

CANADA / JUDGMENT

Borgford v. Ball

2022 BCSC 2026

COURT

Supreme Court of British Columbia

DECIDED

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2022 BCSC 2026 Borgford v. Ball

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Borgford v. Ball,

2022 BCSC 2026

Date: 20221121

Docket: M196754

Registry: Vancouver

Between:

Chantale Christine Borgford

Plaintiff

And

Samantha Joey Ball, The City of Surrey,

ABC Company #1 and ABC Company #2

Defendants

And

Modern Grounds Maintenance Ltd.

Third Party

Before: The Honourable Justice Fleming

Reasons for Judgment

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Place and Date of Trial:

Vancouver, B.C.

May 30 and 31, 2022; and

June 1-3, 6-10, 13-17, 2022

Place and Date of Judgment:

Vancouver, B.C.

November 21, 2022

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Introduction

- [1] The plaintiff Chantale Borgford seeks damages for injuries and losses arising from a very serious motor vehicle accident that occurred at the intersection of 190th Street and 34A Avenue in Surrey, BC on August 7, 2017 (the "Accident"). Although the speed limit was 50 km/h, the defendant Samantha Ball was driving her Dodge Ram 2500, a large diesel pickup truck ("Truck"), at approximately 94 km/h. Ms. Borgford was also speeding at approximately 90 km/h in her Dodge Avenger, an average size sedan ("Avenger"), and failed to stop at a stop sign. She acknowledges her contributory negligence. Ms. Ball denies any liability for the Accident. She also disputes Ms. Borgford's claims for non-pecuniary damages, damages for the cost of future care and an in-trust award.
- [2] There is no dispute that Ms. Borgford sustained multiple, complex orthopedic injuries and a traumatic brain injury ("TBI") in the Accident, although the parties disagree about the severity and consequences of the TBI.
- [3] Ms. Borgford was unconscious when emergency responders arrived at the scene. Air lifted to Vancouver General Hospital ("VGH"), she remained in hospital until August 17, 2017.
- [4] A registered nurse, Ms. Borgford has been unable to work and receiving long-term disability benefits based on various medical conditions and/or diagnoses since the early 1990s. For over ten years prior to the Accident, however, her primary conditions were fibromyalgia and joint pain or rheumatoid arthritis, resulting in chronic pain.
- [5] In addition to alleging a moderate to severe brain injury that she has not recovered from, Ms. Borgford says the Accident caused psychiatric injuries and worsened her chronic pain. She identified many significant ongoing symptoms including impaired short-term memory, poor concentration and focus, constant severe headaches, nausea, dizziness and balance issues, speech and language problems, and a profound change in her personality reflected in disinhibited inappropriate behaviour and emotional volatility.
- [6] The dispute over damages has various aspects to it including the extent to which Ms. Borgford's symptoms and functioning, after a period of recovery, differ from before the Accident. In closing submissions Ms. Ball also took the position that some of Ms. Borgford's ongoing symptoms such as dizziness and balance issues were the result of intervening events.
- [7] I will deal first with the issue of liability and then damages, to which most of the evidence relates. The reliability and less so, the credibility, of some of the witness' testimony are also contested issues, which I address to some extent as I review the evidence but more fully after that review.

Liability

- [8] In addition to some agreed facts, Ms. Ball and parts of her examination for discovery evidence read in by Ms. Borgford, provide most of the fact evidence regarding the circumstances of the Accident. The fact evidence also includes two short videos taken by surveillance cameras located nearby, although they do not depict the Accident itself, and photographs of the damage to both vehicles as well as the location of the Accident, the approach to the intersection, both westbound on 34A Avenue and northbound on 190th Street taken after the Accident by the RCMP, Ms. Borgford's husband Mr. Borgford, and Jonathon Gough, an engineer retained by Ms. Ball to provide expert opinion evidence. Ms. Borgford also retained an engineering expert, Donald Rempel. In addition to their reports, Mr. Rempel and Mr. Gough testified at the trial.

Circumstances of the Accident

- [9] The parties agree Ms. Borgford was driving the Avenger, an average-sized sedan, west on 34A Avenue and Ms. Ball was driving the Truck, north on 190th Street when the Accident occurred. Ms. Ball estimated the Truck's weight at 8,000 pounds, which struck me as somewhat high, but I accept it was a very heavy vehicle. Photographs of the damaged Truck and Ms. Ball's evidence that it had slightly larger after market sized tires, indicate she would have been sitting quite high in the driver's seat.
- [10] Other photographs show that the intersection of 190th Street and 34A Avenue bordered low rise commercial buildings. 34A Avenue has one lane of travel in each direction, separated by a solid yellow line, with sidewalks on both the north and south sides. Between each sidewalk and the curb, is a row of well spaced trees. Westbound traffic has a stop sign and white stop line located some distance from the northeast corner of the intersection.
- [11] For north and southbound traffic on 190th Street there are no traffic control devices at the intersection. The street itself is much wider than 34A Avenue, with parking and bike lanes on both sides, as well as one lane of travel in each direction, separated by a solid yellow line. Similar to 34A Avenue, both sides of 190th Street in the northbound approach to the intersection have a row of well spaced trees between the curb and the sidewalk. Between the sidewalk on the east side of 190th Street and the sidewalk on the southside of 34A Avenue is a raised area landscaped with shrubbery and large rocks.
- [12] Some of Mr. Gough's photographs indicate the sightlines for a driver travelling north on 190th Street toward the intersection looking east onto 34A Avenue were affected by the trees on the east side of 190th Street and the south side of 34A Avenue, and the landscaped area in between. I infer the same would be true for a driver travelling west on 34A Avenue looking south onto 190th Street. Photographs taken by Mr. Borgford and the RCMP facing west on 34A Avenue located some distance back from the intersection also show the trees on the north side of 34A Avenue obscuring the stop sign.

