

CANADA / JUDGMENT

Bath v. Singh

2022 BCSC 431

COURT

Supreme Court of British Columbia

DECIDED

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2022 BCSC 431 Bath v. Singh

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Bath v. Singh,

2022 BCSC 431

Date: 20220316

Docket: M170018

Registry: New Westminster

Between:

Rajwant Bath

Plaintiff

And

Gurupdesb Singh

Defendant

- and -

Docket: M200330

Registry: New Westminster

Between:

Rajwant Bath

Plaintiff

And

Thomas David Garnett and Gurupdesch Singh

Defendants

Corrected Judgment: The front page of the judgment was corrected on March 21, 2022.

Before: The Honourable Justice Lamb

Reasons for Judgment

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Place and Dates of Trial:

New Westminster, B.C.

October 4-8; 12-15, 2021

Place and Date of Judgment:

New Westminster, B.C.

March 16, 2022

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Introduction

- [1] On April 27, 2013, Rajwant Bath, the plaintiff in this action, was the front seat passenger in a vehicle that rear-ended another vehicle ("MVA #1"). On March 20, 2016, Ms. Bath was the front-seat passenger in a vehicle that was struck by another vehicle ("MVA #2"). Liability for both accidents is admitted, and the defendants did not ask for an allocation of damages between the accidents.

- [2] As a result of MVA #1, Ms. Bath experienced pain in her neck, shoulders, back and left hand. Ms. Bath was off work for four and a half months before returning to her full-time job as a psychiatric nurse. A few months later, she reduced her workload to .82 full-time equivalent ("FTE"). As a result of MVA #2, Ms. Bath suffered an aggravation of the injuries from MVA #1. Ms. Bath remained off work for more than two-and-a-half years after MVA #2 before returning to her .82 FTE position. Ms. Bath claims the injuries from the accidents reduced her earning capacity, past and future. Ms. Bath seeks damages for non-pecuniary loss, loss of earning capacity, loss of housekeeping capacity, future cost of care, and special damages.
- [3] The defendants acknowledge Ms. Bath suffered soft-tissue and psychological injuries as a result of the accidents, but the defendants say that the injuries have not interfered with Ms. Bath's earning capacity nor caused the extent of pain and suffering claimed. The defendants say that Ms. Bath's move to a .82 FTE position was a voluntary career choice not related to the accidents.

Background

- [4] Ms. Bath is 57 years old. Gurupdesch Singh has been her spouse for approximately 30 years. They have three adult daughters together. Ms. Bath lives with her youngest daughter, Mr. Singh and Mr. Singh's mother.
- [5] In October 2011, Ms. Bath was diagnosed with bilateral carpal tunnel syndrome. She underwent left carpal tunnel release surgery in May 2012. Post-surgery, she had no residual carpal tunnel symptoms in her left wrist. She did not have surgery on her right wrist, but she was able to manage her symptoms without much difficulty or any limitations. Ms. Bath had no other health issues that were material to her employment or function, though she has hearing loss in one ear. Ms. Bath had no pre-accident psychological concerns.
- [6] Before the accidents, Ms. Bath enjoyed reading, walking and gardening. She did most of the housecleaning, and she helped her mother-in-law cook for the family.
- [7] Ms. Bath's middle daughter, Pavanjot Bath, gave evidence at trial. Pavanjot Bath confirmed that, before the accidents, Ms. Bath was primarily responsible for household tasks and she enjoyed gardening and outdoor chores. Pavanjot Bath described her mother as very active and energetic before the accidents, and reported that she liked walking, hiking and going different places.

MVA #1 and the aftermath

- [8] On April 27, 2013, Ms. Bath was the seat-belted front seat passenger in a Toyota Corolla being driven by her husband. As they merged onto Highway 1 in Vancouver, B.C., her husband braked hard as he tried unsuccessfully to avoid colliding with a vehicle stopped on the highway. Ms. Bath tried to brace herself by placing both hands on the dashboard.

- [9] The collision caused significant damage to the front of the Toyota Corolla, and it was written off.
- [10] Shortly after MVA #1, Ms. Bath felt neck stiffness and right shoulder pain. She had a headache and dizziness. Ms. Bath's left hip and arms were also sore.
- [11] A few days after MVA #1, Ms. Bath saw her family doctor. He recommended physiotherapy, medications and time off work.
- [12] After MVA #1, Ms. Bath experienced disrupted sleep because she could not find a comfortable sleeping position. She started feeling anxious when she was a passenger in a vehicle, especially when another vehicle came close. Ms. Bath reported issues with memory and forgetfulness, which she associated with the accident.
- [13] Over the next few years, Ms. Bath continued to experience symptoms in her neck, shoulders, back, left arm, left hand and legs. Her pain was more right-sided in her neck and shoulders and sometimes moved down into her right arm. She had pain and limited function in her left arm. She continued to have headaches related to neck pain. Neck and shoulder pain disrupted her sleep. She felt dizzy if she looked up or turned too quickly while walking.
- [14] After MVA #1, Ms. Bath limited the amount of housework she did and stopped gardening.

MVA #2 and the aftermath

- [15] On March 20, 2016, Ms. Bath was the front seat passenger in a Lexus RX350 driven by her husband. Their vehicle turned left and was struck on the front-right corner by another vehicle. The Lexus RX350 was written off after MVA #2.
- [16] Ms. Bath was taken by ambulance from the scene of MVA #2 to Langley Memorial Hospital. She had a headache, nausea and dizziness. The emergency room doctor gave Ms. Bath a tetanus injection for a cut across her chest from the seatbelt and prescribed pain medication.
- [17] The second accident aggravated all of Ms. Bath's injuries from MVA #1, which had improved but were still symptomatic right before MVA #2.
- [18] After MVA #2, Ms. Bath's headaches and sleep problems were worse than after MVA #1. Ms. Bath's right shoulder was especially painful after MVA #2, which in turn aggravated her neck pain. Ms. Bath had difficulty lifting her right arm. At times, she had pain that went down the back of her leg and numbness and tingling in her foot.
- [19] Ms. Bath's family doctor recommended physio, massage therapy, medication and time off work.

- [20] Over time, Ms. Bath became depressed when she did not recover. Her low mood was aggravated by ongoing sleep disturbances. Pavanjot Bath noticed her mother's deteriorating psychological health and found her to be more irritable and less social than before the accidents.

Treatment

- [21] Ms. Bath's primary care provider is her family doctor, Dr. Davey Gin. Ms. Bath saw Dr. Gin 127 times for accident-related issues. Dr. Gin did not testify at trial, though some of his clinical records were introduced into evidence as business records.
- [22] In 2017, Dr. Gin referred Ms. Bath to Dr. Navraj Heran, neurosurgeon, for neurological symptoms in her left leg. Dr. Heran prepared an expert report that Ms. Bath filed at trial.
- [23] Dr. Gin referred Ms. Bath to the Jim Pattison Pain Clinic. She went there in 2017 and 2018 for nerve block and trigger point injections that provided temporary relief. She also saw psychologist Dr. Mok a few times and attended education sessions on living with pain.
- [24] Dr. Gin referred Ms. Bath to see Dr. J.S. Jaworski, physiatrist. Ms. Bath has been seeing Dr. Jaworski since April 2018, and he provided non-opinion evidence at trial.
- [25] After MVA #1, Ms. Bath attended regular physiotherapy and massage therapy treatments. She did a work hardening program with a kinesiologist, which was beneficial.
- [26] After MVA #2, Ms. Bath continued with paramedical treatments: From March 2013 to the date of trial, she attended approximately 450 physiotherapy and active rehabilitation sessions, and 80 massage therapy sessions.
- [27] Ms. Bath has taken a number of medications over the years to manage her pain from the accidents. She continues to take Celebrex as required. Ms. Bath takes Amitriptyline to help with sleep, and she started taking Duloxetine for her depressed mood after MVA #2.

Education and employment

- [28] Ms. Bath graduated from high school in 1983. In 1986, she completed a two-and-a-half year psychiatric nursing diploma at British Columbia Institute of Technology and started working full-time as a nurse caring for geriatric psychiatric patients at Riverview Hospital in Coquitlam, B.C.
- [29] In 1999, Ms. Bath moved to California with her family. She upgraded her qualifications and then challenged the nursing exam in order to register as a nurse in California in 2001. Ms. Bath worked full-time as a security guard while taking steps to qualify as a nurse in California.
- [30] From 2001 to 2006, Ms. Bath worked as a nurse at a convalescent facility in San Jose, CA. By the time she left California, Ms. Bath was working as a charge nurse, which is a supervisory position.

