CANADA’S BLOOD SUPPLY TEN YEARS AFTER THE KREVER COMMISSION

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INTRODUCTION

Many Canadians became infected with the human immunodeficiency virus (HIV) and the hepatitis C virus (HCV) in the 1980s through blood and blood products from Canada’s blood system. As early as 1974, transfusion-related cases of hepatitis C (initially called non-A, non-B hepatitis) were identified. About 10 years later, the first case of HIV infection through the blood system was reported. HIV and HCV were the culprits in the contamination of the blood system in the 1980s (an event which came to be known as the “tainted blood scandal”), which happened not only in Canada but in other developed countries as well. The blood scandal was very complex and included a multitude of factors and involved many players. This paper offers an overview of the causes and effects of the blood scandal, the subsequent inquiry (Krever Commission) on the safety of Canada’s blood system, a timeline of important events, and an update on relevant issues with particular focus on the federal government’s role.

THE BLOOD SUPPLY THREATENED BY TWO NEW VIRUSES

Most people acknowledge the inherent risk involved in the use of biological products, such as blood. The risk can be minimized, however, through appropriate screening of donors, public awareness campaigns, testing of donations, etc. By the early 1980s, public health officials and health professionals were aware that two new threats to the safety of the blood system had emerged. The human immunodeficiency virus (HIV) and the hepatitis C virus (HCV, known at the time as non-A, non-B hepatitis) had been described but were not yet identifiable. In Canada, cases of non-A, non-B hepatitis contracted through blood and blood
products began appearing in the mid-1970s, while the first known Canadian case of transfusion-associated AIDS (acquired immune deficiency syndrome) was reported to Health Canada in September 1984.\(^{(1)}\)

**A. Background on HCV**

A variety of diseases that are called “hepatitis” have different causes, symptoms, progression, treatments and prognoses. All forms of hepatitis are characterized by swelling of the liver tissues (hepatic inflammation). Hepatitis can be caused by alcohol, poisons, chemicals and drugs and in each of these cases produces a disease that is non-infectious. The infectious types of hepatitis are caused by viruses and there are several types. The most common are types A, B and C, but types D through G have also been characterized.

Until the 1970s, hepatitis A and B were the only types of viral hepatitis to have been identified. In 1974, the existence of a “non-A, non-B” viral hepatitis was becoming apparent. In 1987, the virus responsible, hepatitis C virus (HCV), was identified, and by 1990 a test had been developed to test for antibodies to the virus. Within a few years, testing became available to directly measure the presence of HCV in blood.\(^{(2)}\)

Hepatitis B and C are similarly transmitted, that is, primarily through the blood (parenterally transmitted), unlike hepatitis A, which is transmitted by mouth (enterally transmitted) through contaminated water or food. While some HCV infections can be overcome, most people who contract HCV do not clear the virus spontaneously from their systems, and the infection becomes chronic. HCV causes damage to the liver slowly over many years, leading to cirrhosis in about 20% of cases, and of these, 1% to 5% progress to liver cancer.

**B. Background on HIV**

AIDS was first described in the United States in 1981, while the first case was identified in Canada in 1982. AIDS and the virus causing it, however, have probably been around for several decades but had remained contained within sub-Saharan Africa.

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The human immunodeficiency virus (HIV) that causes AIDS is transmitted sexually and through blood and was identified in 1983. HIV positive status is characterized by frequent and persistent infections as the body becomes unable to fight pathogens that under normal conditions would pose little threat. In full-blown AIDS, a person becomes vulnerable to life-threatening, opportunistic infections. Initially, HIV infection was considered fatal within 10 to 15 years. However, most industrialized countries, where patients have treatments available to them, have seen a deceleration in the progression to full-blown AIDS and a decline in the death rate since the mid-1990s.(3)

CALLS FOR AN INQUIRY INTO THE SAFETY OF CANADA’S BLOOD SYSTEM

An increasing number of cases of HCV and HIV transmission through blood and blood products during the 1970s and 1980s resulted in calls for a public inquiry into the safety of Canada’s blood system. At least 30,000 Canadians were infected with HCV between 1986 and 1990 through blood and blood products that were detected by look-back, trace-back procedures, and as many as 2,000 people were infected with HIV between 1978 and 1985 (1,150 from transfusion and the rest through blood products).(4) Additional, undetermined transfusion-related transmissions, as well as secondary infections to family members, are acknowledged in the final report of the Krever Commission and may account for the often cited media figures of 60,000 HCV transfusion-related transmissions.(5)

In response to a mounting concern for the safety of Canada’s blood system as blood system-related infections became evident, the House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women struck a subcommittee in 1992 to look into and report on “the circumstances surrounding the contamination of blood,


(4) Look-back refers to the process of finding recipients of blood components from an infected donor. Trace-back refers to the process of finding a donor after a recipient of a blood component contracts HIV/AIDS or HCV.