- [13] The Accident occurred at approximately 6:40 p.m. on Monday, August 7, 2017, which was a holiday. The sky was clear and the weather was warm and dry. Ms. Borgford was driving home from the Langley bus depot, where she had dropped her very-close friend Johanne Chevalier-Cook. Ms. Chevalier-Cook lives in Kelowna and had been staying with the Borgford's for the weekend.
- [14] Although Ms. and Mr. Borgford recalled Ms. Chevalier-Cook's father had just died and his funeral was on the Saturday, Ms. Chevalier-Cook testified her father died a short time later and she travelled from Kelowna that weekend to assist and care for him. I accept her recollection for obvious reasons. The discrepancy is not material, apart from the alignment in the evidence of the Borgford's. I am satisfied that their confusion is well explained by the trauma of the Accident, Ms. Chevalier-Cook's frequent visits, and the proximity to her father's death.
- [15] Much was made of Ms. Borgford's alcohol and drug use that weekend, which I will discuss further on in these reasons. Ultimately however, Ms. Ball did not suggest that Ms. Borgford was impaired at the time of the Accident.
- [16] Ms. Borgford has no memory of the Accident or what occurred immediately beforehand. Somewhat uncertainly, she identified her last memory as driving south on 190th Street, and turning right onto a street she could not recall into an industrial area to avoid heavy traffic. I would note that driving south on 190th Street makes little sense given the location and direction of her Avenger in the intersection. Indicating she would normally turn right on 132nd Street and the industrial area was not one she had driven through before, Ms. Borgford stated she thought there would be a side road that would allow her to cut through.
- [17] Ms. Ball was 19 years old with a new driver's license at the time. She was very familiar with the intersection because she drove through it every day. Ms. Ball and her friends who also had big trucks would "hang out" at what they called the sandpit located on a cul-de-sac at the end of 36A Avenue. Shortly before the Accident, Ms. Ball left the sandpit to buy some food at a nearby Tim Horton's drive-through. As she drove back, travelling north along 190th Street, two other friends who had been behind her at the drive-through were following.
- [18] Although Ms. Ball now agrees she was driving at about 94 km/h, she told police at the scene that her speed was about 60 km/h. She testified at both her discovery and the trial that a split second before the Accident she saw a car coming through the intersection. She responded by hitting her brakes, but she did not think they did anything. At the trial Ms. Ball said she saw the car for the first time as she started to enter the intersection. Consistent with the photographs showing the Avenger after the Accident, however, Ms. Ball also described the front of her truck hitting the back end of the driver's side of the other vehicle.
- [19] Ms. Ball was asked in direct examination about whether she could see onto 34A Avenue based on Mr. Gough's photographs, which as I have said depict the sightlines for an approaching northbound driver. The first two photographs are taken from farthest away. They show five trees on the east side of 190th Street prior to the intersection. The sixth

photograph shows only one tree and some distance back from that tree. There are no trees visible in the last two photographs because they depict the sightlines for a driver parallel to or north of the last tree prior to the intersection. The second to last, or seventh photograph, shows the street light located on 190th Street near the southeast corner of the intersection, an expanse of the sidewalk, and the beginnings of the landscaped area south of the intersection. Among other things, the last three photographs, six, seven and eight, show the stop sign on 34A Avenue located, as I have indicated, some distance back from the north east corner of the intersection. In the seventh and eighth photographs, the sightlines onto 34A Avenue up to at least three trees back or east of the intersection are unobstructed.

- [20] Consequently, I was concerned by Ms. Ball's testimony that she could barely see onto 34A Avenue in the seventh photograph. Although she acknowledged in cross-examination that 34A Avenue was visible through gaps in the foliage in some of the early photographs, for example, the third photograph, she maintained she could not see much of 34A Avenue in photograph seven, an answer that was plainly inaccurate.
- [21] In any event, Ms. Ball also indicated she was not concerned about the sightlines at the time and agreed that she made a deliberate decision to drive the Truck fast knowing this was dangerous to other users of the road.

Engineering Evidence

- [22] The Avenger was equipped with an event data recorder or an airbag control module ("EDR") that recorded five seconds of pre-collision data, which was downloaded by the Surrey RCMP and interpreted by Mr. Rempel and Mr. Gough who viewed it as accurate.
- [23] Mr. Rempel's original report is dated March 4, 2022. He prepared a second report on April 18, 2022, once he realized he had made an error that involved relying on the EDR data for an event recorded subsequent to the Accident, which he identified as the Avenger hitting the curb.
- [24] In addition to the EDR data, Mr. Rempel's analysis relied on the RCMP scene photographs and measurements, as well as the two videos.
- [25] Asked to assess the speed of the two vehicles as they approached and entered the intersection, and the potential for Ms. Ball to avoid the collision had she been driving at the speed limit when she approached the Avenger, Mr. Rempel was also asked to assume that Ms. Ball applied emergency braking prior to impact, although the specific timing of that braking was unknown.
- [26] Based on the EDR data for the Accident, Mr. Rempel found that Ms. Borgford was travelling at a constant speed of approximately 90 km/h as she entered the intersection and at impact. He also calculated the average speed of Ms. Ball's vehicle for the "last interval", or for the travel interval captured by one of the video surveillance cameras prior to impact, at approximately 91 km/h.