- [31] After moving back to British Columbia in early 2006, Ms. Bath secured a full-time position on a two-year contract as manager of care at Blue Spruce Cottage, a private 15-bed facility. In mid-June 2006, she also started working on-call on weekends at the Forensic Psychiatric Hospital in Coquitlam, B.C. Ms. Bath generally worked at least three to four shifts per month at the Forensic Psychiatric Hospital while working full-time during the week at Blue Spruce Cottage.
- [32] In January 2009, Ms. Bath accepted a full-time position as a registered psychiatric nurse in a maximum-security female-only unit at the Forensic Psychiatric Hospital. Ms. Bath continued in that position until MVA #1.
- [33] The Forensic Psychiatric Hospital treats patients who have been found not criminally responsible on account of mental disorder. It is divided into maximum, medium and minimum-security units. Working on the maximum-security unit is the most demanding because the patients are generally less settled, less predictable and more aggressive than in other units. There is a higher risk of physical violence by patients toward staff. All staff are expected to respond to a Code White, which is an emergency situation involving patient aggression against staff, another patient or themselves. A Code White may require staff to lift or restrain a patient.
- [34] Working as a psychiatric nurse is physically and psychologically challenging. Ms. Bath's job duties on the maximum-security ward included performing patient assessments, administering medication, charting, escorting patients between buildings, and attending emergency situations.
- [35] After MVA #1, Ms. Bath was off work receiving paid sick leave from April 29, 2013 to September 8, 2013. On October 4, 2013, she completed a graduated return to work on the maximum-security unit. She continued working full-time for the next five-and-a-half months.
- [36] On March 28, 2014, Ms. Bath moved to a .82 FTE position in Hawthorne, a minimum-security unit at the Forensic Psychiatric Hospital. I will review the reasons for this change when assessing damages for loss of earning capacity.
- [37] Hawthorne is a pre-discharge unit that houses patients who are in the final stages of transitioning back to the community. Some Hawthorne patients spend part of their day in the community before returning to Hawthorne in the evening. The patients in Hawthorne are generally more settled and more stable than those in higher security units. There are fewer episodes of patient aggression, and Code Whites occur rarely. Ms. Bath's job duties include checking on patients every two hours, charting, administering medication, and escorting patients between buildings.
- [38] From March 28, 2014 until MVA #2 happened on March 20, 2016, Ms. Bath worked at Hawthorne in the .82 FTE position. She picked up some additional shifts and overtime.

- [39] After MVA #2, Ms. Bath was off work from March 20, 2016 until December 10, 2018. She attempted a gradual return to work program in June 2017, but it was unsuccessful. Ms. Bath initially received sick leave benefits before collecting long-term disability benefits from July 20, 2016 until July 19, 2018. She was then on an unpaid leave of absence until she returned to work.
- [40] From December 10, 2018 to January 4, 2019, Ms. Bath completed a gradual return to work for her .82 FTE position in Hawthorne. Since her return to work, Ms. Bath has picked up extra shifts, but she does not work full-time hours.
- [41] After returning to work in December 2018, Ms. Bath found it difficult to handle patient charts, which can weigh up to 15 pounds. She had issues with concentration and finding words. Ms. Bath found it challenging to climb stairs, which are in four of the six patient houses in Hawthorne. She is not required to respond to Code White calls because of her condition.

Current condition

- [42] Ms. Bath says that she has not been pain-free at any time since MVA #1. Her pain is mostly in her neck, right shoulder, both elbows and low back. Her neck pain is triggered by looking down to read for pleasure or to document in patient charts at work. The low back pain is worse on the left than the right side, and she has numbness and tingling down her left leg. She has a dull headache all the time, and she develops more significant headaches two or three times per week. She feels dizzy any time she looks up or down for too long. Her pain and headaches are manageable with medication.
- [43] From a psychological perspective, Ms. Bath feels like her pain has lasted a long time and has changed her as a person. Life is less enjoyable, and she misses her pre-accident activities. She is more irritable with her family. Ms. Bath has to focus more at work to avoid making mistakes, and she finds it difficult to concentrate.

Impact on activities

- [44] Ms. Bath has reduced the amount of housework she does, and she barely keeps up. Pavanjot Bath confirmed that her mother asks her family for help and that her house is not as clean as it used to be. Ms. Bath is renovating her kitchen and installing a wall oven so she does not have to look down to cook.
- [45] Ms. Bath is careful going up and down stairs. Her work colleague has observed her difficulties navigating the stairs between patient residences.
- [46] To avoid neck pain and dizziness, Ms. Bath no longer reads for pleasure nor tends to her outdoor gardens.

- [47] To help with lifting patient charts since returning to work after MVA #2, Ms. Bath wears braces on her elbows.
- [48] Ms. Bath is now more irritable with her spouse and daughters than before the accidents.
- [49] As an example of her reduced functional capacity, Ms. Bath reports that she was less involved in preparing for her daughter's wedding in July 2021 as a result of her injuries. Pavanjot Bath says that her mother used to be the life of the party, but she was not able to participate in a traditional wedding ritual.
- [50] Ms. Bath walks and stretches every day. She does physiotherapist-recommended exercises three or four times per week.

Workplace injuries

- [51] In February 2016, Ms. Bath tripped on a desk at work and fell backwards. She extended her left hand to break her fall. Ms. Bath took a few days off work until she had an X-ray and was medically cleared to return to work. I accept that Ms. Bath did not suffer any ongoing effects from this incident, which was not caused by or related to the accidents.
- [52] On February 9, 2021, Ms. Bath reached out to put a heavy patient chart back on the shelf, and she felt pain in her mid-back. Ms. Bath was unable to work for approximately six weeks. On March 25, 2021, she started a graduated return to work program, and she resumed regular duties on May 14, 2021.
- [53] Ms. Bath made a claim to Worksafe BC for the February 2021 incident. Worksafe BC records were filed as business records at trial.
- [54] Ms. Bath believes that the February 2021 work injury is related to the accidents because she feels more susceptible to injury than she was before the accidents. However, Dr. Gin prepared various physician reports for Worksafe BC in respect of the February 2021 work injury, all of which documented "no previous injuries" in answer to the question "prior/other problems affecting injury, recovery and disability". Further, Dr. Faraday, an expert witness called by the plaintiff, opined that the February 2021 work injury was not related to the accidents. None of the other expert witnesses commented on the cause of the February 2021 work injury.
- [55] On the whole of the evidence, I find that the February 2021 work injury was not causally connected to the accidents and the time off work following this incident is not compensable in this action.

Medical evidence

- [56] Ms. Bath filed medical legal reports from Dr. Trent Faraday, general practitioner; Dr. Navraj Heran, neurosurgeon; and Dr. Zohar Waisman, psychiatrist. These experts were cross-examined on their reports. Ms. Bath also called Dr. J.S. Jaworski, her treating physiatrist, to provide non-opinion evidence about his observations and recommendations.
- [57] In response, the defendants filed medical legal reports from Dr. Gabriel Hirsch, physiatrist; Dr. John Wade, rheumatologist; and Dr. Okorie, psychiatrist. Dr. Hirsch and Dr. Wade assessed the plaintiff. Dr. Okorie provided a rebuttal report to Dr. Waisman's report without assessing Ms. Bath.
- [58] Although some of the experts used different medical terms when providing their diagnoses, there is little dispute that Ms. Bath suffered soft tissue injuries to her neck, upper back and low back as a result of the accidents. She has ongoing pain and limitations in those areas. Given the duration of her physical symptoms, the prognosis is guarded.
- [59] Ms. Bath's continuing pain eventually affected her mood. The psychiatrists agree that she developed an Adjustment Disorder. Dr. Waisman believes that she meets the diagnostic criteria for Somatic Symptom Disorder ("SSD"), which would make recovery less likely. Dr. Okorie disagrees with the SSD diagnosis.

Dr. Trent Faraday

- [60] Dr. Faraday is a general physician with a practice focused principally on management of musculoskeletal injuries. Dr. Faraday assessed Ms. Bath on June 12, 2021 at her lawyer's request and prepared a report dated July 9, 2021.
- [61] On physical examination, Ms. Bath reported tenderness on palpation in her neck, in her right shoulder, to her upper back muscles (right greater than left), and to muscles in her hip region. Ms. Bath reported mild tenderness in her lower back on palpation. She had a slight limp, favoring her left leg. She had fair or normal range of motion in most areas, with reduced range of motion for her right shoulder and reduced range of motion when bending forward at the waist. Strength testing was normal, and there were no signs of muscle wasting.
- [62] Dr. Faraday opined that Ms. Bath suffered soft tissue injuries to her neck, upper back, right shoulder, lower back and gluteus muscles as a result of the accidents, all with ongoing pain symptoms that are now chronic. Dr. Faraday opined that the accidents also caused ongoing cervicogenic headaches, sensory disturbance symptoms of pain radiating to her arms and her left leg, and depressive and anxiety symptoms. Dr. Faraday believes the radiating pain in her arms and left leg are likely due to muscle tension in her neck and back rather than nerve root compression.

- [63] Given the duration of Ms. Bath's symptoms, Dr. Faraday expects her pain and headaches to persist indefinitely. Dr. Faraday says the prognosis for improvement of her psychological condition remains poor based on the duration and nature of treatment to date as well as the poor prognosis for her pain.
- [64] Dr. Faraday opines that Ms. Bath's post-accident time away from work and reduced ability to work are "appropriate and related to the effects of her physical and psychological injuries sustained in the two accidents". In light of her poor prognosis for further recovery, Dr. Faraday does not anticipate that Ms. Bath will develop tolerance to resume full-time hours as a psychiatric nurse, though she will likely continue to be able to pick up occasional extra shifts as she has been doing. Dr. Faraday expresses "concern" for Ms. Bath's ability to perform work as she gets older, noting individuals with persistent pain have reduced capacity as they age.
- [65] In terms of future treatment, Dr. Faraday suggests continuing with periodic trigger point injections for flare-ups of pain that do not respond to other measures. He anticipates that she will require her current daily medications indefinitely. Dr. Faraday encourages Ms. Bath to participate in regular active exercise. He anticipates that Ms. Bath will experience acute exacerbations of her pain, likely once per year, and he recommends four sessions of massage therapy or physiotherapy on those occasions. Dr. Faraday says that Ms. Bath will require assistance with housekeeping, particularly seasonal cleaning activities.