(5) While the media frequently reported HCV infection levels of 50,000 or 60,000, the Krever report accepts the estimate of 28,600 people infected through transfusion between 1986 and 1990 and an estimated additional 1,000 hemophiliacs infected through blood products. Estimates from the Krever report are available at Krever Report, Volume 2, Chapter 26, “Consequences of the Contamination of the Blood Supply,” pp. 708–18, [http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/index.html](http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/index.html).
blood components, and blood products, and to reassure the Canadian public of the safety of the blood transfusion system.”(6) In April 1993, the subcommittee tabled its report, called *Tragedy and Challenge: Canada’s Blood System and HIV* which called for a comprehensive review of the blood system in the form of a public inquiry as the subcommittee was unable to determine the answers to many of its questions. In September of that year the federal, provincial and territorial ministers of health (with the exception of the Quebec minister of health) agreed that such an inquiry be established. On 4 October 1993, the Commission of Inquiry on the Blood System in Canada was announced. It was to be headed up by Justice Horace Krever and was subsequently called “the Krever Commission.”

**THE KREVER COMMISSION**

The mandate of the Krever Commission was to “review and report on the mandate, organization, management, operations, financing, and regulation of all activities of the blood system in Canada, including the events surrounding the contamination of the blood system in Canada in the early 1980s.”(7) The Commission was awarded a budget of $2.5 million and was to submit its final report by 30 September 1994. The deadline for reporting was subsequently extended to 30 September 1996, and the budget was increased to $16 million.

Initially, Justice Krever had promised not to assess blame in the scandal. However, by 1995 Justice Krever indicated that some charges of misconduct might be warranted, and he issued notices to the Canadian Red Cross Society, government officials and pharmaceutical companies that the Commission was considering laying allegations of misconduct against them. The parties involved responded by asking the court to have the notices quashed as they violated the promise not to assess blame. In June 1996, a federal court ruled that Krever could name those he found to be responsible in the blood scandal.

The Krever Commission finished hearing from witnesses and collecting evidence in December 1996 after 244 days of public hearings, 353 witnesses and almost 50,000 pages of testimony.(8) Justice Krever issued his report to the minister of health, who released it in

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(7) Ibid., p. 5.

(8) The central organizations involved in the blood scandal included the Canadian Red Cross Society, the Canadian Blood Agency, the Canadian Hemophilia Society, the Government of Canada (Health Canada), provincial and territorial governments, the Hepatitis C Survivors Society, the Canadian AIDS Society and Armour Pharmaceutical.
November 1997, having already announced in July of that year that the Canadian Red Cross Society, which had been responsible for Canada’s blood system for over 50 years, would have no role in a new Canadian blood agency.

The three-volume Krever report contained 50 recommendations that were organized under the following categories:

- Compensation
- The Canadian Blood Supply System: Basic Principles
- The Operator: A National Blood Service
- The Regulator: The Health Protection Branch
- Public Health

**SOME KEY FINDINGS IN THE KREVER REPORT**

As many as 2,000 Canadians became infected with HIV through transfusion or the use of blood products between 1978 and 1985 and 30,000 Canadians contracted HCV through the blood system between 1986 and 1990\(^{(9)}\). Krever’s review of the blood system found fault at all levels, from the Canadian Red Cross Society, to Health Canada, to the provincial and territorial governments, to hospitals, as well as to doctors and their governing bodies. Contamination of the blood supply with HIV and HCV, Krever noted, was essentially inevitable, but failures at all levels made the problem larger than it needed to be. A selection of the findings for each of these players includes:

- **The Canadian Red Cross Society** – Inadequate screening of at-risk groups and communities; failure to implement surrogate testing\(^{(10)}\) for HCV in 1986; failure to abandon a factor VIII product that was suspected of being inadequately treated to kill the HIV;\(^{(11)}\) unacceptable look-back and trace-back processes in place for notification of donors and recipients of contaminated blood.

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\(^{(9)}\) In 1985 the Canadian Red Cross Society began testing blood for HIV, while a test for HCV was not available until 1990.

