeal should be dismissed.

THE ESTATE'S REPLY SUBMISSION:

Existence of Medical Records

220. The Estate maintains the Fund's submissions on the issue of document destruction is based on the logical fallacy that if there is no explicit statement that transfusion documents were destroyed then they must not have been destroyed.

221. The Estate also takes issue with what it characterizes as the Fund's bald assertion that:

> The XGH records include Dr. S's material from 1997 which clearly indicates records were not destroyed. Moreover, OHCAP summonsed XGH records in 1999, only 12 years after the alleged surgery, and there were no records of that surgery.

222. The Estate submits this analysis of Dr. S's 1997 letter and the 1999 OHCAP request is wrong. It points out that nowhere in his correspondence does Dr. S comment on the completeness of the Deceased's medical file, and what is more, nowhere does the response to the 1999 OHCAP request for records indicate the completeness of the file. Instead, it simply indicates that no records of transfusions could be found, which is consistent with them being destroyed.

223. The Estate points out this fits with sad history of Hep C-infected blood transfusions in Canada, and points to the Krever Report, which determined that record destruction was a regular occurrence:

> Look-backs were impeded by the inadequacy of records in many hospitals. Hospital blood banks kept records of the disposition of the components they had received, but there was no uniform requirement that such records be kept, and often records had been destroyed by the time look-backs were undertaken. Legislation in most provinces required that hospital records be kept for periods of five, ten, or even

> twenty years. This requirement did not necessarily mean that records sufficient for tracing the disposition of blood components would be kept. [a]
> ……… [b]
>
> In August 1996, the Ministry released the names of 500 to 600 hospitals that might have administered non-heat-treated factor concentrates to non-hemophiliac patients, in the hope that patients would come forward to be tested. Previous efforts were hampered because many hospitals had routinely destroyed patient records.

224. The Estate maintained this woeful historical context cannot be ignored in this appeal. Rather, it submits it is the very same context that requires this case to determine one question: on a balance of probabilities, did the Deceased have a blood transfusion in the Class Period.

225. The Estate further maintains the Fund's unequivocal pronouncements on the completeness of the medical record are contradicted by documents produced by the Estate. Specifically, the Estate refers again to the XHN response that it has been unable to locate any record of the Deceased being seen in the 1950s nor the 1980s. The Estate suggests this is contrary to the Fund's assertion that the Deceased's full medical record has been disclosed.

226. Further, the Estate argues the record indicates that, at the very least, it was acceptable to destroy patient records as a matter of course after 10 years, pursuant to the *Public Hospitals Act*.

227. The Estate submits that the inference to be drawn is that the completeness and accuracy of the disclosure by various medical centres is at best questionable, and certainly not strong enough in-and-of-itself to find the Deceased did not have a blood transfusion in 198X.

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[a] Krever H. Final report: Commission of Inquiry on the Blood System in Canada. Ottawa: The Commission; 1997 at Vol. 2, P. 58, as submitted to the Referee by email on May 7, 2020.
[b] Krever H. Final report: Commission of Inquiry on the Blood System in Canada. Ottawa: The Commission; 1997 at Vol. 3, P. 171, as submitted to the Referee by email on May 7, 2020.

228. The Estate relies on S. 3.01(2) of Transfused HCV Plan, and specifically subsections 4-6, which cover instances when relevant hospital records for blood transfusions are missing, or do not confirm transfusion. It points out that protocol allows a Referee to accept "any evidence it deems reliable" including affidavits from a medical practitioner involved in the applicant's care at the time of the relevant transfusions.

229. The Estate submits that is exactly what it has done by submitting the evidence of Dr. X.

230. The Estate submits the fact that transfusion records do not exist cannot be dispositive of whether a transfusion took place, especially when both the Transfused HCV Plan and its related SOP specifically provide a protocol for corroborating evidence in such a case, and it is this gap that Dr. X clearly fills.

Dr. X's Evidence

231. The Estate maintains Dr. X was emphatic and uncontradicted that medical records detailing the 198X transfusion were in the Deceased's file, and that he reviewed them. The Estate points out it is uncontradicted that this file was destroyed in 2015.