Dr. Navraj Heran

- [66] Dr. Heran is a neurosurgeon who initially saw Ms. Bath on a consult in February 2017 on a referral from her family doctor. At that time, Ms. Bath had no focal neurological abnormalities on examination. Dr. Heran referred her for nerve block injections in her neck and low back for suspected nerve root compression.
- [67] Ms. Bath returned to see Dr. Heran for a medical legal assessment on June 25, 2021. He prepared a report dated July 2, 2021 that was filed at trial.
- [68] On examination, Ms. Bath reported some discomfort on palpation to the left lower back region and to the right side of her neck that extended to her upper back. Dr. Heran found no nerve root irritation on examination of her low back. Ms. Bath had restricted range of motion in her neck. She had almost full range of motion of her low back but with some increased pain on forward and backward bending. She had full strength and normal gait.
- [69] As a result of MVA #1, Dr. Heran diagnosed Ms. Bath with soft tissue injuries of her neck, upper back (more on the right side), and low back; mechanical neck pain (pain with movement) with associated right-sided nerve irritation; mechanical low back pain with left-sided nerve irritation; headaches related to neck pain; and posttraumatic dizziness. Dr. Heran diagnosed exacerbation of her neck and upper back symptoms and possible aggravation of her low back symptoms as a result of MVA #2.

- [70] Dr. Heran believes Ms. Bath's condition has plateaued. He noted there were no major changes in her symptom complex between February 2017 and June 2021, though there were aggravations at times. He anticipates that she is "definitely at increased risk for exacerbations and aggravations at her source of symptoms", and she should have active and passive treatment when they happen.
- [71] Dr. Heran recommends updated imaging of her neck and low back and repeat bone scans to assess progress. He suggests more aggressive management of her chronic pain should be considered if imaging does not show progression of spine degeneration.
- [72] Dr. Heran endorsed all treatments utilized to date as reasonable, even though they provided only transient symptomatic relief. He recommends adding CBD with a THC combination to her current medications.
- [73] Dr. Heran anticipates that Ms. Bath should be able to continue working at her current capacity, though she is at increased risk of aggravation of symptoms that may lead to early retirement. Her limitations related to housekeeping and recreational activities will likely continue. She is capable of sedentary to light duties, and she should avoid static, weight-bearing and jarring activities.

Dr. Jaworski

- [74] In his testimony at trial, Dr. Jaworski summarized his findings on treatment visits between April 6, 2018 and September 29, 2021.
- [75] Dr. Jaworski confirmed that Ms. Bath continues to have good days and bad days in terms of her pain levels. A major focus of managing her condition is to keep her as functional as possible and to maintain emotional stability.
- [76] In May 2018, Dr. Jaworski prescribed Duloxetine, an anti-depressant, at a dose of 30 - 60mg per day. He increased the dosage to 90mg per day in August 2018 and to 120mg per day in July 2019. Since February 2020, the prescribed dosage has varied from 90mg to 120mg per day depending on her mood.
- [77] In July 2021, Dr. Jaworski recommended that Ms. Bath be referred to a psychiatrist based on his concern about "her emotional well-being in the context of symptomatic pain flare-ups". Her family doctor made the referral, and Ms. Bath remains on a wait list to see a psychiatrist.

Dr. Hirsch

- [78] Dr. Hirsch is a physiatrist who assessed Ms. Bath at the request of the defendants on January 27, 2020 and prepared a report of the same date.

- [79] On examination, Ms. Bath had reduced range of motion in her neck and back. Dr. Hirsch noted that Ms. Bath had more complete neck movements without pain mannerisms when he was not examining her. Ms. Bath complained of widespread tenderness in the neck, shoulder girdle region and low back. Ms. Bath reported pain in her left hip when she moved through range of motion testing.
- [80] Dr. Hirsch diagnosed soft tissue injuries arising from MVA #1, in particular to her neck. He concluded that Ms. Bath suffered neck and back injuries as a result of MVA #2. He suspects that she may have suffered joint injuries to her neck and low back as a result of MVA #2 or alternatively that MVA #2 made pre-existing degenerative conditions symptomatic.
- [81] Dr. Hirsch suggested that Ms. Bath's clinical course was complicated by her emotional and psychological reaction to her circumstances. He noted that anxiety, depression and sleep disturbance can lower the pain threshold and amplify disability.
- [82] Dr. Hirsch concluded that Ms. Bath had "nonspecific" neck and low back pains, meaning that he could not identify the anatomical reason for her ongoing pain. He concluded that her headaches seem to be related to neck pain.
- [83] Dr. Hirsch recommended that Ms. Bath continue with her existing self-directed home-based exercise program. He thinks she has had enough guidance in this regard and does not need a personal trainer. He did not recommend passive therapies (such as physiotherapy or massage) or further trigger point injections or nerve blocks.
- [84] Dr. Hirsch thought it reasonable to conclude that Ms. Bath's physical complaints were intertwined with her mental health issues and that improvement of the latter would probably reduce her pain complaints. He also thought that improving her fitness level would probably reduce her pain and increase her function, though fully reversing her deconditioned state was only a possibility.
- [85] Dr. Hirsch opined that Ms. Bath will be able to continue working as a psychiatric nurse in the capacity she was working at the time of his assessment (which was .82 FTE with some additional shifts). He thinks she can perform all domestic tasks, though she may have to pace herself.
- [86] As of January 2020 when he prepared his report, Dr. Hirsch expected her pain would last at least another year if not longer. Dr. Hirsch did not expect her pain would "significantly adversely affect her professional endeavours in the long-term".

Dr. Wade

- [87] Dr. Wade is an internal medicine specialist and rheumatologist who conducted a medical legal assessment on May 10, 2019 and prepared a report dated November 5, 2019.

- [88] On examination, Ms. Bath had reduced forward and side bending in her neck and reduced forward bending in her low back. Otherwise, her range of motion was within normal limits. Ms. Bath reported pain when bending her neck to the side, diffuse tenderness throughout her upper back and low back, and pain along her spinal muscles in the mid-back (left more than right). She also reported tenderness in her feet.
- [89] Dr. Wade opined that Ms. Bath had probable moderate soft tissue injury to her neck and mild soft tissue injury to her low back as a result of MVA #1. She improved with physiotherapy. As a result of MVA #2, Ms. Bath sustained a probable moderate soft tissue injury to her neck and moderate soft tissue injury to her low back.
- [90] As of the date of his assessment, Dr. Wade diagnosed Ms. Bath with mechanical neck pain with known degenerative changes and symptoms of mechanical low back pain. He found no significant neurological injury. Dr. Wade noted that Ms. Bath had symptoms and findings of mild inflammatory arthritis in her wrists and feet that was not related to the accidents. Ms. Bath also had mild right carpal tunnel syndrome and mild nerve irritation in her right elbow.
- [91] Dr. Wade suggested that Ms. Bath's history of sleep disturbance could be related to restless leg syndrome (which would not be related to the accidents). He conceded on cross-examination that poor sleep could also be caused by her neck and back pain or her depression and anxiety.
- [92] Dr. Wade suspected that Ms. Bath had mild fibromyalgia that waxes and wanes even though she did not strictly fulfill the criteria of tender points for fibromyalgia.
- [93] As of May 2019, Dr. Wade recommended that Ms. Bath pursue a structured rehabilitation program, including gentle gradual strengthening of her neck and back. He emphasized that she needed to continue to exercise daily to strengthen her neck and back muscles in order to reduce mechanical neck and back pain and muscle spasm.
- [94] As of May 2019, Dr. Wade expected Ms. Bath would be able to continue working unless her condition changed.

Dr. Waisman

- [95] Dr. Waisman is a psychiatrist with a subspecialty in forensic psychiatry. He conducted a psychiatric assessment of Ms. Bath on May 25, 2021 at the request of her counsel, and he prepared a report dated July 9, 2021.
- [96] At the time of his assessment, Ms. Bath was taking 120mg of Duloxetine for mood and 75mg of Amitriptyline as a sleep aide. She was also taking Celebrex for pain.
- [97] Her only psychological treatment and counselling was done in 2018 at the pain clinic.