\(^{(10)}\) Surrogate testing refers to measuring certain enzymes in the blood that are usually elevated in those infected with HCV. This type of screening identifies a large proportion of HCV-contaminated blood, but not all. It also produces some false positives, that is, uncontaminated donations.

\(^{(11)}\) Factor VIII is a clotting factor that those with hemophilia A lack. Factor VIII was extracted from pooled blood plasma donations but is now available as a recombinant protein.
• **Health Canada** – Lax monitoring by the Bureau of Biologics (the regulator), which should have recognized the threat; no national blood policy that clearly defined roles and authority; reluctance to trace recipients of blood and blood products; passive rather than active regulation of blood and blood products.

• **Provincial governments** – A pact to deny compensation to infected claimants; poor surveillance of infectious diseases; failure to properly fund adequate blood screening; failure to build a network of blood manufacturing plants across Canada, which resulted in the necessity to import the product from the United States, where donors were paid and blood was collected from prisoners (practices that increase the risk of contamination).

• **Physicians/Hospitals** – Some reluctance by physicians to tell patients of their HIV status due to stigma; reluctance to trace recipients of contaminated blood and blood products; homophobia.

• **Provincial governing bodies** – Poor enforcement of physicians’ duty to report infectious diseases.

• **Manufacturers** – Misleading information provided to and crucial information withheld from Health Canada with respect to product safety.

**RESPONSE TO THE KREVER REPORT**

**A. Compensation (Recommendation 1)**

Well before the inquiry was established, there were calls for compensation, primarily for those infected through the blood system with HIV. In February 1988, the Canadian Hemophilia Society requested compensation from the federal government for those who had contracted HIV through tainted blood and blood products, but it received no response. Two months later the Royal Society of Canada made a public demand to compensate these victims. In December 1989, the federal government announced a $150-million package, the Extraordinary Assistance Program (EAP), to be offered to those who had contracted HIV through the blood system, and who agreed, in exchange, not to sue them. The federal government offered a lump sum $120,000 payment to 1,250 individuals infected with HIV, but not all eligible people applied. In 1993, the Multi-Provincial/Territorial Assistance Program expanded this package. Once approved for EAP, individuals were eligible for this package, which offered $30,000 a year for life.\(^{(12)}\)

Justice Krever’s first recommendation in his report was that “the provinces and territories devise statutory no-fault schemes for compensating persons who suffer serious, adverse consequences as a result of the administration of blood components or blood products,” implying that all victims of tainted blood, past, present and future be automatically compensated through provincial/territorial schemes. This recommendation has not been implemented. It should be emphasized that Krever did not recommend a federal compensation package.

In 1998, despite the recommendation to compensate all victims, the federal and provincial governments announced a $1.2-billion compensation package for those who had contracted HCV, but only between January 1986 and July 1990, as well as those who contracted HIV secondarily from those covered under the earlier package. Justification for the HCV infection “window” was that prior to January 1986 there was no accepted means of screening blood for HCV, and after July 1990 the Canadian Red Cross Society had implemented a screening test. Between 1986 and 1990, the Red Cross had not implemented “surrogate testing” for HCV, despite the United States having done so. Such testing would have identified upwards of 90% of contaminated donations. This compensation approach did not embrace Justice Krever’s recommendation of a “no-fault” approach to compensation. As such, calls for extending compensation to all individuals infected with HCV through the blood system, regardless of when, were renewed.

Some provinces subsequently began to offer compensation to people infected with HCV outside the 1986–1990 window: Ontario offered compensation in 1998, Quebec in 1999, Manitoba in 2001 and British Columbia in 2003.\(^{(13)}\)

In July 2006, the Prime Minister announced that the federal government had reached an agreement on the elements of a settlement for those Canadians who contracted hepatitis C from the blood system before 1 January 1986 and after 1 July 1990, and the agreement was approved by the courts in June 2007. The settlement package, worth $1 billion, is based on parity with the package for those infected within the 1986–1990 window.\(^{(14)}\)


B. The Canadian Blood Supply System: Basic Principles (Recommendation 2)

This recommendation laid down the principles that should govern the Canadian blood system. The five principles are these:

- Blood is a public resource.
- Donors should not be paid.
- Sufficient blood should be collected so that importation from other countries is unnecessary.
- Access to blood and blood products should be free and universal.
- Safety of the blood supply system is paramount.

Canadian Blood Services indicates that it has embraced all of these principles.

