THE HIGH COURT

IN THE MATTER OF THE HEPATITIS C COMPENSATION TRIBUNAL ACTS 1997 TO 2006

AND

IN THE MATTER OF AN APPEAL PURSUANT TO THE PROVISIONS OF SECTION 5(11)

2017 6 CT

BETWEEN

MM

APPELLANT

AND

THE MINISTER FOR HEALTH

RESPONDANT

JUDGMENT of Mr. Justice Bernard J. Barton on the 28th June, 2018.

1. The Appellant was born on the 30th April, 1951, and is married with six children, three of whom are sadly already dead as a direct or indirect consequence of intravenous drug abuse. These proceedings arise by way of an appeal from a decision of the Hepatitis C HIV Compensation Tribunal delivered the 10th July, 2017, whereby the Appellant's application was refused on the grounds that a necessary criterion for entitlement to compensation had not been satisfied, namely, that the infection had resulted from the transfusion of blood or a blood product within the State.

2. The Application for the assessment of compensation by the Tribunal is dated the 25th August, 2015, and was brought on foot of a diagnosis of Hepatitis C, Genotype 1b, made in February, 2013 during investigations and follow up of the Appellant for dysphagia at St. James's Hospital, Dublin. The source of the infection was attributed to a blood transfusion given during an operation which the Appellant underwent for a perforated appendix at the same hospital in November 1982.

3. The grounds for refusal of the application maybe summarised as follows:

> (i) The Appellant had not established that he had been transfused with blood during the operation in 1982 as suggested and;
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> (ii) The threshold proof of non-transmission of the infection through other potentially competing sources had not been discharged.

4. Professor Gregor Shanik, Consultant Surgeon,was attached to St James Hospital at the time of the Appellant's admission and treatment there in 1982. He gave evidence at the hearing of the appeal but not on the hearing of the application before the Tribunal. The transcript of the evidence and the medical reports upon which the Tribunal based its decision were exhibited in the affidavit grounding the notice of appeal and have been read by the Court. Professor Shanik gave his evidence at a special sitting of the Court on the 20th December 2017, in the course of which he proved a letter, dated 26th November 2017, he had written to the Appellant's GP, as follows:

> *Dear Dr. Rowan,*
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> *Mr. M was admitted 14th November 1982 with a two-day history of severe abdominal pain. On examination he had signs of defused peritoneal irritation and our clinical impression was that he had a perforated duodenal ulcer. He was operated on that afternoon and was found to have a burst appendix with faecal peritonitis.*
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> *He had an uneventful postoperative recovery and was discharged on the 24th November. He returned to the outpatients on 26th November and he developed a superficial wound infection. This was probed and a small amount of pus obtained. He is at present returning daily for dressings and we will review him in the outpatients weekly.*
>
> *Yours sincerely,"*

5. Not surprisingly, by the time he came to give evidence Professor Shanik could not recall having specifically treated the Appellant; however, the content of this letter suggests that he almost certainly did so. His testimony was that in the 1980's blood transfusions were far more common during operations than is presently the case. Given the seriousness of the condition for which the surgery had been performed it would have been standard practice to give a blood transfusion. In this regard a surviving laboratory record disclosed that four units of blood, for which the Appellant would have had to have been crossed matched, had been requested for delivery 'as soon as possible'.

6. In his opinion the significance of this information arose from the potential for a negative outcome if the Appellant was not transfused. The diagnosis of a serious sepsis in the form of faecal peritonitis which had developed as a consequence of the perforated appendix carried with it a mortality rate of 50%; in such circumstances a transfusion would have been almost inevitable. He explained the reason for transfusing the four units. This would have led to an increase in the volume of red blood cells and consequently improved oxygenation. Professor McKiernan, Consultant Gastroenterologist and Hepatologist, treated the Appellant, and gave evidence to the Tribunal. Her evidence to the effect that a sepsis from any source would be expected to result in a drop of haemoglobin and that in 1982 the first line of therapy would have been to give a blood transfusion was corroborated by the evidence of Professor Shanik.

7. The Appellant gave his evidence at the adjourned hearing of the hearing of the appeal on the 23rd April, 201. He recounted, as best he could, the events which led up to the diagnosis of Hepatitis C. However, he could not recall receiving a blood transfusion in 1982 or for that matter at any other time. He did remember having a catheter drain in situ as well as an intravenous feeding tube from which he described 'black stuff was coming out'. He also gave evidence that he had never been in hospital on any other occasion for

any illness that would have required a blood transfusion nor had he ever used intravenous drugs.

8. As to other possible sources of infection, he stated that he had never been sexually promiscuous nor had he ever had a tattoo. He also gave evidence concerning contact with and the residential circumstances of his now deceased children. He was at all times very conscious that they were drug addicts and had been infected with Hepatitis. He and all the unaffected members of the family were careful about hygiene in general and in particular avoided sharing any utensils which might have given rise to a risk of infection.