232. The Estate submits Dr. X' evidence was clear, and based on his personal knowledge of his patient. It points out that as the Deceased entered palliative care, on May 16, 2001, Dr. X described him "…with terminal liver failure secondary to hepatitis C contracted many years ago while an inpatient at the X General Hospital for surgery and received a blood transfusion".

233. The Estate points out there is no mention of the surgery being an "emergency".

[However, I note that at paragraph 6 of in his Affidavit of September 18, 2019, Dr. X stated:

> In October 198X [the Deceased] was admitted into the X General Hospital for

> an ***emergency*** surgery of which I can't remember and he received 3 units of blood post-op. [emphasis added]

234. The Estate takes issue with the Fund's position that Dr. X' affidavit evidence in this proceeding is disingenuous.

235. It submits the Fund essentially relies on two elements to impugn Dr. X' evidence. The first is Dr. X' hand-jotted consultation report drafted prior to the Deceased's death, where Dr. X described the Deceased as having contracted Hepatitis C "30 to 40 years ago". The Estate points out this would be about 1960 to 1970, so would be an approximation, in any event.

236. The second is what the Estate describes as "a few ticks in the wrong boxes on a single page" [which I understand refers to Schedule B]. In this regard, the Estate relies on Dr. X' evidence in cross-examination that he signed the form even though the Deceased filled it out. The Estate submits that fact has nothing to do with Dr. X' credibility as to the issue of whether the Deceased had a blood transfusion in 198X. Rather, on that relevant point, the Estate points out Dr. X was emphatic in his viva voce evidence.

237. The Estate submits that with all of Fund Counsel's parsing of documents and impugning of Dr. X, when viewed in its entirety, the record shows that Dr. X' statements paint a clear picture that the Deceased was at one point an inpatient for routine surgery at the X General Hospital in 198X, and had a blood transfusion while there. As an aside, the Estate points out that Dr. G, the Fund witness, was frank in his own cross-examination that he could not remember the details of the approximately 3,000 patients he had seen in his own medical career.

238. The Estate further submits that to see a few mis-ticked boxes as anything more than inadvertence requires that the Blood Transfusion History, which explicitly indicates a transfusion date of 198X, be ignored.

239. The Estate maintains that regardless of how the Fund would like to colour Dr. X' evidence, the reality is that occasional approximations in his record, or mistakes in his box-ticking do not make him disingenuous or detract from his credibility. Rather, they simply show him for what he is - a dedicated doctor who is sometimes imperfect when filling out forms or remembering exact dates from time-to-time.

240. Similarly, the Estate submits that the Fund's reliance on the Deceased having only mentioned his 195X-5X transfusion in documents prior to this post-1986 application is problematic. It points out that Dr. X testified in cross-examination that it is not uncommon for an unconscious surgical patient to be unaware of a blood transfusion.[I note, however, that as set out above in paragraph 80, Dr. X also testified he subsequently advised the Deceased of the transfusion]

241. In any event, the Estate relied on Dr. X testimony that the Deceased had dementia. Accordingly, it argued that even if the Deceased did have specific knowledge of this 198X transfusion at some point, his mental decline in the last years of his life would likely have affected his ability to share those recollections.

242. The Estate submits that as much as the Fund attempts to underplay the Deceased's dementia diagnosis, the evidence shows he was likely hobbled by this disease in the years prior to his death. In that regard, it points out his submissions for his 1999 OHCAP application appear to have been made around May 1999, and under one year later, Dr. X reported the Deceased suffered from multi-infarct dementia.

243. The Estate points out Dr. X referred again to this fact in his January 6, 2020 Affidavit, and noted it in his Discharge Summary for the XX General Hospital.

244. Also, a Dr. M noted the Deceased's multi-infarct dementia in a consultation he conducted while the Deceased was at the hospital in April 2001.

245. The Estate points out Dr. M also noted: "This man is known to have chronic hepatitis C although it is not clear what the exposure was", and submits this perhaps summed up the historical record compiled by several different medical professionals better than anyone.