C. The Operator: A National Blood Service (Recommendations 3 to 28)

These recommendations laid out the requirements for overhauling Canada’s blood supply system. As indicated earlier, the Health Minister announced in July 1997 that the Canadian Red Cross Society would no longer run Canada’s blood system and that a new agency would be established. In February 1998, Canadian Blood Services was incorporated, and in September it took over the role of blood supplier for Canada, with the exception of Quebec, which operates Héma-Québec. Canadian Blood Services states that it is self-sufficient in blood and is striving to become self-sufficient in plasma, addressing one of the report’s concerns regarding the importation of blood from the United States. Recommendations with regard to the operation of the new agency have largely been implemented. Some of the changes include greater transparency and accountability, clear authority to make decisions, clearer lines of governance and administrative structure, improved communication with governments and hospitals and an improved tracking system for donors and recipients.

Notable examples of recommendations that were not implemented include those regarding the legislative basis for the agency and its funding structure. Justice Krever recommended that the new agency be created by an Act of Parliament. Canadian Blood Services was incorporated pursuant to the Canada Corporations Act and not by specific legislation. With respect to funding, Justice Krever recommended that the new agency be funded by the payments
made by hospitals for the blood and blood products they purchased and that provinces and territories increase their funding to the hospitals for those purchases. However, Canadian Blood Services receives its operational funding from the provincial and territorial ministers of health. Under the old system, the Canadian Red Cross Society did not have the authority to make financial decisions, but instead had to consult with the provinces and territories who were represented on the Canadian Blood Committee (later renamed the Canadian Blood Agency). This structure resulted in slow decision-making and, as Krever pointed out, poor decision-making. This system has been dismantled, and Canadian Blood Services has clear decision-making authority.

D. The Regulator: The Health Protection Branch (Recommendations 29 to 45)

The recommendations contained in Krever’s report that were directed at Health Canada’s Bureau of Biologics and Radiopharmaceuticals had to do with improving the *Food and Drug Regulations* with respect to blood and blood products; distancing the regulator from the interests of manufacturers and distributors; establishing an advisory body; and improving post-market surveillance of blood and blood products. The Bureau of Biologics and Radiopharmaceuticals was restructured as a consequence of the recommendations, but the *Food and Drug Regulations* have not undergone the improvements recommended by Krever. In its response the Government referenced its legislative renewal process,¹⁵ but this process has yet to produce an outcome with respect to Krever’s recommendations. In 1998, Health Canada established the National Blood Safety Council as an advisory body to the health minister. Its mandate was to act as a watchdog to ensure that the actions and organizational structure of the blood system were in the best interests of public safety, to identify emerging risks, and to facilitate communication between all the parties involved. The Government also established an Expert Advisory Committee on Blood Regulation¹⁶ to advise Health Canada on technical and scientific matters. However, in July 2003 the federal government announced that it was consolidating the two bodies under the name, membership and mandate of the Expert Advisory Committee on Blood Regulation and naming to it two members of the National Blood Safety


Council. Stakeholders such as the Canadian Hemophilia Society expressed concerns that this measure would reduce transparency, as the National Blood Safety Council, unlike the Expert Advisory Committee, had held public forums.\(^{(17)}\)

Health Canada has indicated that it has addressed recommendations 35 to 38, which recommend changes to the *Food and Drug Regulations*. While the department contends that some of the improvements are still a work in progress, it indicates that other recommendations have been accomplished without the need to change regulation.\(^{(18)}\)

### E. Public Health (Recommendations 46 to 50)

The final recommendations of the Krever report, which aimed to improve reporting of infections from blood and blood products, increase funding and promote transfusion medicine, were directed at the provincial and territorial ministries of health and at the physician and surgeon governing bodies. Krever’s report identifies that the provinces and territories are responsible for reporting transfusion–transmitted infections, and recommends that the provincial and territorial medical licensing boards should make such reporting a standard of practice. A related recommendation is that there should be active surveillance of transfusion-related events. In response, the Blood Safety Surveillance and Health Care Acquired Infections Division of the Public Health Agency of Canada established the Transfusion Transmitted Injury Surveillance System (TTISS) within the Transfusion Transmitted Infections (TTI) Section, which promotes reporting and tracking of adverse reactions to transfusions. The most recent report available, however, is the program report for 2003–2004 published in March 2008. The TTI also has a National Working Party for Data Review, which provides guidance to the Public Health Agency on emerging issues related to serious adverse events associated with the use of blood and blood products.