- [98] On assessment, Ms. Bath reported anxiety, worry, irritability and frustration. She found less pleasure in activities. She reported sleep disruption and reduced energy. She complained of being forgetful and having reduced concentration as compared to before the accidents. She reported bi-weekly panic attacks.
- [99] Dr. Waisman conducted a mental status examination. Dr. Waisman noted that Ms. Bath was somewhat restless, and her affect was constricted and flat. She described her mood as depressed and frustrated.
- [100] Based on his review of records, the history provided and his examination, Dr. Waisman concluded that the accidents "led Ms. Bath to collapse her defenses and develop an Adjustment Disorder with mixed depression and anxiety". This diagnosis stems in part from Dr. Mok's psychological consult report from June 2018 remarking that Ms. Bath "expected herself to push through and rise above her pain" and that she was disappointed after a failed attempt to return to work in the summer of 2017.
- [101] According to Dr. Waisman, Ms. Bath also meets the criteria for SSD with predominant pain, moderate and persistent. Dr. Waisman found that Ms. Bath suffered from "excessive thoughts and feelings related to the chronic pain condition as manifested by [a] persistently higher level of anxiety about health or her pain symptoms".
- [102] Dr. Waisman's diagnosis of SSD is based on his finding that Ms. Bath meets the three criteria prescribed by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition ("DSM-5"). He believes that she meets the first criterion of "significant disruption" because her pain has affected her function in many areas of her life, including work and enjoyment of life. In particular, she has not returned to full-time work or full duties in that she does not attend Code Whites, and she has lost pleasure in life and no longer engages in her preferred hobbies. Dr. Waisman believes that she meets the second criterion because she thinks excessively about her pain as compared to the average person, and she has spent a significant amount of time on treatment and rehabilitation. The third criterion recognizes that the disorder may have periods of remission or exacerbation in the context of persistent symptomology, which is consistent with Ms. Bath's history.
- [103] In defending his diagnosis of SSD, Dr. Waisman explained that the DSM-5, the source of the diagnostic criteria, is a tool to facilitate communication between medical people and is not a legal text. Dr. Waisman emphasized that clinical judgment is engaged in deciding whether criteria for a diagnosis are satisfied.
- [104] Dr. Waisman offered a guarded prognosis because it is very difficult to manage patients with several psychiatric conditions. He opined that Ms. Bath's Adjustment Disorder and SSD are intertwined, but the treatment for Adjustment Disorder (anti-depressants and psychotherapy) may not effectively treat SSD. Dr. Waisman opined that Ms. Bath requires multi-disciplinary treatment that is difficult and complicated due to the nature and effects of her condition. He recommended weekly psychotherapy for one year and a referral to a chronic pain multidisciplinary program.

- [105] Dr. Waisman acknowledged on cross-examination that Ms. Bath's anxiety and depression may decrease if her physical pain goes away.
- [106] Dr. Waisman anticipates that Ms. Bath's ability to cope with her psychiatric conditions will decrease as she ages, which will affect her ability to handle her demanding work environment. He notes that "[f]uture stressors may trigger her current fragile condition and lead to further suffering".
- [107] Dr. Waisman testified that he is very familiar with the demands on nursing staff in a forensic psychiatric setting. He opines that her chronic pain issues and adjustment disorder prevent her from assisting when patients are violent and make her more vulnerable to attacks by patients.

Dr. Okorie

- [108] Dr. Okorie is a psychiatrist. He prepared a report dated September 8, 2021 in response to Dr. Waisman's report without assessing Ms. Bath.
- [109] Dr. Okorie agrees with Dr. Waisman that Ms. Bath meets the diagnostic criteria for Adjustment Disorder with depressed mood and anxiety. He agrees that her Adjustment Disorder was caused by accident-related pain and functional limitations.
- [110] Dr. Okorie disagrees with Dr. Waisman's diagnosis of SSD. He says that a diagnosis of SSD indicates "the patient has a maladaptive relationship with their pain such that their pain-related thoughts, emotions, behaviors are unreasonably much worse than that of an average patient with a similar condition".
- [111] Dr. Okorie says that patients with SSD are so preoccupied with their pain that it "consumes and dominates their lives" to the point where they cannot carry out daily activities. He says that although Ms. Bath has chronic neck and back pain, there is no indication that she has developed a "maladaptive and obsessive relationship" with her pain. Dr. Okorie emphasized that the fact Ms. Bath continues working as a psychiatric nurse is incompatible with a diagnosis of SSD. He notes that Drs. Faraday and Heran opined that "her current work, recreational, domestic, and personal functioning is reasonable and proportionate to her residual pain".
- [112] Dr. Okorie agrees with Dr. Waisman that Ms. Bath would benefit from psychological treatments such as cognitive behaviour therapy, mindfulness training and acceptance, and commitment therapies. Dr. Okorie says that in regular clinical practice, the usual recommendation is 12-16 sessions to teach patients how to cope with their pain and negative emotional response, pending review by the therapist. Dr. Okorie expects this treatment would improve her Adjustment Disorder. Further, he anticipates that improvement of her physical symptoms or learning to cope with her pain would positively affect her Adjustment Disorder.

- [113] Dr. Okorie views Dr. Waisman's recommendation for weekly therapy for a year to be excessive and potentially harmful in that it likely would create an unhealthy dependency on the therapist.

Other expert evidence

- [114] The plaintiff also filed expert reports from kinesiologist Hardip Jhaj and economist Kevin Turnbull. Mr. Turnbull's evidence will be considered under the loss of capacity heading below.
- [115] Ms. Jhaj completed a functional capacity evaluation of Ms. Bath on September 3, 2021. The functional capacity evaluation included standard tests of physical abilities and work simulation.
- [116] Ms. Jhaj concluded that Ms. Bath's subjective complaints of pain were consistent with her limitations during the assessment, which included severely limited neck extension, left side bending and rotation.
- [117] On testing, Ms. Bath demonstrated fair to normal strength, with relative weakness in her neck, mid-back, shoulders, hips, left knee and ankle. Ms. Bath used compensatory movements during testing. Ms. Jhaj opined that Ms. Bath would likely have difficulty doing daily activities over a sustained period of time.
- [118] An industry-accepted standardized job classification rates the physical demands of a psychiatric nurse as "Medium". Ms. Bath was not able to meet the Medium standard for lifting, carrying or stooping. Ms. Jhaj opined that Ms. Bath is best suited to work that has Light to Medium physical demands. Although Ms. Bath met some of the Medium strength standards, her form deteriorated over time.
- [119] Testing revealed that Ms. Bath was able to lift 15 lbs safely and at most 20 lbs from waist to above her shoulders on an occasional basis, which means up to one third of her work day. She was able to meet the walking and stair climbing standardized requirements for a psychiatric nurse.
- [120] Ms. Jhaj did not do a site visit or attempt to compare Ms. Bath's actual job duties to the standard job classification.
- [121] Ms. Jhaj recommended that Ms. Bath continue physiotherapy, massage therapy and chiropractic treatments combined with active rehabilitation with a kinesiologist to manage pain, improve function and address the malalignment that Ms. Jhaj found in Ms. Bath's neck and back.
- [122] Ms. Jhaj recommended support from an occupational therapist to help Ms. Bath return to full job duties and housekeeping responsibilities by teaching her pain management strategies.

- [123] Functional testing demonstrated that Ms. Bath is capable of doing more than she believed based on a self-assessment form she completed as part of Ms. Jhaj's assessment. Ms. Bath was not asked about this on cross-examination, and the defendants did not suggest that I should attach any significance to her under-estimation of her abilities.
- [124] Ms. Jhaj noted in her report that Ms. Bath performed testing without taking pain medication to allow "for the opportunity to observe true functional ability". This was not canvassed on cross-examination, including whether or not Ms. Bath might demonstrate greater functional capacity if she took her usual pain medication.
- [125] Ms. Jhaj offered a prognosis for improvement and recovery. I am not satisfied that she is qualified to offer an opinion on prognosis, and I have ignored it.

Credibility and reliability

- [126] I accept that Ms. Bath's account of her pain and how it has affected her function and mood is generally credible and reliable. Her complaints to her treating health professionals have been consistent over the years, and the medical experts who examined her found that her complaints were consistent with their findings. One of her work colleagues confirmed that she has difficulty lifting heavy charts at work and that she moves a little slower than she did before the accidents. The same colleague sees "pain in her face" at times. Her daughter confirmed Ms. Bath's limitations at home and her increased irritability since the accidents.
- [127] The defendants argued that the plaintiff is not a credible witness even though they acknowledge that she suffered soft tissue and psychological injuries as a result of the accidents. They point to her demeanour when giving evidence, describe her as evasive when answering questions in direct examination, and highlight three inconsistencies they identified in her testimony.
- [128] It is fair to say that Ms. Bath's demeanour changed depending on who asked her questions at trial. Under direct examination, Ms. Bath was soft-spoken with a flat affect, and she generally wore a sombre facial expression. In cross-examination, she was more animated when challenged by defence counsel. A difference in demeanour is a factor that may affect the assessment of credibility: *Bradshaw v. Stenner*, 2010 BCSC 1398 at para. 186 (aff'd 2012 BCCA 296; leave to appeal ref'd: [2012] S.C.C.A. No. 392). However, in this case, the change in demeanour was not extreme. It is not surprising that Ms. Bath was more on edge and somewhat defensive when under cross-examination. However, she was not argumentative, and she remained responsive throughout her testimony.
- [129] As for the defendants' second point, I do not agree that Ms. Bath was evasive, either in direct or cross-examination, simply because she described pain in one part of her body when asked about injuries in another.

- [130] As for the inconsistencies identified by the defendants, there was only one that was material to the issues in this action: Ms. Bath's evidence on direct examination that she did most of the family's cooking prior to the accidents differed from her evidence on discovery and what she told the functional capacity assessor (though the latter discrepancy was not put to her in cross-examination). When confronted with her discovery evidence in which she said her mother-in-law did "all of the cooking", Ms. Bath suggested she must have misunderstood or misheard the discovery question. Although she has a hearing deficit in one ear, Ms. Bath's explanation rang hollow given the clear answer she gave on discovery. That said, I am nevertheless satisfied that this single inconsistency does not significantly undermine Ms. Bath's credibility and that it is more likely than not that both Ms. Bath and her mother-in-law did some of the cooking before the accidents. I note that her daughter testified that Ms. Bath was primarily responsible for cooking for the family before the accidents, evidence that was not challenged on cross-examination.
- [131] As for the other inconsistencies identified by the defendants, I am not persuaded that the tax status of a rental dwelling Ms. Bath co-owns has any impact on the reliability of her evidence on the material issues. Finally, I find there was no clear inconsistency between her discovery evidence and evidence at trial about whether or not she hired anyone to help with yard work as a consequence of her injuries. I accept that she did not hire anyone to help with yard work as a result of the accidents.
- [132] I accept Ms. Bath's testimony relating to the nature and frequency of her pain and how it has affected her function and mood.