- [27] Mr. Rempel's first report had included a fairly complex analysis of the speed of the Truck that was much simpler in his second report based on the correct EDR event.
- [28] The first report also included an accident avoidance analysis for Ms. Ball that relied on the braking assumption and a perception reaction time ("PRT") of 1.5 seconds, which he testified was an average or typical PRT, for a sudden unexpected laterally occurring hazard. In his first and second report, Mr. Rempel opined that Ms. Ball would have avoided the collision if her approach speed had been 50 km/h.
- [29] Asked to do so, during his testimony Mr. Rempel provided some basic calculations. At 94 km/h a vehicle travels 26.1 metres per second; at 60 km/h, 16.7 metres; and at 50 km/h, 15.9 metres.
- [30] Cross-examined about the braking assumption, Mr. Rempel agreed there was no evidence of braking at the scene, but explained he would not have expected to find any because in the "modern era", meaning with normal braking systems, pre-impact braking does not lead to tire marks or physical scene evidence.
- [31] Mr. Rempel was also cross-examined about Ms. Ball's sightline to 34A Avenue based on the second of Mr. Gough's photographs. It depicts five trees on the east side of 190th Street leading to the intersection. Agreeing the trees obscured the view onto 34A Avenue, Mr. Rempel denied the suggestion that he failed to consider the presence of the trees in analyzing Ms. Ball's ability to avoid the Accident. He emphasized despite the trees, Ms. Ball "got on the brakes" before impact, which means she saw the Avenger at least one second but more likely 1.5 seconds before impact. Mr. Rempel also added that a driver who was able to brake before impact, would have arrived later had they been driving at an incrementally lower speed.
- [32] During cross-examination about various scenarios involving lower speeds for the Avenger, Mr. Rempel agreed that if Ms. Borgford had been driving at a constant speed of 60 or 80 km/h, the Accident would not have occurred. He clarified this would also be the case if the speed of either vehicle was reduced by even a few kilometres per hour. Noting the average vehicle length of five metres, a travel distance of 25 metres per second at a speed of 90 km/h, Mr. Rempel explained that varying the arrival time by as little as roughly 1/5th of a second would mean avoiding the Accident. Mr. Gough reduced this estimate even further to .1 or 1/10th of a second, agreeing that Ms. Borgford needed to travel only 2.5 metres further to avoid the Accident, given the front of the Truck impacted the rear half of the driver's side of the Avenger, or as he stated in his original report, the left side, starting at the rear edge of the driver's door and continuing to the left corner.
- [33] Mr. Gough also prepared two expert reports. In his original report dated March 2, 2022, he discussed his examination of both vehicles as well as the Accident location. Based on the EDR data for the five seconds before impact, similar to Mr. Rempel, Mr. Gough found the speed of the Avenger gradually decreased from 93 km/h to 90 km/h and travelled approximately 127 metres, indicating Ms. Borgford did not stop at the stop sign before

entering the intersection. He also concluded the speed of the Truck was approximately 94 km/h.

[34] Mr. Gough's second report dated less than three weeks after his first, reviewed Mr. Rempel's first report focusing on his error in interpreting the EDR data, which Mr. Rempel identified and addressed in his second report.

[35] In addition, Mr. Gough criticized Mr. Rempel's accident avoidance analysis as incorrect based on the assumption Ms. Ball did not brake prior to impact:

Until Ms. Ball became aware of the hazard posed by the Borgford vehicle, she would have had no reason to begin her perception-reaction time. Insufficient time would have been unavailable for most drivers to even begin to brake prior to reaching the point of impact (p. 2).

[36] Mr. Gough's reports do not explain how he determined that Ms. Ball did not brake, apart from referring in his second report to an absence of information to suggest she applied her brakes prior to impact. In re-examination, he testified there was no physical evidence of Ms. Ball braking at the scene, without addressing Mr. Rempel's point that none would be expected or Ms. Ball's evidence about braking.

[37] In his second report and in cross-examination Mr. Gough emphasized the need to assess the accident avoidance opportunity by starting with the onset of the perception reaction time. Based on his view that Ms. Ball did not brake, he concluded the point at which Ms. Ball began to perceive the hazard posed by the Avenger could not be identified and the effect of speed on Ms. Ball's ability to avoid the Accident therefore could not be assessed.

[38] Having calculated the Avenger was 17 metres beyond the stop line at the point of impact, which at a speed of 90 km/h would take .7 of a second to reach, Mr. Gough testified this was not enough time for most drivers to even begin braking, again relying on his view Ms. Ball did not brake or attempt to break. Mr. Gough maintained this perspective when asked to consider the effect of Ms. Ball driving at a lower speed, responding for example, that travelling at a different speed implies she already reacted.

[39] Mr. Gough acknowledged however the accuracy of a number of basic calculations: at 94 km/h a vehicle travels 26.1 metres per second, and 18.2 metres in .7 seconds; at 60 km/h it takes 1.57 seconds to travel 26.1 metres. He also agreed that if Ms. Ball was driving at 60 km/h for the last second before impact, the Accident would have been avoided by about .4 of a second.

Findings of Fact

[40] Ultimately, there are few significant disputes about the circumstances of the Accident. The conflict over liability relates mostly to the inferences and legal conclusions to be drawn from those circumstances.

- [41] Again, as agreed I find that Ms. Borgford was driving approximately 90 km/h; and Ms. Ball, approximately 94 km/h, when the Accident occurred. Ms. Borgford failed to stop at the stop sign before entering the intersection. There is no direct evidence about why she did not stop. Relying to some extent on the photographs taken looking westbound on 34A Avenue that show the stop sign obscured by the trees, Ms. Borgford's high speed, and her lack of familiarity with the area, it seems most likely that she simply failed to see the stop sign. Given her speed either decreased only slightly, as Mr. Gough indicated, or remained the same, in the five seconds before impact, I also accept she did not see the Truck.
- [42] Accepting Mr. Rempel's evidence that no physical evidence of pre-impact braking would be expected and Ms. Ball's testimony about braking, I find that she saw the Avenger before the Accident and was slamming on her brakes when the Truck hit the Avenger, although she perceived that her brakes "did not do anything". Also accepting Mr. Rempel's evidence about the average or typical PRT for a laterally occurring hazard, I infer Ms. Ball first saw the Avenger approximately 1.5 seconds before impact.
- [43] Accepting Mr. Gough's estimate that the Avenger was 17 metres past the stop line at impact, at a constant speed of 90 km/h it was 20.5 metres before the stop line at 1.5 seconds before impact (total distance travelled 37.5 metres), and 8 metres before the stop line at 1 second before impact (total distance travelled 25 metres). At 94 km/h, the Truck was 39.2 and 26.1 metres away at 1.5 and 1 seconds before impact.
- [44] Given the Avenger was approximately 5 metres in length and the Truck impacted the rear half of the driver side, it becomes tragically apparent the Accident would not have occurred if the Truck had arrived a fraction of a second later. Even if only speeding less, at 80 km/h, the Truck would have arrived .26 of a second later, allowing the Avenger to travel 6.5 metres further, more than double the distance needed to avoid the Accident.
- [45] Assessing the avoidance opportunity based on the onset of the perception reaction time, as Mr. Gough suggests, it is also obvious Ms. Ball could have avoided the Accident, had she been driving at the same or even less of a reduced speed when she first saw the Avenger approximately 1.5 seconds before and located 39 metres from the impact location. Leaving aside the reality of the Avenger moving out of the path of the oncoming Truck and although neither engineer provided evidence about the time and distance required for a vehicle with the Truck's mass to stop hard braking, common sense tells me both would lessen with reduced speed. Further, as the Avenger drives further toward the other side of the intersection, Ms. Ball's opportunity to avoid an impact by veering right also increases.