**ACQUITTALS IN THE BLOOD SCANDAL**

**CRIMINAL NEGLIGENCE TRIALS**

Subsequent to the release of the Krever report in which blame was assessed, the RCMP undertook a five-year investigation before laying charges in 2002. Those charged were Dr. Roger Perrault, former director of the Canadian Red Cross Society, Dr. John Furesz and


Dr. Wark Boucher, who were officials at the Bureau of Biologics, Health Canada, and Dr. Michael Rodell, who was a vice-president at Armour Pharmaceutical. The defendants were accused of being negligent in the distribution of HT Factorate, a blood-clotting product produced by Armour Pharmaceutical for the treatment of hemophilia between July 1986 and December 1987, a period when, it was alleged, the parties should have been aware that the heat treatment being used by Armour was inadequate to kill any HIV that the product may have contained. In her ruling, following the trial in 2007, Madam Justice Mary Lou Benotto stated that “the allegations of criminal conduct on the part of these men and this corporation were not only unsupported by the evidence, they were disproved.”(19) Victims of the scandal have expressed outrage and frustration over the acquittals.

THREATS TO THE BLOOD SYSTEM SINCE THE TAINTED BLOOD SCANDAL

The most notable threats to public health since Justice Krever issued his final report in 1997 have been severe acute respiratory syndrome (SARS) and West Nile virus. The SARS outbreak occurred between February and June 2003. West Nile virus was first confirmed in humans in Canada in 2002. Infections declined for a few years after a spike in 2003, but the summer of 2007 saw the highest number of Canadians infected with West Nile virus. Canadian Blood Services (CBS) and Héma-Québec work closely together and have adopted similar policies in order to safeguard the blood supply.

Shortly after SARS appeared in Canada, it was identified as a respiratory infection. There was no scientific evidence to suggest that the pathogen causing it could be transmitted through blood. Nevertheless, as a precautionary measure, CBS introduced a deferral policy in April 2003 for potential blood donors.(20) CBS questioned potential donors as to whether they had conducted any recent out-of-country travel to areas of high risk for SARS, had been in detention in a quarantined facility in Canada, had placed themselves under quarantine, or had contact with or cared for anyone with SARS. Those who answered “yes” to any of these scenarios were required to defer their donation for 14 days. In May, CBS further required that


potential donors who had or who were suspected to have had SARS would have to defer their
donation for 28 days following resolution of symptoms or treatment. Furthermore, CBS urged
donors to report back to them if they developed SARS-like symptoms within 14 days of donation
and CBS would retrieve and quarantine the donations of those individuals who subsequently
were diagnosed with SARS.

CBS has also had a strategy in place since 2003 to minimize the threat posed to
the blood system by West Nile virus. In Canada, the virus was first confirmed in birds in Ontario
in 2001, and the first human case of West Nile virus was confirmed in Ontario in September
2002.\(^{(21)}\) Screening of blood donations includes testing of “mini-pools” where small samples
from six donations are pooled and tested for the virus. Any tests that come back positive then
cause all six original donations to be tested. Single unit testing is performed in areas where
humans have contracted West Nile virus at rates of 1 in 1,000 in rural areas, or 1 in 2,500 in
urban areas. Additionally, CBS may decide not to collect blood in highly affected areas and
invoke efforts to increase donations in unaffected parts of the country. When samples test
positive for West Nile virus, the donations are withdrawn and the donors are notified.
Nevertheless, it has been reported that two Canadians have contracted West Nile virus through
blood transfusions, and one has died.\(^{(22)}\) This information is not available on the CBS or Public
Health Agency of Canada websites. The following statistics were derived from information from
the Public Health Agency of Canada’s surveillance of West Nile virus and from CBS.

<table>
<thead>
<tr>
<th>Year</th>
<th>Human Cases of West Nile Virus(^{(1)})</th>
<th>Blood Donations with West Nile Virus(^{(2)})</th>
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<tr>
<td>2002</td>
<td>414</td>
<td>Not tested</td>
</tr>
<tr>
<td>2003</td>
<td>1,481</td>
<td>14</td>
</tr>
<tr>
<td>2004</td>
<td>25</td>
<td>0</td>
</tr>
<tr>
<td>2005</td>
<td>225</td>
<td>15</td>
</tr>
<tr>
<td>2006</td>
<td>151</td>
<td>8</td>
</tr>
<tr>
<td>2007</td>
<td>2,213</td>
<td>70</td>
</tr>
</tbody>
</table>

Sources:


Finally, CBS has deferral policies to protect the blood supply against variant Creutzfeldt-Jacob disease. This is a neurodegenerative disease called a transmissible spongiform encephalopathy, and there is a probable link between this disease and bovine spongiform encephalopathy (BSE), or mad cow disease. In 1999, CBS introduced a deferral policy for potential donors, which they have further revised over the years as new information has come to light. At this time, the deferral policy states that people are not eligible to donate “if they have spent a cumulative total of three months or more in the United Kingdom or France between 1980 and 1996, or a cumulative total of five years or more in Western Europe outside of the United Kingdom and France since 1980. In addition, people are not eligible to donate blood or plasma if they have had a blood transfusion or have received medical treatment with a product made from blood in the United Kingdom, France or Western Europe since 1980.”