Findings and conclusions concerning Ms. Bath's injuries

- [133] Based on all of the evidence, I accept that Ms. Bath suffered soft-tissue injuries to her neck, shoulders, and low back as a result of the accidents. She continues to have pain from these injuries. She has regular headaches related to her neck pain. Her sleep is affected. After MVA #2, Ms. Bath became depressed when she did not recover as anticipated.
- [134] Given the duration of her pain and limitations, and the extensive treatment she has pursued, I accept Dr. Faraday's prognosis that Ms. Bath's current pain complaints are likely to last indefinitely. While there may be potential for reduced pain and increased function with improved fitness, it seems unlikely that Ms. Bath will progress beyond her current fitness level given the time that has passed and the extensive active rehabilitation she has already had. I accept that she remains at risk for aggravations of her current symptoms from time to time.
- [135] As for her psychological condition, both psychiatrists opined and I accept that Ms. Bath developed an Adjustment Disorder with mixed depression and anxiety when her physical symptoms did not resolve. Based on the timing of her consult with Dr. Mok, I find that Ms. Bath developed this condition by at least 2018.

- [136] The only real conflict between the psychiatric experts is whether or not Ms. Bath meets the DSM-5 diagnostic criteria for SSD. I accept that the DSM-5 is a diagnostic tool for clinicians and that it was not created for medical legal purposes. Use of the DSM-5 involves an exercise of clinical judgment, which suggests that different clinicians may reach different conclusions about whether a patient fits a certain diagnosis. In this case, relying on the same factors, one psychiatrist opines that the criteria are satisfied and the other disagrees. For the purpose of assessing Ms. Bath's losses, the significance of the difference between the psychiatric opinions is that the prognosis is worse if Ms. Bath's psychiatric condition is complicated by a dual diagnosis.
- [137] In order to distinguish his opinion, and in effect advocate for its preference, Dr. Waisman emphasized the importance of a mental status exam when assessing a patient. Dr. Waisman insisted that it is impossible to give a psychiatric diagnosis without meeting a patient. On cross-examination, Dr. Okorie explained that he was not offering a "diagnostic opinion" but rather critiquing Dr. Waisman's report: He had no concerns regarding Dr. Waisman's assessment and methodology, but he disagreed with Dr. Waisman's conclusion that Ms. Bath met the criteria for SSD. Dr. Okorie's rejection of Dr. Waisman's conclusion turns on factors unrelated to her mental status exam.
- [138] I find Dr. Okorie's explanation as to why he concluded that Ms. Bath does not meet the diagnostic criteria for SSD to be persuasive. I accept his view that close to full-time employment in a physically and mentally demanding job would not be consistent with the first diagnostic criterion relied on by Dr. Waisman, namely chronic pain that significantly disrupts daily life. Additionally, in relation to the second criterion, none of the medical experts suggested that Ms. Bath pursued excessive treatment based on her physical symptoms. While I accept that Ms. Bath expressed concern to Dr. Waisman about how her condition will impact her ability to continue working, the evidence overall is consistent with Dr. Okorie's view that she does not have a "persistently higher level of anxiety" about her symptoms as compared to others in her condition.
- [139] I accept that there is some potential for improvement of Ms. Bath's Adjustment Disorder with appropriate treatment. She had only a few sessions with a psychologist between January and June 2018, and it is not clear from the evidence at trial whether she was taking an anti-depressant at that time. However, given the duration of her depression and its connection to her physical complaints, I find that the potential for improvement of her psychological symptoms is likely limited.
- [140] I accept that Ms. Bath finds it difficult to concentrate when she is in pain and sleep-deprived. However, there was no medical evidence suggesting a distinct cause or diagnosis for her concentration difficulties. I do not accept her counsel's submission that her inability to recall all of the minute details of visits to her family doctor three or four years ago demonstrates a significant problem in this regard. From my observation, Ms. Bath was able to maintain her focus and respond to questions over many hours of testimony. Her work supervisor has no concerns about her delivery of patient care.

Damages

Past Loss of Earning Capacity

- [141] The claims for past and future loss of earning capacity were the most contentious at trial. At the heart of the dispute is the reason for the change from a full-time position in a maximum-security unit to a .82 FTE position in the minimum-security unit in March 2014. The defendants accept that Ms. Bath should be compensated for her lost earnings for the time she was completely off work after each accident, but they argue that the change to a .82 FTE position on the Hawthorne unit was a "strategic choice" not attributable to her injuries.
- [142] Ms. Bath says that she moved to Hawthorne because the patients are more settled, which makes her job less stressful. Ms. Bath says she was having trouble with headaches, concentration and pain while working full-time in the maximum-security unit. By working less than full-time, Ms. Bath is able to attend medical appointments and pace herself by having more days off between shifts.
- [143] In support of their position, the defendants emphasize the emails Ms. Bath sent to management of the Forensic Psychiatric Hospital when she inquired about the Hawthorne position, none of which referenced her medical condition.
- [144] I am not convinced that Ms. Bath's email exchange with management in March 2014 supports the defendants' position. Ms. Bath asked management how it would work "[i]f a nurse took part time position of .80 and wanted full time position hours". She also expressed concern about whether part-time hours could be further reduced at management's discretion. A manager responded by email and explained that she would work fewer hours if she took the part-time position, but the difference in pay would be small given a recent change in the collective agreement. The manager also explained that she would be eligible for overtime or other straight time shifts based on seniority. When she accepted the position, Ms. Bath wrote, "I will take the [.82 FTE] shift at [Hawthorne] on nights. I would have liked a full time but that is as close as it gets at this time." She also asked whether any full-time positions on the nursing resource team were likely to be posted. At trial, Ms. Bath explained that she did not anticipate she would be part-time forever; she anticipated she would get better and return to full-time.
- [145] The defendants also point to the fact that there is no expert evidence that says Ms. Bath could not work full-time as of March 2014. Ms. Bath testified that she spoke to Dr. Gin many times about how working full-time was too much from a physical perspective. He wrote a note dated May 20, 2014, addressed to the Forensic Psychiatric Hospital, that said she needed to work ".8 time" for now. Dr. Gin's note was filed as a business record at trial. There was no evidence explaining the genesis of the note and whether it was provided to her employer for any purpose.

- [146] While there is no contemporaneous medical opinion, it is significant that none of the medical experts who prepared reports and testified at trial suggest that Ms. Bath is capable of working more hours than she is currently working. Based on the evidence of Ms. Bath and her colleagues who testified at trial, Ms. Bath could easily pick up extra shifts to supplement her .82 FTE position, and she has done so. In 2019 and 2020, she worked close to .9 FTE. However, she has not returned to working the equivalent of full-time hours. Ms. Bath's work history demonstrates that she consistently worked full-time and more prior to the accidents.
- [147] The defendants called evidence from Shaman Ishak, clinical services manager for the Hawthorne unit at the Forensic Psychiatric Hospital since June 2020. Mr. Ishak confirmed that Hawthorne is the lowest security unit at the Forensic Psychiatric Hospital and a preferred unit to work on because the incidence of violence is so much lower than other units. Mr. Ishak testified that Code Whites are quite rare on Hawthorne.
- [148] Mr. Ishak said that permanent full-time positions on the Hawthorne unit do not open up very often. He confirmed that it is very common for nurses to pick up overtime or extra shifts and that shifts are always available throughout the hospital. Mr. Ishak described Ms. Bath as a great worker who is patient-centred and passionate about her work.
- [149] Ron Morley, a British Columbia Nurses Union steward, testified that there are full-time positions available and that it would be very easy to pick up enough shifts in Hawthorne to go from .82 FTE to full-time hours.
- [150] I accept Ms. Bath's evidence that she loves working as a psychiatric nurse. Her emails in March 2014 suggest that she wanted a full-time position in Hawthorne. Although Ms. Bath insisted that she only changed from full-time to part-time to accommodate her injuries, I accept that many senior nurses prefer to work in the minimum-security unit, and this was probably a factor in Ms. Bath's decision to take the .82 FTE position in Hawthorne. However, given her work history, attachment to her chosen profession, stated preference for a full-time position in March 2014, and the availability of extra shifts, I am satisfied on the whole of the evidence that Ms. Bath likely would have worked the equivalent of full-time hours until the trial date but for the injuries she suffered in the accidents. I accept that she has worked less than full-time hours due to the pain and psychological symptoms caused by the accidents.
- [151] Ms. Bath is entitled to be compensated based on what she would have earned but for the injuries sustained in the accidents: *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141 at para. 30.
- [152] The plaintiff tendered reports from Kevin Turnbull, economist, dated July 5, 2021 and October 1, 2021, providing calculations to assist the court in the assessment of loss of earning capacity and pension loss. The October 1, 2021 report provided revised calculations based on additional information and set out his final opinion.