Legal Framework

- [46] The basic principles of the law of negligence are firmly established and well known.

- [47] To prove a claim the plaintiff must establish four elements: (1) the defendant owed them a duty of care; (2) the defendant breached the standard of care; (3) the plaintiff sustained damage (injury and loss); and (4) that damage was caused, in fact and in law, by the defendant's breach: *Mustapha v. Culligan of Canada Ltd.*, 2008 SCC 27 at para. 3.
- [48] Regarding the last element, the primary test for factual causation is the "but for" test. The plaintiff must show that "but for" the defendant's negligence the damage or loss would not have occurred, or put another way, the defendant's negligence was necessary to bring about the damage or loss: *Athey v. Leonati*, [1996] 3 S.C.R. 458 at para. 14, and *Borgford v. Boizard*, 2016 BCCA 317 at para. 54. However, the negligent conduct is not required to be the sole or predominant cause of the injury. Further, factual causation is determined in a "robust common sense fashion". Scientific proof is not required. Inferences drawn from proven facts may suffice: *Clements v. Clements*, 2012 SCC 32 at para. 9; *Athey* at para. 16.

Standard of Care

- [49] The standard of care, which defines the content of the duty of care, is the measure for determining whether a defendant's particular act or omission breached that duty: *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201 at para. 25. Generally speaking, to avoid liability a person must exercise the standard expected of an ordinary, reasonable and prudent person in the same circumstances. In the context of a motor vehicle accident, then, the standard of care is that of a reasonably prudent motorist in all the circumstances.
- [50] In *Ryan*, Justice Major summarised how to determine what is reasonable:
- [28] The measure of what is reasonable depends on the facts of each case, including the likelihood of a known or foreseeable harm, the gravity of that harm, and the burden or cost which would be incurred to prevent the injury. In addition, one may look to external indicators of reasonable conduct, such as custom, industry practice, and statutory or regulatory standards.
- [51] To be foreseeable, it is not necessary for a risk of harm to be more likely than not; nor is it required to reach a particular degree of statistical probability. *Mustapha* articulated the correct approach:
- [13] The degree of probability that would satisfy the reasonable foreseeability requirement was described in *The Wagon Mound (No. 2)* as a "real risk", i.e. "one which would occur to the mind of a reasonable man in the position of the defendan[t] and which he would not brush aside as far-fetched" (*Overseas Tankship (U.K.) Ltd. v. Miller Steamship Co. Pty.*, [1967] A.C. 617 (P.C.), at p. 643).
- [52] *Ryan* also discussed the relevance of statutory standards to the standard of care:
- [29] Legislative standards are relevant to the common law standard of care, but the two are not necessarily co-extensive. The fact that a statute prescribes or prohibits certain activities may constitute evidence of reasonable conduct in a given situation, but it does not extinguish the

underlying obligation of reasonableness. Thus, a statutory breach does not automatically give rise to civil liability; it is merely some evidence of negligence. By the same token, mere compliance with a statute does not, in and of itself, preclude a finding of civil liability. Statutory standards can, however, be highly relevant to the assessment of reasonable conduct in a particular case, and in fact may render reasonable an act or omission which would otherwise appear to be negligent. This allows courts to consider the legislative framework in which people and companies must operate, while at the same time recognizing that one cannot avoid the underlying obligation of reasonable care simply by discharging statutory duties.

[Citations omitted.]

[53] Here a number of provisions of the Motor Vehicle Act, R.S.B.C. 1996, c. 318 [MVA], are relevant, including ss. 125, 144, 146, 148, 175 and 186. Sections 125 and 186 apply specifically to Ms. Borgford's failure to stop at the stop sign:

Obeying traffic controls

125 Unless otherwise directed by a peace officer, every driver of a vehicle and every pedestrian must obey the instructions of an applicable traffic control device.

Careless driving prohibited

144 (1) A person must not drive a motor vehicle on a highway

- (a) without due care and attention,
- (b) without reasonable consideration for other persons using the highway, or
- (c) at a speed that is excessive relative to the road, traffic, visibility or weather conditions.

Speed limits

146 (1) Subject to this section, a person must not drive or operate a motor vehicle on a highway in a municipality at a greater rate of speed than 50 km/h, and a person must not drive or operate a motor vehicle on a highway outside a municipality or . at a greater rate of speed than 80 km/h.

Excessive speeding

148 (1) A person who drives a motor vehicle on a highway at a speed greater than 40 km/h over the applicable speed limit set under the authority of an enactment commits an offence and is liable on conviction to not less than the aggregate of the fine amount and the applicable supplemental fine amount, if any, prescribed under section 148.1 for this offence and, subject to those amounts, section 4 of the Offence Act applies.

Entering through highway

175 (1) If a vehicle that is about to enter a through highway has stopped in compliance with section 186,

- (a) the driver of the vehicle must yield the right of way to traffic that has entered the intersection on the through highway or is approaching so closely on it that it constitutes an immediate hazard, and
 - (b) having yielded, the driver may proceed with caution.
- (2) If a vehicle entering a through highway in compliance with subsection (1), traffic approaching the intersection on the highway must yield the right of way to the entering vehicle while it is proceeding into or across the highway.

Stopping at intersections

186 Except when a peace officer directs otherwise, if there is a stop sign at an intersection, a driver of a vehicle must stop

- (a) at the marked stop line, if any

[54] The parties have agreed that Ms. Borgford's failure to stop at the stop sign breached s. 186 and by speeding both she and Ms. Ball breached s. 146 of the MVA.

[55] Driving at approximately 94 km/h, Ms. Ball also engaged in excessive speeding as defined by s. 148(1), which is an offence.

[56] In my view, both parties also breached the prohibition on careless driving set out in s. 144, Ms. Ball by speeding and Ms. Borgford on a number of grounds.