Infection with Hepatitis C

246. The Estate maintains the record provides no evidence the Deceased contracted Hepatitis C earlier than 198X. Rather, there exist only repeated references to the Deceased having hepatitis at some point in-or-around the 1950s, following a blood transfusion that accompanied emergency surgery for a fall.

247. However, it points out that none of these references specify this diagnosis was of Hepatitis C. Rather, the Estate relies on the 1982 consultation report authored by Dr. Sa from XX General Hospital which notes the Deceased had hepatitis with jaundice 20 years ago.

248. The Estate submits this suggests a temporally-limited flare-up of "hepatitis writ large" – and is therefore equally likely to be Hepatitis A or B, as there is no dispute Hepatitis C was not a recognized identified variant of the disease until the mid 1980s.

249. Further, while the 1994 report from Dr. C also mentions the Deceased's hepatitis of "thirty years" prior, the Estate points out that again there is no mention of surgery, emergency surgery, a fall from an antenna, or the particular variant of hepatitis.

250. In contrast, the Estate refers to Dr. X' summary when the Deceased was admitted for palliative care, where he noted the Deceased contracted Hepatitis C "during routine surgery at the X General Hospital many years ago". The Estate again maintains this is hardly the stuff of an emergency intervention following a fall from a TV antenna in the 1950s where the Deceased almost lost his leg.

251. The Estate submits that other than those of Dr. X, even the most definitive statements on the Deceased's history of infection are assumptions.

252. Specifically, the Estate refers to Dr. S's assertion, in his correspondence of April 23, 1997, that the "likely etiology" of the Deceased's Hepatitis C diagnosis was a blood transfusion "42 years ago". However, the Estate points out there is no indication of the basis for Dr. S's assumptions as to the etiology of the Deceased's hepatitis.

253. The Estate points out that Dr. S also noted the Deceased had a history of hepatitis, and suggested this was probably Hepatitis A because his son was infected at the time, as were many children in his son's school.

254. Further, the Estate submits Dr. G's evidence is of no weight.

255. Specifically, and in the first instance, the Estate submits his evidence goes beyond what is at issue in this appeal, in that it is undisputed the Deceased died of Hepatitis C.

256. Accordingly, the Estate submits the only question is whether it has been proven, on a balance of probabilities, that the Deceased received a blood transfusion in the Class Period.

257. The Estate submits the clear evidence of Dr. X resolves that issue.

258. Secondly, the Estate submits that in any event, Dr. G's evidence is "generalist to put it mildly". It points out his report consists of four summary answers to general questions – none of which are provided with any reference to the Deceased's medical record or personal circumstances. The Estate submits this was a deficiency Dr. G essentially acknowledged when he admitted on cross-examination that not all Hepatitis cases fit the typical or standard circumstances he opined upon.

259. In conclusion, the Estate maintains the best, most reliable evidence regarding whether the Deceased was transfused in 198X comes from the personal recollections of Dr. X. It submits that "nitpicking about historical details aside", it is clear his evidence is that the Deceased had a blood transfusion in 198X – within the Class Period, and imperfections in the record aside, that evidence is unshaken.

260. The Estate maintains the Administrator's Denial of the Claim ought to be overturned.

ANALYSIS:

Abuse of Process, Estoppel and Res Judicata

261. The Estate submits that having relied on Dr. X' assertion of a transfusion in 198X to deny its OHCAP claim, the Administrator cannot subsequently change its mind with respect to the veracity of Dr. X' evidence. It submits to do so is an abuse of process.

262. OHCAP is administered by the Ministry of Health and Long-Term Care. Epiq Global, which currently administers the 8690 Program, is a separate and distinct entity. The two entities administer different programs, with different criteria, and different parties. The decision of one cannot bind or preclude a determination by the other.

263. Accordingly, there is no basis on which to find there has been an abuse of process in the processing of this application. Further, the doctrines of estoppel and res judicata are not applicable.