- [153] Mr. Turnbull prepared estimates of Ms. Bath's past loss of earnings using her average earnings between 2009 and 2012 as a starting point and projecting what she would have earned if the accident had not happened. I accept that Mr. Turnbull's approach for estimating Ms. Bath's without-accident earnings is reasonable given that she works a variable schedule that includes different rates for night shifts, overtime and other reasons.
- [154] Using this approach, Mr. Turnbull estimated that Ms. Bath's net past income loss is \$244,968 based on her actual earnings since MVA #1. This calculation takes into account deductions pursuant to s. 98 of the Insurance (Vehicle) Act, R.S.B.C. 1996, c. 231.
- [155] When preparing his calculation, Mr. Turnbull assumed that the two workplace accidents would not have occurred without the injuries sustained in MVA #1 and MVA #2. I have found that the two workplace accidents were not caused by the motor vehicle accidents. As a result, I would deduct the Worksafe BC benefits that Ms. Bath received from the estimated gross loss for each of those years. These benefits totaled \$452 in 2016 and \$16,440 in 2021.
- [156] There are no other non-accident-related factors or contingencies that have a real and substantial possibility of affecting the assessment of Ms. Bath's past loss of earning capacity.
- [157] As a result, Ms. Bath is entitled to an award of \$232,512 for her net loss of earnings to the date of trial.
- [158] Ms. Bath led evidence about her employer's subrogated claim and in particular the amount of sick leave hours that she is required to repay her employer pursuant to her collective agreement. I accept Mr. Turnbull's evidence that the employer's loss is not necessarily the same as the employee's loss and that his calculations reflect Ms. Bath's losses.
- [159] At trial, Ms. Bath sought an award for the amount of sick leave benefits paid by her employer in addition to the past loss of earnings calculated by Mr. Turnbull. However, when preparing his estimate of past loss, Mr. Turnbull compared projected annual earnings to "actual gross earnings excluding paid sick benefits", having assumed that sick leave benefits received by Ms. Bath would not reduce her claim for past loss of earnings because she had an obligation to repay her employer. This assumption is consistent with the law: *Ratych v. Bloomer* (1990), [1990] 1 S.C.R. 940, 1990 CanLII 97 (SCC). In other words, Mr. Turnbull properly accounted for sick leave benefits in his calculation of past loss of earnings. Increasing the award by the amount of sick leave benefits she received would lead to double recovery.

Future Loss of Earning Capacity

Legal Principles

- [160] The BC Court of Appeal recently released a trilogy of cases that provide guidance on how to assess a claim for future loss of earning capacity: *Dornan v. Silva*, 2021 BCCA 228 [Dornan]; *Rab v. Prescott*, 2021 BCCA 345 [Rab]; and *Lo v. Vos*, 2021 BCCA 421 [Lo].

[161] In *Dornan*, at para. 156, Justice Grauer cited *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para. 32, where the Court described an award for loss of earning capacity as follows:

An award for future loss of earning capacity thus represents compensation for a pecuniary loss. It is true that the award is an assessment, not a mathematical calculation. Nevertheless, the award involves a comparison between the likely future of the plaintiff if the accident had not happened and the plaintiff's likely future after the accident has happened: *Rosvold v. Dunlop*, 2001 BCCA 1 at para. 11; *Ryder v. Paquette*, [1995] B.C.J. No. 644 (C.A.) at para. 8

[162] Once a loss of capacity is found, the court must determine what the value of that lost asset is and how much it has been impaired: *Dornan*, para. 156.

[163] In *Rab*, after reviewing the leading authorities, Grauer J.A. distilled a three-step process for assessing claims for loss of future earning capacity:

[47] The first is evidentiary: whether the evidence discloses a potential future event that could lead to a loss of capacity (e.g., chronic injury, future surgery or risk of arthritis, giving rise to the sort of considerations discussed in *Brown*). The second is whether, on the evidence, there is a real and substantial possibility that the future event in question will cause a pecuniary loss. If such a real and substantial possibility exists, the third step is to assess the value of that possible future loss, which step must include assessing the relative likelihood of the possibility occurring - see the discussion in *Dornan* at paras 93-95.

[164] In *Dornan* at para. 94, Grauer J.A. adopted the following explanation of "real and substantial possibility" from *Gao v. Dietrich*, 2018 BCCA 372 para. 34:

The standard of a "real and substantial possibility" is a lower threshold than a balance of probabilities but a higher threshold than that of something that is only possible and speculative.

[165] Once a future loss of capacity is established, the third step of the *Rab* test involves the quantification of that loss by using the "earnings approach", as in *Pallos v. Insurance Co. of British Columbia* (1995), 100 B.C.L.R. (2d) 260, [1995] B.C.J. No. 2 (C.A.), or the "capital asset approach" from *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d) 353, [1985] B.C.J. No. 31 (S.C.). Both of these approaches are correct. The earnings approach will be more useful when the loss is easily measurable: *Perren v. Lalari*, 2010 BCCA 140 at para. 32.

[166] While assessing an award for future loss of income is not a purely mathematical exercise, the Court should endeavour to use factual mathematical anchors as a starting foundation to quantify such loss: *Jurczak v. Mauro*, 2013 BCCA 507 at paras. 36-37.

[167] After following the three-step process from *Rab*, the Court must consider whether the proposed award for loss of earning capacity is fair and reasonable: *Lo* at para. 117.

Does the evidence disclose a potential future event that could lead to a loss of capacity?

- [168] In this case, Ms. Bath continues to suffer from ongoing pain and depression. While there is a possibility that her mood symptoms might improve with treatment, I have found as a fact that her pain complaints are likely to last indefinitely. Ms. Bath's injuries from the accidents interfered with her capacity to earn income leading up to the trial by preventing her from taking on additional shifts and working full-time hours. Dr. Faraday did not anticipate a return to full-time hours and expressed "concern" for reduced work capacity in the future.
- [169] In short, her chronic pain and physical limitations, which are expected to continue, could lead to a loss of capacity by limiting her ability to work as many hours as she would have been able to work if the accidents had not happened.

Is there a real and substantial possibility that the future event will cause a pecuniary loss?

- [170] Ms. Bath's current position is a .82 FTE position. Witnesses confirmed that additional shifts are readily available. I am satisfied that if her injuries did not prevent her from working more, then she could earn more.
- [171] In short, there is a real and substantial possibility that Ms. Bath's ongoing chronic pain will result in a continuation of the pecuniary loss that she suffered leading up to the trial date.

What is the value of the possible future pecuniary loss?

- [172] At this stage of analysis, I must quantify Ms. Bath's loss by comparing what her future earning capacity would have been if the accidents had not happened to what it is now that the accidents have happened. For this crystal ball gazing exercise, I will consider the real and substantial possibilities based on the evidence and consider their relative likelihoods.
- [173] Prior to the accidents, Ms. Bath says that she planned to retire at age 65 and to continue working on-call by picking up shifts at the Forensic Psychiatric Hospital. Ms. Bath says that she planned to work on-call for three to four shifts per week, similar to the .82 FTE position she works now. Ms. Bath enjoys her work and "could see [herself] doing that" in order to keep busy and stay connected to nursing.
- [174] Mr. Turnbull testified that the average age of retirement for nurses is 61 years old. He suggested that someone like Ms. Bath who does not have a huge amount of pensionable earnings might work to age 65 or 66. Statistically, 15-20% of nurses work past the age of 65 and 10% work past the age of 70. Mr. Turnbull qualified his comments by saying that these figures are statistical averages, and it is important to consider the individual's circumstances.
- [175] Ms. Bath led evidence from Merville Holmes, one of her nursing colleagues, and from Mr. Morley, the union steward, regarding the potential for working past the usual age of retirement.
- [176] Mr. Holmes, now almost 73 years old, continues to work on-call as a psychiatric nurse at the Forensic Psychiatric Hospital after retiring 10 years ago. I accept Mr. Holmes' evidence that there are several nurses who work on-call after retirement, including five or six who are his

age. Mr. Holmes confirmed that there are plenty of shifts available, and he generally works the equivalent of full-time hours. With his seniority, Mr. Holmes is able to select shifts in the minimum-security unit, his preferred place to work. Mr. Holmes described the work as physically and emotionally challenging. Even on minimum security units like Hawthorne, staff need to be alert because patients can change quickly.