Case Law

[57] At common law, drivers have an overarching duty to exercise reasonable care, which includes an obligation to keep a proper lookout and exercise reasonable caution in response to apparent potential hazards: *Stewart v. Dueck*, 2012 BCSC 1729 at para. 38. Drivers are "entitled to assume, within reason, that the other users of the [road] will obey the law or the rules of the road": *Dueck* at para. 39; *Henry v. Bennett*, 2011 BCSC 1254 at para. 60; and *Mills v. Siefred*, 2010 BCCA 404 at para. 26. However the assumption flows both ways: *Hynna v. Peck*, 2009 BCSC 1057 at para 61.

[58] The case law dealing with collisions between through drivers and drivers with an obligation to yield has focused on the interpretation and application of s. 175 of the MVA. The threshold issue is whether the through driver was approaching so closely as to constitute an immediate hazard, assessed at the moment the other driver entered the intersection. If so, the through driver is considered the dominant driver with the right of way and the other driver, the servient driver. When a servient driver proceeds in breach of their statutory duty, the dominant driver may also be found liable if they could have avoided the accident had they acted with reasonable care: see *Kokkinis v. Hall* (1996), 19 B.C.L.R. (3d) 273 (B.C.C.A.) at

para. 10.

- [59] This same framework has been applied where the through driver was speeding.
- [60] Recently *D'Amici v. Fahy*, 2020 BCCA 89, affirmed that excessive speed on the part of the dominant driver, even if blameworthy, does not lead to liability unless the speed prevented them from taking reasonable steps to avoid the collision (at para. 46), citing *Cooper v. Garrett*, 2009 BCSC 35 and other authorities.
- [61] In *Cooper*, the servient driver failed to yield the right of way when turning left and was struck by the speeding dominant driver. Although three out of four accident reconstruction engineers expressed the view the accident could have been avoided had the dominant driver not been speeding, the servient driver was found 100% liable. Paragraph 44 of the decision reads:
- [44] While it seems attractive to attribute blame based on the speed of the dominant driver and hypothesize on what would have happened if [the dominant driver] kept to the speed limit, the fact is that [he] drove at the speed he did and there was nothing he could have done, driving at the speed he did, to avoid the collision. When [the servient driver] decided to proceed with his left-hand turn, [the dominant driver] was approximately 40 metres away. He was an immediate hazard and [the servient driver] should have yielded.
- [62] *D'Amici* endorsed subsequent decisions that rejected an interpretation of this passage as establishing a rigid rule or broad proposition, including *Hynna* and *Gorman v. Meghji*, 2018 BCSC 1904.
- [63] In *Hynna*, Justice Ballance concluded that *Cooper* should not be read as precluding the court from considering whether and how the speed of the through driver may have caused the accident, where the other driver failed to yield. She also expressed concern that resolving liability between two substandard drivers by giving unrestrained license to a speeding through driver, would have the effect of attaching absolute liability to a driver who fails to yield pursuant to s. 175. Addressing the standard of care Ballance J. observed:
- [83] In *Santos v. Raes* (18 February 1998), Vancouver Registry B964310, the Court confronted the point directly in the context of speeding stating, in part, at paras. 11 and 15:

While travelling with other traffic over the speed limit does not itself constitute negligence in this case, it will constitute contributory negligence if excessive speed probably prevented the defendant from taking reasonable measures to avoid the accident.

...All drivers who exceed the speed limit run the risk of being found liable if speed has prevented them from taking reasonable evasive action to avoid an accident.

- [64] In *Gorman*, Justice Butler as he then was, expressed a similar view:

- [117] The statement [in Cooper] that, "there was nothing he could have done, driving at the speed he did, to avoid the collision", does not establish a principle that can be applied in all cases. Indeed it would lead to an absurdity; every through driver, no matter what speed the vehicle was going, would not be found at fault.
- [65] Although Justice Willcock cautioned against conflating the standard of care with factual causation in D'Amici, he also specified that the cause in fact enquiry was "clearly assisted by" evidence that a driver with perception response time at the 50th percentile could have avoided the collision by driving at an acceptable speed (at para. 52).
- [66] None of the through drivers in Cooper, D'Amici or Hynna were speeding as fast, or as far over the same posted speed limit of 50 km/h, as Ms. Ball was.

Discussion

- [67] Returning to Ryan's approach to determining the standard of care, it could not be clearer to me that driving the Truck, a heavy, large vehicle, at 94 km/h, almost twice the speed limit, was a marked departure from the standard of a reasonably prudent motorist in all the circumstances. Whether or not Ms. Borgford's particular acts of negligence were reasonably foreseeable, Ms. Ball's excessive speed would have made it almost impossible to avoid any emergent hazard, including a vehicle that had stopped at the stop sign on 34A Avenue before proceeding into the intersection, not appreciating or able to perceive how fast Ms. Ball was travelling. At the same time, the gravity of the harm posed by her speed, particularly given the size and weight of the Truck was very serious.
- [68] I have already found, essentially, that Ms. Ball's speed was a cause of the Accident. Again, based on Avenger's speed of 90 km/h speed and the Truck's impact to its rear half, only a mere fraction of a second more time was required for Ms. Borgford to travel 2.5 metres further in order to avoid the Accident.
- [69] I am frankly troubled by the suggestion that arises from cases involving speeding through drivers that had Ms. Ball failed to detect and react to the Avenger before the Collision she would escape liability, despite the serious danger posed by her excessive speed while driving a large, heavy vehicle. It concerns me that the servient/dominant driver analysis may have affected an overemphasis on statutory requirements that are supposed to inform, but not determine the requisite standard of care.
- [70] It is unnecessary to consider the issue any further, however, because Ms. Ball did perceive the Avenger and was braking at the time of the Accident. Clearly, had she not been speeding excessively when she first saw the Avenger approximately 1.5 seconds before the Accident and 39 metres from impact, she could have avoided hitting it, by slowing, stopping and or swerving in time to avoid hitting it. I find, in other words, that Ms. Ball's excessive speed prevented her from acting with reasonable care, or from taking reasonable evasive action to avoid the Accident.

[71] As stated, Ms. Borgford concedes her negligence caused the accident, which I find in addition to speeding and failing to stop at a stop sign, included failing to keep a proper lookout and failing to yield the right of way.

[72] I conclude the negligent conduct of each party was a necessary cause of the Accident.