Existence of Medical Records

264. The Estate's initial and Reply submissions reference the historic shortcomings in the retention of hospital records. This is not in dispute. Rather, the terms of the 1986-1990 Hepatitis C Settlement Agreement were negotiated in the context of such shortcomings,

and allow, in the absence of hospital records, for evidence such as that at issue in this Reference.

265. In this instance, no medical records demonstrating the Deceased received a blood transfusion during the Class Period, as required by Article 3.01(1)(a) of the Plan, were produced.

266. While the Estate maintained this was because the records had been destroyed, I find that is inconsistent with the evidence.

267. In the first instance, UHN, in its response to the Administrator's request for a CBS traceback for the Deceased, expressly stated: "Patient record is available - patient was Not Transfused".

268. The Estate relies on that portion of Ms. S's e-mail which states the UHN is only required to keep hospital records for 10 years, to prove that a record existed from 198X and was destroyed. However, I do not find that comment can be interpreted to say a record existed and was destroyed.

269. Rather, I understand Ms. S's comment regarding the requirement to keep hospital records only for 10 years, as well as the hearsay comments attributed to her in a telephone conversation by the Executor, i.e. that physical records from the 1950s, 1980s and 1990s were destroyed on the basis there was no a continuum over the subsequent years that warranted their retention, to be a general statement of policy.

270. To the extent there is any ambiguity in that regard, I note that records as far back as the Deceased's hospitalization in 198X were available and provided in 1999 to the OHCAP program. If a transfusion had occurred in 198X, that record would also have been provided to OHCAP.

271. Further inquiries in the context of this Appeal revealed the existence of additional records, not only at UHN but also at the XX General Hospital. While they documented hospitalizations or assessments in 198X, 199X, and 199X, none record or reference an admission, transfusion or procedure involving the Deceased in 198X.

272. Accordingly, I find the medical records for the Deceased are available, and do not support the Estate's assertion the Deceased received a blood transfusion in 198X, or at any other time during the Class Period.

273. In any event, if as the Estate asserts, the documents were destroyed, this alone does not constitute proof of a transfusion.

Dr. X' Evidence

274. Article 3.01(2) of the Plan provides that if a person claiming to be a Primarily-Infected Person cannot comply with Article 3.01(1)(a), that individual 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.

275. In this instance, in the absence of medical records supporting its assertion the Deceased received a blood transfusion in 198X, the Estate relies on the evidence of Dr. X –or at least that portion of Dr. X' evidence which supports this application. Therein lies the difficulty with Dr. X' evidence. His evidence is perplexingly inconsistent.

276. As has been set out above, in support of the Deceased's OHCAP application, Dr. X signed the Physician Form, dated December 16, 1998, indicating the only time the Deceased received a transfusion was "on or before December 31, 1985".

277. Subsequently, on November 1, 2009, Dr. X, signed two documents. Schedule B is consistent with the Physician Form referred to above. In it, Dr. X indicates that to the best of his knowledge, information, and belief, the Deceased was infected with HCV before January 1, 1986.

278. However, on the Blood Transfusion History, signed the same date, Dr. X indicates the Deceased only received a blood transfusion in 198X at the X General Hospital. Despite being asked to include information concerning all blood transfusions received in Canada at any time, the area for entry of any transfusion
"Before January 1, 1986" is left blank.

279. Dr. X testified that only the Blood Transfusion History is accurate. However, it clearly is not, as it makes no reference to the transfusion received in 195X/5X, which is not in dispute.

280. Dr.X explanation for what he subsequently alleged is incorrect information contained in the Physician Form and the Schedule B, is that they were completed by someone else and he simply signed them. This is difficult to accept given the similarity between his signature and the handwriting in all three documents, as well as the nature of the entries such as Dr. X's CPSO number, which presumably would not be common knowledge.

281. However, if true, that is a startling admission. These are important documents, the purpose of which is to access monetary benefits based on specific entitlement criteria. Dr. X evidence on its face, at the very least, suggests a somewhat cavalier

approach to his professional responsibility to ensure the truth and accuracy of the contents of the documents.