9. Four possible sources of infection were postulated by Dr Orla Crosbie, Consultant Gastroenterologist and Hepatologist at Cork University Hospital, in an independent medical report which she provided at the invitation of the Tribunal. The potential sources identified were (i) the transfusion in 1982,(ii) household transmission from three infected sons (iii) transmission from an infected brother or vertical transmission from his mother or both, and (iv) transmission from a relationship he had outside marriage prior to the operation in 1982.

10. All but one of these, sexual transmission, were considered and commented upon by Professor McKiernan who gave evidence to the Tribunal. In her view the Appellant was unlikely to have contracted Hepatitis C within in his own household through his now deceased sons who were known intravenous drug users. These individuals were found to be Hepatitis B and C positive; two of whom also tested positive for HIV.

11. In addition to his deceased sons consideration had to be given to the Hepatitis C status of other family members. In this regard, the Appellant's brother had tested positive for Hepatitis C. It transpired that the strain of his virus was Genotype 1a and not 1b. Professor McKiernan quantified the risk of transmission by reference to early studies carried out in America which found the level of risk to be 1%, though this was not conclusive. She expected this risk level to change once the results of further tests studies on the baby boomers generation became available. However, while the risk undoubtedly exists in Ireland the percentage remains very small.

12. The other area of contention between the parties focused on whether or not any of the four units which had been ordered for the Appellant were infected with Hepatitis C. The units implicated have all been identified. Enquiries made with the Irish Blood Transfusion Service (IBTS) established that two of the four donors, each of whom tested negative, have returned to donate since screening was introduced in October 1991 and may thus be excluded as the source of the infection. The donors of the other two units have not returned to donate, consequently, the Hepatitis C status of these donors is unknown. None of the units were associated with donors whose donations are the subject of the Hepatitis C look back programme.

Decision
13. The law casts on the Appellant the onus of proof to establish the case he brings, the burden which he bears is to do so on the balance of probabilities. The Court has read and considered the transcript of the evidence and the medical reports which were before the Tribunal. The appeal proceeds by way of a *de novo* hearing. I had the opportunity of observing the demeanour of the Appellant in the witness box. He gave his evidence in a matter of fact and forthright manner. I found him to be a credible witness upon whose evidence the Court may rely. I make the same observation and reach the same conclusion with regard to Professor Shanik, whose evidence I found to be of great assistance.

Conclusion: Transfusion
14. The first hurdle which the Appellant has to overcome in order to establish causation is to show as a matter of probability that he was transfused with the four units of blood which had been ordered for him at the time of the operation in November 1982. I accept the evidence given by and on behalf of the Appellant and am satisfied that the onus of proof with regard to this question has been discharged, accordingly, the Court finds as a matter of probability that four units of blood were transfused in the course of the operation.

Conclusion; Source of Infection
14. Turning to the issue on the source of the infection, I accept the evidence given by Professor McKiernan to the Tribunal that though there was a risk of infection by transmission from the family members known to be infected, the risk was very low, probably no more than 1%. When the Appellant's evidence concerning contact with and the residency circumstances of his now deceased sons is taken into consideration it is difficult too see whether in reality there was any risk at all of transmission from any of them. It follows that while this route cannot be completely ruled out it is highly unlikely to be have been the source of the infection. Nor could the other members of the family have been the source. Testing on the Appellant's spouse, two daughters and surviving son was reported as negative for Hepatitis C. Although his brother had tested positive for Hepatitis C, his was a different genotype and may thus be excluded.

15. I am fortified in reaching these conclusions by the opinion expressed in a report dated 14th January 2017 prepared by Dr.Bhagani, Consultant Physician attached to the Royal Free Hospital, London, who was retained on behalf of the Appellant. On the basis of the documentary evidence and information available, he was quite emphatic in discounting household transmission as the vehicle for the Appellant's infection.

16. Finally, Dr Crosby also accepted, for reasons largely similar to those of Dr Bhagani, that it was very unlikely household transmission was implicated. Commenting on the possibility of sexual transmission resulting from a brief partnership with another woman which the Appellant had had many years ago during a period of marital separation DrCosbie stated that it would probably be impossible at this juncture to ascertain whether his partner was infected, however, what she could say was that sexual transmission was known to be a less likely source of Hepatitis infection. Vertical transmission from the Appellant's mother can also be excluded;

Conclusion
17. I accept the evidence of the Appellant concerning the other risk factors which have been suggested as potential competitors for the transmission of the infection. Accordingly, having due regard to the findings on the medical evidence and in the absence of any probable explanation to the contrary the conclusion of the Court regarding the source of the infection is that in all probability this maybe attributed to one or other or both of the transfused units donated by donors whose Hepatitis C status remains unknown.

18. For completeness, I should observe that the Court is aware of other cases in which compensation has been awarded where (i) the Hepatitis C status of the donors of the transfused units is unknown, the donors not having returned to donate blood following the introduction of screening in October 1991, and (ii) where there were no other probable sources or risk factors to explain transmission of the infection.

Ruling
19. For all these reasons the Court will allow the Appeal and remit the matter back to the Tribunal for the assessment of compensation. And the Court will so order.