Apportionment of Liability

[73] Acknowledging she is more at fault for the Accident than Ms. Ball, Ms. Borgford takes the position that liability should be apportioned 60% to her and 40% to Ms. Ball, a split that places 50% more fault on Ms. Borgford. In the alternative she suggests an apportionment of 66.6% and 33.3%, which allocates twice as much fault to her than Ms. Ball. In the event of being found negligent Ms. Ball argues Ms. Borgford should be found 75%, if not 80% or 90% liable.

[74] Section 1 of the Negligence Act, R.S.B.C. 1996, c. 333 provides:

(1) If by fault of 2 or more persons damage or loss is caused to one or more of them, the liability to make good the damage or loss is in proportion to the degree to which each person was at fault.

[75] In other words, liability must be apportioned based on the degree to which each person was at fault, not the degree to which each person's fault caused the damage. Fault means blameworthiness: *Cempel v. Harrison Hot Springs Hotel Ltd.* (1997), 43 B.C.L.R. (3d) 219 (B.C.C.A.) at para. 19, and *Bradley v. Bath*, 2010 BCCA 10 at para. 24. Evaluating relative blameworthiness involves assessing the relative degree to which each tortfeasor departed from the standard of reasonable care: *Aberdeen v. Township of Langley, Zanatta, Cassels*, 2007 BCSC 993 at paras. 62-63, rev'd on other grounds 2008 BCCA 420. A number of factors are considered relevant:

The nature of the duty owed by the tortfeasor to the injured person;

The number of acts of fault or negligence committed by a person at fault;

The timing of the various negligent acts (with the person whose acts occur first typically being found more at fault than the person whose negligence occurs as a result of the initial fault);

The nature of the conduct held to amount to fault (with indifference to the results of the conduct or deliberate misconduct generally being more blameworthy than an imperfect reaction to a crisis);

The extent to which the conduct breaches statutory requirements;

The gravity of the risk created;

The extent of the opportunity to avoid or prevent the harm;

Whether the conduct was deliberate, or unusual or unexpected; and

The knowledge one person had or should have had of the conduct of another person at fault.

- [76] Ms. Borgford identifies *Knight v. Li*, 2011 BCSC 184, where liability was assessed 75% against the plaintiff and 25% against the defendant, as the closest comparator case. It too involved a plaintiff who failed to stop at a stop sign, before entering an intersection and colliding with the defendant who was driving at 75 km/h in a 50 km/h zone. Found to be the dominant driver with the right of way, the defendant was also found to be driving too quickly because the intersection was controlled by a pedestrian activated flashing green light and he was an inexperienced new driver. Unlike Ms. Borgford, the plaintiff was not speeding but severely impaired at the time of the Accident.
- [77] Ms. Borgford suggests given the comparative speeds of the defendant and Ms. Ball, and the degree of blameworthiness involved in severe impairment, the allocation of fault should be more even here.
- [78] Ms. Ball relies on *Currie v. Taylor*, 2012 BCSC 1553, aff'd 2014 BCCA 51, which also apportioned liability 75% against the plaintiff and 25% against the defendant. The facts involved the plaintiff failing to yield the right of way by leaving a stop sign and attempting to turn left into the path of the defendant who was there to be seen but speeding along Highway 97, more than one-third over the speed limit. Although it took the plaintiff 10 seconds to travel across the highway and defendant saw the plaintiff's vehicle moving away from the stop line, he took no evasive action, neglecting to keep a proper lookout for the "emergency that was developing in front of him".
- [79] In comparison, Ms. Ball's speed was 88% over the speed limit, although she had a much briefer opportunity to take evasive action.
- [80] Turning to consider the relevant Aberdeen factors, as motorists the parties owed each other comparable duties of care. Ms. Borgford had additional and important obligations to stop at the stop sign and yield the right of way. Failing to stop at a stop sign is dangerous conduct. The same is true of speeding at 40 km/h and 44 km/h over the post speed limit of 50 km/h. Both parties breached a number of provisions of the MVA, although Ms. Borgford's breaches were more numerous. Both parties also created a serious risk of harm that was easily avoided. Ms. Ball acknowledges that she decided to speed knowing it was dangerous. Although Ms. Borgford does not remember, she too must have chosen to drive as fast as she did, although failing to stop at the stop sign was not deliberate.
- [81] Based on my evaluation of the extent to which each party departed from the standard of care, I apportion the liability for the Accident 65% against Ms. Borgford and 35% against Ms. Ball.

Damages

Discussion of the Evidence

- [82] A multitude of fact and expert witnesses gave evidence related to Ms. Borgford's claims for damages. In addition to Ms. Borgford, Mr. Borgford and Ms. Chevalier-Cook, her fact witnesses included one of her sisters Lynn Murphy, another long-time friend Emil Beaulieu, first responder Jordan Wall, treating rheumatologist Dr. Michael Ramsden, family doctor Dr. Jennifer Compton, treating neurologist Dr. John Diggle, and treating occupational therapist Naomi Baker. The medical experts retained on Ms. Borgford's behalf included physiatrist Dr. H.A. Anton, psychiatrist Dr. Mitchell Spivak, and occupational therapist Nazneen Chow. Ms. Ball's experts included orthopedic surgeon Dr. J.P. Thompson, psychiatrist Dr. Derryck Smith, life expectancy expert Dr. Tom Elliot, and forensic toxicologist W.K. Jeffery.
- [83] Several of Ms. Borgford's witnesses and Ms. Borgford in particular were cross-examined at length based on an enormous volume of documents related to her disability insurance benefits dating back to the late 1980s (the "Disability Records"). Ultimately a much smaller subset of the Disability Records from 1993 onward were admitted into evidence as part of a joint document book, along with some pre- and post-Accident medical records from 2013 to 2022 (the "Joint Medical Records"). The Joint Medical Records include imaging reports, hospital records and clinical records.
- [84] A number of other documents, including the clinical records of Dr. Crompton and Ms. Baker were also admitted into evidence although not as part of the Joint Medical Records.
- [85] Toward the end of the trial the parties entered into a document agreement that stipulates the documents in the Joint Medical Records must be treated as business records. However, no document is admissible to prove any expert opinions it may contain. I take the same approach to Dr. Crompton and Ms. Baker's clinical records.