282. Further, there are additional aspects of Dr. X' evidence which raise concerns regarding its reliability.

283. Dr. Phillips indicated in his September 18, 2019 Affidavit that the Deceased was admitted to hospital in October 198X for an "unknown" emergency surgery which resulted in his receiving a transfusion. It is not surprising, perhaps, that a physician with an 1800 patient roster would have difficulty recalling that level of detail, some 32 years after the event.

284. However, on October 16, 2020, Dr. X testified that he recalled "very vividly" that in 198X/8X, he referred the Deceased to the X General Hospital, and the Hospital documents he subsequently received indicated the Deceased had had a laparotomy to explore abdominal pain, and this ultimately led to his transfusion.

285. As noted earlier, there are no medical records of such a procedure, and it is troubling that Dr. X' memory suddenly and "very vividly" recovered.

286. Further, as noted by Counsel for the Fund, Dr. X has on three different occasions attested to the Deceased having received three differing numbers of units of blood. On the November 1, 2009 Blood Transfusion History, Dr. X indicated the number of units was 4; in his September 18, 2019 Affidavit, he indicated the Deceased had received 3 units of blood; then less than four months later, in his Affidavit dated January 6, 2020, Dr. X indicated the Deceased received 2 units of blood.

287. While Dr. X maintained the more recent references to 2 and 3 units were done from his memory and an error, this again points to the unreliability of his evidence. It appears he did not recollect what he had attested to less than four months prior, so it is difficult to be confident regarding his recollection of events from 198X.

288. Dr. X also testified he was unaware that monies had already been granted to the Deceased pursuant to his OHCAP application. However, this is contrary to Dr. X's Discharge Summary for the Deceased which stated he had received compensation from the "Provincial Government's Compensation Program for the victims of Hepatitis C".

289. Finally, in his testimony, Dr. X' disputed his own assessment in the consultation request he had completed in May 2001, and in which he referred to the Deceased's "terminal hep failure [indecipherable] Hep C of 30 – 40 yrs". Rather, Dr. X testified he was now aware such a long period of infection was not possible, and that it was more likely the Deceased was infected during his 198X transfusion.

290. Dr. X maintained this position even when confronted with other references in the medical records to the Deceased's hepatitis of many years prior. For example, the April 23, 1997 correspondence of Dr. S a Hepatologist, indicated "The likely etiology [of the Deceased's Hepatitis C] was blood transfusions associated with surgery after trauma 42 years ago".

291. Rather, Dr. X suggested the Deceased's earlier infection might have been Hepatitis D. Again, this is perplexing. As a physician, Dr. X ought to know that Hepatitis D occurs only simultaneously with Hepatitis B. However, his evidence was that he had tested the Deceased for both Hepatitis A and B and he was infected with neither.

292. In light of the above concerns arising from his evidence, both documented and viva voce, as well as the various attempts at explanations which were less than compelling, I am left with a distinct impression that Dr. X had lost his professional objectivity in this matter, and was crafting his evidence to assist the Estate.

293. However, Dr. X conceded he made the “odd error” in filling out forms, and that his 1800 patient roster resulted in his having to keep track of a lot of information. If my assessment above is too harsh, and the explanation is simply that Dr. X was careless in his various inconsistent statements, the result is the same. I find his evidence to be too unreliable to be persuasive.

294. The Estate has argued that Dr. X' evidence, in isolation of all of the other evidence, ought to be determinative, and that the Fund's position that it must be weighed with all the evidence is incorrect, as the SOP makes no reference to such weighing. This is incorrect, as s.3.01.(2) 4. of the SOP, set out again below for convenience, states:

> … the Administrator may accept any evidence it deems reliable as proof on the balance of probabilities of a transfusion during the Class Period in satisfaction of s.3.01(2) of the Transfused HCV Plan:
> …

295. Accordingly, in addition to the difficulties related to Dr. X evidence set out above, his evidence must also be considered in the context of the other evidence available regarding whether the Deceased received a transfusion in 198X.

296. Aside from the fact that the Deceased's medical records are available and contain no reference to a hospitalization, procedure or transfusion in 198X, I must consider the historic documents provided to OHCAP in pursuit of the Deceased's claim to that program when he was alive.