- [177] Mr. Morley testified that on average 6-10 psychiatric nurses retire each year and three or four return to work post-retirement. He confirmed that there are lots of shifts available for on-call nurses to get to full-time hours. Mr. Morley did not provide any evidence about how many hours or for how many years retired nurses tend to work past retirement.
- [178] In light of her injuries, Ms. Bath does not anticipate working "too many shifts" post-retirement. She is hopeful that her condition will improve, but she is worried about additional injuries.
- [179] Mr. Turnbull provided estimates of Ms. Bath's anticipated future loss of earnings and pension loss for different anticipated retirement dates. His calculations were prepared based on an assumption that she would continue to work .82 FTE rather than full-time.
- [180] Aside from Mr. Turnbull's calculations, there was no evidence at trial as to Ms. Bath's anticipated annual pension based on any particular retirement date. In particular, there was no evidence as to when it might make economic sense for Ms. Bath to start collecting her pension and continue working on-call and whether that "optimal retirement date" has changed as a result of the accidents.
- [181] Ms. Bath proposes three options for quantifying her loss of earning capacity:
- 1) Combining the "income earning approach" and "capital asset approach" by awarding loss of future earnings based on Mr. Turnbull's calculations to age 67 (i.e. \$180,000 plus pension loss of \$16,000) plus three years annual salary as the value of her lost ability to work on-call after retirement (i.e. \$315,000);
 - 2) Awarding four years of her average salary using the capital asset approach to reflect the increased risk of exacerbations of her injuries, which would reduce her ability to work and make early retirement a real possibility (i.e. \$420,000); or
 - 3) Awarding loss of earnings based on Mr. Turnbull's calculations to a retirement age of 70 (i.e. \$214,000 after accounting for a pension adjustment).
- [182] Given Ms. Bath's earnings history and the effect the injuries have had on her earning capacity, I am satisfied that the earnings approach to quantifying her loss of capacity is the most reasonable in the circumstances. As a result, the starting point for the quantification is to consider what Ms. Bath's earnings would have been if the accidents had not happened.
- [183] Based on all the evidence, I accept that, but for the accident, it is very likely that Ms. Bath would have continued to work full-time and would likely have "retired" at age 65. I accept that there is a real and substantial possibility that she would have continued to work on-call

after retirement. Based on her stated intention, her attachment to her profession, and the experience of those who work at the Forensic Psychiatric Hospital after retirement, I find that Ms. Bath was more likely to work past age 65 than the statistical average of 15-20% quoted by Mr. Turnbull. Based on all of the evidence, I find that there was a 60% likelihood that Ms. Bath would have continued to work after age 65, the equivalent of .5 FTE for approximately three years. Although Ms. Bath mused that she would have worked .82 FTE after officially retiring, I am satisfied that Mr. Holmes is exceptional and that Ms. Bath would have worked less than he does and for a shorter period of time.

- [184] Using Mr. Turnbull's figures and multipliers as a starting point, Ms. Bath's without accident future earning capacity would be approximately \$827,000 to age 65 and approximately \$96,000 for post-retirement earnings based on my assessment of the likelihood of the hypotheticals.
- [185] Ms. Bath has been working closer to .9 FTE over the last two years by picking up extra shifts. I have found as a fact that her current level of pain is likely to continue indefinitely, which means that her reduced capacity is likely to continue.
- [186] Using Mr. Turnbull's figures, based on actual earnings at .9 FTE, a starting point for assessing Ms. Bath's future loss of earnings from now to age 65 is \$82,777 plus pension loss of \$18,889. I accept that there is a significant likelihood that Ms. Bath will not continue to work past the age of 65 at the same rate or for as long as she would have if the accident had not happened. I estimate that she has lost 75% of her post-retirement capacity, i.e. a loss of \$72,000. The total of these figures is \$173,666.
- [187] In my view, this figure ought to be adjusted upward slightly because I accept that the contingency that she may retire earlier than age 65 is slightly more likely than the contingencies that might result in a higher residual earning capacity. The latter include the real and substantial possibility that the planned psychological therapy may successfully increase her ability to cope with her pain (thus allowing her to work more than she is currently able to do) and the possibility that her workplace will finally introduce electronic charts (thus lightening one of the physical requirements that makes her current working conditions more challenging given her injuries). I would increase the award for future loss of earning capacity to \$200,000 to account for these contingencies.
- [188] Moving to the final stage of the analysis, I am satisfied that an award of \$200,000 for future loss of earning capacity is a fair and reasonable assessment of Ms. Bath's loss. I note that this award is between 20% and 25% of her without accident future earning capacity, which I find to be a fair estimate of her overall loss of future earning capacity.

Non-Pecuniary Damages

- [189] An award for non-pecuniary loss is intended to compensate a plaintiff for her pain and suffering and for her loss of enjoyment of life. The factors to be taken into account in making such an award include the plaintiff's age; the nature of the injury; the severity and

duration of pain; disability; emotional suffering; impairment of life; impairment of family, marital and social relationships; impairment of physical and mental abilities; loss of lifestyle; and the plaintiff's stoicism (a factor that should not, generally speaking, penalize the plaintiff): *Stapley v. Hejslet*, 2006 BCCA 34 (leave to appeal ref'd: [2006] S.C.C.A. No. 100) at paras. 45-46. An award of non-pecuniary damages must be fair and reasonable to both parties.

[190] Ms. Bath's protracted and persistent pain and Adjustment Disorder have reduced her enjoyment of life and interfered with her activities such as housecleaning, gardening and reading. She was unable to work at the job she loves for an extended period of time, and she no longer enjoys it as much as she did before the accidents.

[191] Comparable cases may provide some guidance as to a non-pecuniary award that might be fair to all parties, though each case turns on its facts.

[192] The plaintiff seeks an award in the amount of \$160,000. Her counsel referred me to cases with similar soft-tissue injuries in which the court awarded non-pecuniary damages in the range of \$140,000 to \$200,000:

- *Noftle v. Bartosch*, 2018 BCSC 766;
- *Felix v. Hearne*, 2011 BCSC 1236;
- *Cumpf v. Barbuta*, 2014 BCSC 1898;
- *Redmond v. Krider*, 2015 BCSC 178;
- *Khosa v. Kalamatimaleki*, 2014 BCSC 2060;
- *Cornish v. Khunkhun*, 2015 BCSC 52; and
- *Ferguson v. Watt*, 2018 BCSC 1587.

[193] In general, these cases involve injuries that were more severe, more disabling or interfered more with function than in Ms. Bath's situation.

[194] The defendants submit that the appropriate award for non-pecuniary damages is \$75,000. They referred me to the following cases:

- *Javan Parast v. Curry*, 2020 BCSC 877;
- *Park v. Targonski*, 2015 BCSC 555 (aff'd in part: 2017 BCCA 134);
- *Uppal v. Judge*, 2016 BCSC 642; and
- *Schweitzer v. Li*, 2021 BCSC 52.

[195] In my view, a number of the defendants' cases involve pre-existing conditions or other factors that do not apply in Ms. Bath's case.

[196] Ms. Bath seeks a separate award for loss of housekeeping capacity in the amount of \$45,000. Although her daughter provides some assistance and she is renovating her kitchen to make cooking easier (a cost which was not claimed), Ms. Bath is generally able to complete housekeeping tasks, though with some discomfort and less effectively than before the accidents. In these circumstances, I find it is more appropriate to consider the impact of the accidents on her housekeeping abilities as part of the non-pecuniary award rather than making a separate award for loss of housekeeping capacity: *Kim v. Lin*, 2018 BCCA 77 at paras. 33-34.

[197] In all the circumstances, I find that an award of \$120,000 for non-pecuniary loss is appropriate in this case. This award reflects the impact Ms. Bath's chronic pain and psychological injuries have had on her and her enjoyment of life.

Future Cost of Care

[198] In *Golkar-Karimabadi v. Bush*, 2021 BCSC 990 at para. 107, Justice Adair summarized the principles that apply to the assessment of future cost of care claims:

An award for cost of future care is based on what is reasonably necessary, on medical evidence, to promote the mental and physical health of the claimant. The award must (1) have medical justification, and (2) be reasonable. The medical necessity of future care costs may be established by a health care professional other than a physician, such as an occupational therapist, if there is a link between a physician's assessment of pain, disability and recommended treatment, and the health care professional's recommended care item. See *Gao v. Dietrich*, 2018 BCCA 372, at paras. 69-70. No award is appropriate for costs that a plaintiff would have incurred in any event: *Shapiro v. Dailey*, 2012 BCCA 128, at paras. 51-55. Moreover, future care costs must be likely to be incurred by the plaintiff. The onus is on the plaintiff to show that there is a reasonable likelihood that she will use the suggested services: see *Lo v. Matsumoto*, 2015 BCCA 84, at para. 20.

[199] Ms. Bath relies on *Krangle (Guardian ad litem of) v. Brisco*, 2002 SCC 9 [Krangle] at para. 21 for the proposition that an assessment of damages for cost of future care is not a precise accounting. At para. 21 of Krangle, Chief Justice McLachlin (as she then was) said this about the manner in which such damages are assessed:

Damages for cost of future care are a matter of prediction. No one knows the future. Yet the rule that damages must be assessed once and for all at the time of trial (subject to modification on appeal) requires courts to peer into the future and fix the damages for future care as best they can. In doing so, courts rely on the evidence as to what care is likely to be in the injured person's best interest. Then they calculate the present cost of providing that care and may make an adjustment for the contingency that the future may differ from what the evidence at trial indicates.

[200] Ms. Bath seeks an award of \$100,000 to \$110,000 for future cost of care. She argues such an amount is justified by extrapolating from the special damages claim for \$30,550.45 in respect of treatment over the last eight years. However, the special damages claim is for the

amount paid by her extended health provider and by her in user fees; it ignores the amounts paid by the Insurance Corporation of British Columbia for treatment. In other words, the actual cost of treatment per year since MVA #1 was actually much higher than the pro-rated special damages claim. In any event, I am not satisfied based on the evidence that the annual cost of care over the remainder of the plaintiff's lifetime will be the same as it was in the years immediately following the accidents. In my view, it is necessary to consider the recommended future care rather than relying on the past costs incurred when assessing damages for future care in this case.