Background

- [86] Ms. Borgford was born in 1964 to a very large francophone family living in Labrador. The youngest of 13 siblings, she left home at the age of 16 and moved to Alberta, where she finished high school and then her nursing education at the University of Alberta.
- [87] As a registered nurse, Ms. Borgford worked in hospitals in Alberta before moving to Vancouver around 1990, when her first marriage failed. After more training, she worked as an operating room nurse at Shaughnessy Hospital and then St. Paul's Hospital.
- [88] In the late 1980s and early 1990s, Ms. Borgford was injured in a series of motor vehicle accidents and some workplace incidents. As a result, she received short term disability benefits at times, until in or about 1994 when her long-term disability benefits began.
- [89] Ms. Borgford lived in Winnipeg for a period of time, returned to BC and then moved to Nova Scotia for a few years, before again returning to the Lower Mainland where she has lived since.

The Disability Records

- [90] The Disability Records indicate Ms. Borgford has claimed for long-term disability benefits based on chronic pain since 1993. From about 1993 to 2003, her long-term disability claims, which include statements from various "attending" physicians, also referred to various psychiatric issues, including alcohol abuse until the late 1990s, psychosis, and most consistently depression. A claim document from 1996 identified paranoid schizophrenia as the primary diagnosis. In a 2003 claim document, "schizophrenia" was listed as a secondary diagnosis. Ms. Borgford strongly denied being schizophrenic. Her expert psychiatrist Dr. Spivak viewed the schizophrenia diagnoses, which involve severe life long mental health conditions, as inaccurate. Nor were they endorsed by the defence psychiatrist Dr. Smith.
- [91] Similarly, a claim form from 2002 referred to "bi-polar" as the primary diagnosis and "manic depression/bi-polar disorder" as a secondary diagnosis. Leaving aside a problem of overlap, there is no evidence of past symptoms or admissible opinion evidence to establish this diagnosis or diagnoses.
- [92] Notably, after 2003, the Disability Records do not refer to psychiatric diagnoses.
- [93] Consistent with Ms. Borgford's testimony, most of the claim forms and other documents in the Joint Medical Records, as well as the other medical records in evidence, identify and or discuss a chronic pain condition(s) and include many references to chronic back and neck pain, chronic pain syndrome, fibromyalgia, and starting in 2007, rheumatoid arthritis. One claim form in 2017 also refers to ankylosing spondylitis and lumbar degenerate disc disease.
- [94] Addressing the earlier references to psychiatric conditions, Ms. Borgford said she become very depressed and really not herself in or about the mid-1990s while living in Winnipeg with a boyfriend who was often working out of town. Medicated for depression, she said she experienced a psychotic break that she understood was caused by the interaction of two medications, and was hospitalized. Ms. Borgford readily acknowledged drinking a lot as a way of coping. She also said her boyfriend convinced her she was an alcoholic.
- [95] Ms. Murphy, who has lived in the Lower Mainland since 1983, flew to Winnipeg to support Ms. Borgford during this period. Stating she viewed her sister's relationship as abusive, Ms. Murphy described Ms. Borgford as in a very dark place.
- [96] In or about 1997, Ms. Borgford ended that relationship, moved back to Vancouver and then lived for a while in Nova Scotia. She stopped drinking for eight years and attended Alcoholics Anonymous faithfully. Eventually realizing, she said, it was her boyfriend who was the alcoholic, not her. Ms. Borgford testified she returned to drinking socially without a problem. Mr. Borgford, Ms. Murphy, Ms. Chevalier-Cook and Mr. Beaulieu corroborated this evidence. Aware she did not drink for many years, Ms. Murphy testified she never thought her sister had a drinking problem and stated when they get together they drink wine. Ms. Chevalier-Cook and Mr. Beaulieu, who have known Ms. Borgford for about 30 years, gave similar evidence. Mr. Borgford said the two of them would have wine with dinner when they

went out and Ms. Borgford may have a few drinks on the weekend, but there was no issue with her overdrinking.

Ms. Borgford before the Accident

- [97] Various witnesses provided entirely consistent and uncontradicted evidence about Ms. Borgford before the Accident, describing her as very bright, articulate, meticulous, outgoing, witty and caring, with an excellent if not exceptional memory. Always very slim and well dressed, she cared about her appearance. Her home was tastefully decorated and immaculate. Ms. Borgford loved being around people. She had lots of friends and many close family relationships. She was very close to Ms. Murphy and Ms. Chevalier-Cook. Both of them identified her as an important confidante and sounding board.
- [98] Ms. Borgford met Mr. Borgford in 2007 while she was living in a condominium and the president of the strata, which had two buildings and about 120 units. Mr. Borgford was working in strata maintenance and did repairs under her supervision. Ms. Borgford impressed him as very smart, resourceful and on the ball.
- [99] They began dating in late 2008 and started living together in May 2009 before getting married in October 2010. Each described their relationship and life together before the Accident, as did other witnesses, as especially loving, happy and fulfilling.
- [100] Mr. Borgford's work has involved both a maintenance business and strata management. Before the Accident Ms. Borgford helped him with his business by doing the "office work", ordered supplies and even doing some of repair work, such as painting, repairing fences and house washing.
- [101] Before the Accident they took many trips together to Jamaica, other parts of the Caribbean, Mexico and Hawaii. Ms. Borgford participated in many activities including swimming, snorkeling, some scuba diving, boat cruises, walking and riding mopeds. On a trip to eastern Canada with Mr. Borgford's children, they drove around the Maritimes, visited beaches and went horseback riding.
- [102] In addition to travelling, the two of them enjoyed camping with Mr. Borgford's trailer. They also took the trailer to a couple of family reunions, one as far away as Saskatchewan. Mr. Borgford owns a motorcycle that they used for many other excursions. The two of them also went fishing, canoeing and white water rafting together. Mr. Borgford taught Ms. Borgford how to shoot and would take her to the shooting gallery on weekends, which she really enjoyed.
- [103] After Ms. Borgford moved into Mr. Borgford's home, they made a number of improvements. Ms. Borgford was very handy and able to do some of the physical labour, for example ripping out baseboards and carpet and painting.