297. The Estate suggests the correspondence in the OHCAP file cannot be relied upon as the Deceased suffered from dementia in 199X, and his wife had diminished capacity.

298. However, I am not persuaded the Deceased's communications in the context of his application for OHCAP ought to be discounted. There is no evidence before me to suggest the lack of cognitive abilities to drive safely (a distinct skill set), renders the Deceased's evidence in the context of his application to OHCAP unreliable. There

appears no indication in the OHCAP records that there are any issues regarding his ability to complete the forms correctly, or adequately answer the questions put to him.

299. Further, as pointed out by the Fund, the Deceased executed his Will the subsequent year, which suggests he retained enough cognitive capacity to do so.

300. Further, there is no documentation to support the suggestion that the Deceased's wife's capacity was so diminished she could not reliably provide the simple history of having to find blood donors to replace the blood used in the Deceased's 195X/5X transfusion. I will discuss this further below.

301. I also conclude that the unsubstantiated assertions by the Estate that the letters submitted to OHCAP by the Deceased and his wife were in fact "contrived by other parties" to be completely without merit.

302. That having been said, however, even if true, without further details, this alone would not render the documents unreliable. There is nothing nefarious in the Deceased and his wife seeking the assistance of a trusted confidant in filing their OHCAP documents, if indeed, as suggested by the Executor and Dr. X, they may have found this challenging or lacked the tools to do so.

303. Rather, the consistency between the documentary information and the verbal answers provided to the OHCAP Investigating Nurse, lead me to conclude the documentation is reliable.

304. In making that determination, I also do not give any weight to Dr. X suggestion that the signature on the Deceased's letter did not resemble his signature. In the first instance, it would be extraordinary for Dr. X' to have recalled, from memory, the Deceased's signature from sometime before 2001. Further, a review of the

Deceased's signature on various documents e.g. his Will and his acknowledgement of the payment from the OHCAP program does not support that assertion.

305. Accordingly, I give weight also to the fact the Deceased, in his application and communications with OHCAP, attested to the transfusion in 195X being the only transfusion he ever received.

306. This again is inconsistent with Dr. X' evidence of a subsequent transfusion in 198X.

307. For the reasons set out above, I do not accept Dr. X' evidence as reliable proof, on the balance of probabilities, of a transfusion during the Class Period.

308. Rather, I find on a balance of probabilities, that the Deceased did not receive a blood transfusion during the Class Period.

Evidence of Infection

309. Contrary to the submissions of the Estate, the issue of whether the Deceased received a transfusion during the Class period is not the only issue to be determined in this matter.

310. As argued by the Fund, even if the Deceased had received a blood transfusion in 198X, there remains the requirement that the Deceased be infected for the first time during the Class Period.

311. The Fund points out that Article 3.01(1)(c)(ii) requires a person claiming to be a Primarily-Infected Person to deliver, with their application form, a statutory declaration that to the best of their knowledge, information and belief, they were not infected with Hepatitis Non-A Non-B or HCV prior to 1 January, 1986.

312. While such a statutory declaration is not available when a claim is made by the Estate of a Deceased individual, it is worth noting that in this instance, the Deceased's only "declaration", made in the context of OHCAP Program, was that he was infected with Hepatitis C as a result of his transfusion in 195X, and that this was the only transfusion he received.

313. Further, where there is no positive trace back, Article 3.04(2) places the onus on, in this instance the Estate, to establish the Deceased was infected for the first time with Hepatitis C by a blood transfusion received during the Class Period.

314. However, I find the evidence is overwhelming that the Deceased had hepatitis years before the alleged 198X transfusion relied upon by the Estate, (and which I have found did not occur).

315. Specifically, the November 15, 1982 report from the XX General Hospital, as well as the reports from the X General Hospital, dated November 24, 1982, indicate the Deceased had hepatitis with jaundice 20 years prior.