CONCLUSION

The Commission of Inquiry on the Blood System in Canada, headed by Justice Horace Krever, was conducted over four years, and it resulted in a comprehensive report with 50 recommendations regarding not only the operator responsible for collecting, storing and disseminating blood, but also the federal regulator, provincial/territorial governments and the professional medical bodies. Now Canada has a new blood agency which operates more transparently than the previous blood administration system under an improved governance structure and seems to have earned the trust of Canadians. In addition, the other players involved have exhibited a commitment to reducing the risk inherent in a blood supply system. Should there ever be a threat to the blood supply again, similar in magnitude to that of HIV and HCV, the measures outlined in this paper should help to minimize contamination of the supply.


APPENDIX\(^{(1)}\)

TIMELINE

1971 – The Canadian Red Cross Society discontinues collecting blood in prisons due to risk of hepatitis, which was higher than in the general Canadian population.

1974 – First case of transfusion-related non-A, non-B hepatitis (later called hepatitis C) transmission.

1983 – Compulsory reporting of hepatitis C (HCV) by the Canadian Red Cross Society begins; 134 cases identified.

1984 – First known case of HIV infection through the blood system.


The Canadian Red Cross Society begins testing blood products for HIV.

1986 – The United Kingdom stops using Armour Pharmaceutical’s HT Factorate due to speculation that it may be contaminated with HIV.

The United States implements “surrogate testing” to screen donated blood and blood products for HCV, but Canada does not follow suit.

1987 – Chiron Corporation identifies HCV, permitting development of a specific test to screen blood.

Armour Pharmaceutical recalls all of its HT Factorate.


1990 – The Canadian Red Cross Society begins testing for HCV using a newly developed process that tests for the antibody to the virus.


\(^{(1)}\) This timeline has been compiled using various references cited in this paper.

Some provinces announce that they will compensate those who contracted HIV through the blood system.

The Commission of Inquiry on the Blood System in Canada [Krever Commission] is created by an Order in Council.

The Krever Commission begins its inquiry.

1995 – Krever notifies certain people and organizations that he may name them for misconduct in the scandal. Those involved try to have Krever’s authority to assess blame struck down by the courts, which delays the inquiry.

1996 – The Supreme Court of Canada rules that Krever can name specific parties for wrongdoing.

1997 – The final report of the Krever Commission is released.

1998 – The RCMP launches an investigation into allegations of misconduct.

Federal and provincial health ministers announce a $1.2-billion compensation package for those infected with HCV through the blood system between January 1986 and July 1990.

Canadian Blood Services takes over as the operator of Canada’s blood system. Federal Health Minister Alan Rock announces the “Care, not Cash” package for those infected with HCV before January 1986 and after July 1990.

Ontario announces compensation for those infected with HCV through the blood supply outside the 1986–1990 period. Quebec makes a similar announcement in 1999, Manitoba follows suit in 2001 and British Columbia in 2003, although all packages differ significantly.

2001 – The Supreme Court of Canada rules that the Canadian Red Cross Society was negligent in managing the blood system during the early years of the AIDS crisis.

The Ontario Court of Justice approves a Canadian Red Cross Society settlement for those infected with HCV through the blood system outside the 1986–1990 period.
2002 – The RCMP lays criminal negligence charges against four physicians from the Canadian Red Cross Society, the federal government and Armour Pharmaceutical.


The Canadian Red Cross Society pleads guilty to distributing a contaminated product and is fined $5,000, the maximum allowable under the Food and Drugs Act, in exchange for dropping six criminal charges against the organization. The Red Cross also agrees to donate $1.5 million to the University of Ottawa for a research endowment and scholarship for family members of those affected.

2006 – The trial of those accused of criminal negligence begins.

The Prime Minister announces a compensation package for those infected with HCV before January 1986 or after July 1990.

2007 – Final approval is granted for a compensation package for those who contracted HCV through blood or blood products outside the 1986–1990 period.

All defendants in the criminal negligence trial are acquitted.