- [201] A number of medical experts provided their opinions regarding the types of future care that Ms. Bath may require in the future. There was little direct evidence regarding the cost of such care, and there was no expert report that summarized the present value of anticipated future care costs. This leaves the court with limited evidence upon which to make an award.
- [202] Ms. Bath has attended a significant number of physiotherapy, massage therapy and active rehabilitation treatments. She argues that these treatments are necessary to allow her to continue to work. However, the medical evidence does not support a continuation of such treatments at the same rate going forward. Dr. Faraday anticipates that four sessions per year of passive paramedical care will be required to address expected flare-ups. Dr. Heran opined that active and passive modality therapies should be available if her symptoms worsen, though he did not opine on the anticipated frequency or number of treatments required when exacerbations occur.
- [203] When he saw her in May 2019, Dr. Wade recommended that Ms. Bath participate in an active rehabilitation program. It is not clear from the evidence whether any of the therapy Ms. Bath received after May 2019 fit that description. In any event, I prefer Dr. Faraday's recommendation regarding future therapies over that of Dr. Wade primarily because Dr. Faraday's recommendation was based on an assessment done a few months before trial. I accept that a few annual passive modality treatments to address flare-ups of her pain symptoms would be reasonable.
- [204] Ms. Jhaj, occupational therapist, recommended ongoing physiotherapy, massage therapy and chiropractic treatments in addition to intermittent active rehabilitation with a kinesiologist. This volume of therapy far exceeds the amount recommended by any of the medical experts, and I find Ms. Jhaj's recommendation is unreasonable. Further, Dr. Faraday is better qualified, which leads me to rely on his opinion.
- [205] There was limited evidence regarding the cost of passive paramedical care. A print-out from one of the physiotherapy clinics indicates that the cost of such treatments is currently approximately \$70 per visit. Based on the available evidence, I find that the plaintiff is entitled to \$280 per year going forward for physiotherapy or massage.

- [206] Dr. Faraday also recommended continuation of the plaintiff's current medications. Again, I had very limited evidence regarding the annual costs. A print-out from two pharmacies indicates that the cost of medications between October 2020 and October 2021 was \$320.75. I will use this as the basis for an award for medication costs going forward, based on Dr. Faraday's recommendation.
- [207] Dr. Heran recommends adding CBD with a THC combination to Ms. Bath's medications. I have no evidence regarding the cost of this recommendation, and I am not prepared to speculate.
- [208] Dr. Faraday also recommended the purchase of a TENS machine, which would require replacement every five years. There was no evidence as to the cost of such a device. As a result, I am not prepared to include this item in a cost of care award.
- [209] All of the medical experts recommended that Ms. Bath remain active in order to minimize her pain complaints. Dr. Heran recommended "maintenance therapies" that would include a gym membership, a swimming program and a swimming pass. Dr. Faraday and Ms. Jhaj agreed that a gym membership was a reasonable expense. Dr. Hirsch suggested that the plaintiff could continue with her home-based exercise program. I am not satisfied that there is any reasonable likelihood that Ms. Bath would use a gym membership or follow a swimming program or that it would provide more benefit than adhering to her current home-based program.
- [210] Both psychiatrists agree that Ms. Bath would benefit from psychotherapy. Dr. Waisman recommends treatment once per week for one year. Dr. Okorie recommends reassessment after 12 to 16 sessions. I am satisfied that it would be appropriate to include the cost of an initial course of treatment recommended by Dr. Okorie plus a contingency for the possibility that more psychotherapy is required. In total, I find that it would be reasonable to provide funding for 24 sessions of psychotherapy.
- [211] There is no evidence regarding the anticipated hourly cost of psychotherapy. The defendants submitted that an award of \$3500 for future care would cover the cost of active rehabilitation therapy as recommended by Dr. Wade and 12 to 16 sessions of psychotherapy without any evidence as to the anticipated cost of either forms of treatment.
- [212] Dr. Waisman also recommended a referral to a multidisciplinary chronic pain program. I note that Ms. Bath already attended a pain clinic in 2017-2018 that I assume was publicly funded, as there was no out-of-pocket cost incurred by Ms. Bath. It is not clear whether Dr. Waisman was recommending a different type of program, and there was no evidence as to the cost of such a program in any event. As a result, I am not prepared to include this item in an award for future care.
- [213] In summary, I accept that the following items should be included in an award for future cost of care:

- 1) \$280 per year for anticipated passive therapy for aggravations of pain symptoms;
- 2) \$320.75 per year for medication; and
- 3) The cost of 24 sessions for psychotherapy.

[214] As of the date of trial, Ms. Bath was 57 years old. I was provided no evidence as to how many years Ms. Bath might require medications or therapy for aggravations. Based on my finding that her symptoms are expected to last indefinitely, it would have been helpful if the parties could have agreed upon life expectancy or alternatively provided an appropriate multiplier for future cost of care. Ms. Bath argued that the cost of future care should be awarded based on a multiplier of approximately 25, which would equate to a life expectancy of 92 years based on the CIVJI: Civil Jury Instructions, 2nd ed. (Vancouver: Continuing Legal Education Society of British Columbia, 2009) (loose-leaf 2022 update) [CIVJI] present value multipliers. This strikes me as unreasonable and lacks a foundation in the evidence.

[215] In the circumstances, I am prepared to award passive treatments and medications to age 68, the age at which I anticipate that Ms. Bath will stop working. Using the CIVJI multiplier of 9.7868 to age 68, this would result in an award of \$5880. I would add an allowance of \$5000 for psychotherapy and round the award for future cost of care up to \$11,000.

Special Damages

[216] Ms. Bath attended many physiotherapy, active rehabilitation and massage therapy treatments. The defendants take no issue with respect to the cost of these treatments. Ms. Bath is entitled to be reimbursed \$30,550.45 for these treatment costs. The defendants accept that an ambulance fee, medication expenses and the cost for various medical notes for Ms. Bath's employer are properly compensable. These fees total \$698.57.

[217] The defendants say the cost of a private MRI in October 2014 is not a reasonable special damage. Ms. Bath says that she paid to have a private MRI of her lumbar spine and sacroiliac joints because Dr. Gin told her to order it and it would have taken a long time through the public health system.

[218] An injured person is entitled to recover the reasonable out-of-pocket expenses incurred as a result of an accident. This is grounded in the fundamental governing principle that an injured person is to be restored to the position they would have been in had the accident not occurred: *X. v. Y.*, 2011 BCSC 944 at para. 281; *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33, 1985 CanLII 175 (BCSC) (aff'd: [1987] B.C.J. No. 1833, 49 B.C.L.R. (2d) 99 (BCCA)) at 78.

[219] There was no direct evidence from Dr. Gin or any other medical expert establishing a need to expedite the MRI by paying for it to be done privately. In the circumstances, I am not satisfied that Ms. Bath has established that the MRI expense was reasonable: *Lewis v. Rubboli*, 2018 BCSC 17 at para. 140.

- [220] The defendants say the plaintiff's mileage claim for travelling to and from treatment should be dismissed on the basis that those costs would be offset by the savings Ms. Bath realized by not commuting to work in the same period: *Bricker v. Danyk*, 2015 BCSC 2404 at paras. 182-185. Ms. Bath acknowledged on cross-examination that most of her 534 accident-related appointments were close to home. She did not commute to work for approximately three years. I am satisfied that her mileage claim in the amount of \$6017.32 should be discounted to \$1000 in recognition of the savings arising from not commuting to work.
- [221] The final item on Ms. Bath's list of special damages is a claim for extended health benefit premiums that Ms. Bath paid while on a leave of absence between July 19, 2017 to November 8, 2018, which totals \$6670.64. These premiums would ordinarily be paid by Ms. Bath's employer, and they were covered by the long-term disability insurer while she was collecting long-term disability insurance benefits. Ms. Bath says that it was reasonable for her to pay the premiums to maintain her extended health coverage and that this expense was incurred because she could not work as a result of her injuries. The defendants say that the expense was not reasonably incurred because Ms. Bath declined to appeal the termination of her long-term disability insurance benefits in July 2018. Ms. Bath denied the proposition put to her on cross-examination that she did not pursue an appeal because she was reluctant to appear before a panel of three physicians at the behest of her disability insurer.
- [222] I have already determined that Ms. Bath was unable to work due to her accident-related injuries. The cost of extended health premiums was simply another aspect of the losses she sustained as a consequence of not being able to work. I am satisfied that it was reasonable for Ms. Bath to pay the premiums to ensure continuous extended health coverage for herself and her family, particularly at a time when her extended health insurer was paying some of her treatment costs. I am not satisfied that her failure to appeal her disability insurer's decision with respect to coverage affects the recoverability of this cost. Ms. Bath should be reimbursed \$6670.64 for the premiums that she was required to pay as a consequence of her injuries.

Conclusion

[223] To summarize, the defendants are liable to pay the following damages to Ms. Bath:

Head of Damage

Award

Past Loss of Earning Capacity

\$232,512

Future Loss of Earning Capacity

\$200,000

Non-Pecuniary Damages

\$120,000

Future Cost of Care

\$11,000

Special Damages

\$38,919.66

TOTAL

\$602,431.66

[224] Ms. Bath is also entitled to her costs, subject to any offers or other matters that may require an adjustment to her costs entitlement. If the parties wish to address costs, they may arrange with Scheduling in the next 30 days to make submissions before me for this purpose.

"Lamb J."

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