316. Similarly, Dr. C's report, dated June 13, 1994, reports the Deceased "apparently had hepatitis thirty years ago."

317. Further, in all those documents, there is no reference to a transfusion or even a procedure in 198X.

318. Rather, as set out above, Dr. S's 1997 notes indicate the likely source of the Deceased's Hepatitis C was "blood transfusions associated with surgery after trauma 42 years ago".

319. Finally, as indicated above, even Dr. X' contemporaneous notes point to an infection much earlier than 198X. Specifically, his referral of May 23, 2001 refers to terminal hepatic failure from Hepatitis C "of 30 – 40 yrs".

320. While Dr. X testified he now believes this was not possible, I prefer the evidence of Dr. G regarding the most likely timeline for the Deceased's infection with Hepatitis C.

321. While the Estate suggested Dr, G's evidence should be given no weight because it was "generalist", it did not challenge his expertise in this area. Further, while Dr. G did testify regarding some general characteristics of a Hepatitis C infection, he also commented specifically with regard to the likely timeline of the Deceased's infection, on the basis of his review of the Deceased's file. In his expert view, it was not likely the Deceased had developed cirrhosis of the liver in a 7 year period, as suggested by the Estate. Further, Dr. G testified it was "absolutely" possible the Deceased could have had Hepatitis C for 40 years with no other symptoms.

322. I found Dr. G's testimony to be direct and consistent, while, as indicated above, I am of the view Dr. X' evidence was unreliable. Dr. X' amended timeline, in contradiction to the current medical information as conveyed by Dr. G, simply added to that perception.

323. While the Executor suggests the Deceased could not have been infected with Hepatitis C through the 195X/5X transfusion, as the blood came from family members who did not suffer from Hepatitis C or any other liver disease, the evidence does not support this assertion. Rather, the information provided by both the Deceased and his wife to OHCAP was that they needed to find friends to donate blood to replace the blood the Deceased received from the Red Cross.

324. While the Estate's assertion that the transfusion came from family members is repeated in Dr. X' January 6, 2020 Affidavit, Dr. X is clear this information was

conveyed to him by the Deceased, and reiterated by the Executor. The fact this assert comes via Dr. Phillips does not change the character of the evidence as that of the Deceased and of a family member, and renders it inadmissible under Article 3.01(2) of the Transfused Plan and section 4A. of the SOP. In any event, and again as pointed out by the Fund, the Executor would have no first-hand knowledge, given that the transfusion was in 195X/X.

325. I further find Dr. X' suggestion that the Deceased's earlier hepatitis infection was Hepatitis D rather that Hepatitis C to without any merit, as his own evidence was that the Deceased had tested negative for Hepatitis B, which is required in order for Hepatitis D to co-exist. I note as well that Dr. X testified the Deceased was also tested for Hepatitis A, with a negative result. His only positive test was with regard to Hepatitis C.

326. Finally, the Estate submitted the Deceased's earlier hepatitis could not be Hepatitis C as it was not an identified variant of the disease until the mid 1980s. However, that does not mean it did not exist. As Dr. G testified, it was simply known as Non-A and Non-B Hepatitis until it was identified as Hepatitis C around 1990.

327. Accordingly, I find that on a balance of probabilities, the Deceased was not first infected with Hepatitis C during the Class Period.

DISPOSITION:

328. Neither the Administrator, nor I as a Referee, have discretion to grant compensation to individuals infected with Hepatitis C who cannot show they were first infected as a result of having received a transfusion in Canada within the timelines of the Class Period i.e. between January 1, 1986 and July 1, 1990.

329. In this instance, the Estate has provided no reliable evidence indicating the Deceased received a Blood transfusion or was first infected with Hepatitis C during the Class Period.

330. Accordingly, for all the reasons set out above, I find the Administrator correctly determined the Estate is not entitled to compensation pursuant to the Hepatitis C 1986-1990 Class Action Settlement.

331. The decision of the Administrator to deny the Estate compensation pursuant to the Hepatitis C 1986-1990 Class Action Settlement is upheld, and the Appeal is dismissed.

DATED AT (City), THIS 17TH DAY OF MAY 2021.

"Tatiana Wacyk"
Referee