- [104] Ms. Borgford also provided support to Mr. Borgford's mother when she became ill with cancer. They would visit her on weekends at her home in the interior. Ms. Borgford cooked and helped with cleaning. Her nursing background meant she was able to talk to her mother-in-law about her illness. Very ill by then, in 2014 the Borgfords took her to Mexico with them. Ms. Borgford spent a lot of time with her on the trip getting her meals and sitting with her on the beach.
- [105] Until the Accident and despite her chronic pain condition, Ms. Borgford did all of the housework herself. She said she had to pace herself by doing small amounts and taking breaks. She also did her own gardening, although not the grass cutting due to an allergy.
- [106] Ms. Borgford had a very busy social life. Mr. Borgford described their social calendar as full. Ms. Borgford frequently had friends and family over for big dinners, barbecues, and birthday and holiday celebrations. Ms. Chevalier-Cook recalled Ms. Borgford cooking massive meals.
- [107] Mr. Borgford commented that sometimes during these events, he could tell his wife was in pain from the look on her face or how she stood, but she never complained. Instead she would lie down for 15 minutes or so and then bounce back.
- [108] Mr. Borgford said he first learned Ms. Borgford had a "back issue" and was receiving long-term disability benefits on their first trip, to Jamaica. He noticed her grimacing at times. Overtime he realized sitting was hard on her "big time".
- [109] Ms. Murphy referred to Ms. Borgford experiencing a lot of back and neck pain before the Accident that was managed with medication. Describing her sister as previously calm and a good communicator, Ms. Murphy said she would talk openly at social gatherings about having fibromyalgia and needing to lie down or explain why she was sitting and getting up constantly. Aware that Ms. Borgford had been injured in a number of previous accidents, Ms. Murphy also knew she had headaches which she attributed to those injuries and a right eye injury.
- [110] Ms. Chevalier-Cook had similar recollections from before the Accident. She knew Ms. Borgford had fibromyalgia and experienced wide spread pain. Although she had to stand up from sitting and lying down once in a while, Ms. Chevalier-Cooke did not remember Ms. Borgford having a problem with standing or walking, also indicating that she loved dancing and would wear high heels. Ms. Chevalier-Cook recalled Ms. Borgford "always saying" she had a headache that was related to "her neck thing" but also seemed to remember Ms. Borgford's headaches starting after she injured her right eye.

- [111] The eye injury occurred in or about 1998 while Ms. Borgford was camping. It required surgery to repair a retinal tear. Indicating she lost some peripheral vision and her pupil was no longer contracting properly, Ms. Borgford stated her right eye also became very light sensitive, which required her to wear a dark contact lens or sunglasses. In cross-examination, Ms. Borgford acknowledged occasional or periodic dizziness after the eye injury. Ms. Chevalier-Cook recalled her having dizziness that lasted quite a while.
- [112] Asked to describe her pain symptoms before the Accident, Ms. Borgford said she had pain in her muscles and joints from fibromyalgia and rheumatoid arthritis, and pain in her lower back, that was worse in the winter but she was coping. She described long drives as a real problem, stating they would "put me in bed". Although she used pain medication, heat pads and massage, the only thing that really helped was lying flat. Ms. Borgford added that her body would shut down if she did too much. She also described needing to stop and stretch during motorcycle rides and using extra pain medication to ride further.
- [113] For many years if not decades before the Accident Ms. Borgford relied on opiate medication to manage her chronic pain. She also took Lyrica. In his report dated February 17, 2022, toxicologist Mr. Jeffery identified her oxycodone and Lyrica dosages starting in January 2017 based on Pharmanet printouts and discussed typical dosages. In cross examination he agreed that the dosage of oxycodone prescribed for Ms. Borgford before the Accident was "very much" within typical dosage levels and her daily dose for Lyrica was at the low end.
- [114] Dr. Ramsden is a rheumatologist who has been treating Ms. Borgford for pain complaints since 2007. He testified that before the Accident, her treatment was complicated by the difficulty involved in distinguishing how much of her pain was due to fibromyalgia as opposed to rheumatoid arthritis. Dr. Ramsden commented she did not have the swollen joints that would confirm a diagnosis of rheumatoid arthritis, although she experienced other factors along with widespread pain that can result from both conditions. Based on his clinical records, Dr. Ramsden also gave evidence that Ms. Borgford's pain was not well managed in the year or two before the Accident. During an appointment in February 2016, for example, Ms. Borgford was in tears and complaining of being sore all over, which she related in part to caring for Mr. Borgford after surgery. Dr. Ramsden's record reads in part: "[t]his has left her exhausted at times she's had to sleep 12-14 hours to recover".
- [115] That day, Ms. Borgford also reported tapering off prednisone or steroids the week before and complained about a switch in medication made by her family doctor from Percocet to slow release morphine. Similarly, in May 2016, it was apparent to Dr. Ramsden from her squirming and unusual posturing that she was feeling a lot of pain. She wanted to discuss narcotic pain medication. Dr. Ramsden explained that family doctors manage those prescriptions for patients taking them long term. At her last appointment before the Accident, in December 2016, Ms. Borgford complained of soreness in her back, hip, knees, elbows and shoulder. Dr. Ramsden suggested Cymbalta, an anti-depressant used for pain management, to treat pain related to her fibromyalgia, because her joints appeared normal.

- [116] Ms. Borgford gave similar evidence about her pain being poorly managed during this time frame, after her long-term family doctor retired and she was being treated by other general practitioners at the same medical clinic. Consistent with the clinical records, she testified that they changed a long-term stable prescription for oxycodone, which she found effective, to morphine, which she said did not work, even at an increased dose. Ms. Borgford indicated that when she tried Cymbalta as suggested by Dr. Ramsden, it too was ineffective and caused side effects.
- [117] She also described seeking or receiving other treatments to help with her back and neck pain, including for example, spinal injections, spinal surgery, breast reduction surgery, which did not occur, and marijuana. Ms. Borgford disputed the accuracy of a clinical record that commented she could not, meaning ought not to, take narcotics and marijuana at the same time. She and Mr. Borgford maintained that before the Accident, she was asking to be taken off opiates and prescribed medical marijuana instead.
- [118] Ms. Borgford also testified about having headaches before the Accident which she distinguished from the constant intense headaches she says she has experienced since the Accident. She recalled frequent but not ongoing headaches after "fender benders" or car accidents due to whiplash, and migraines before it snowed.
- [119] There is no dispute Ms. Borgford also experienced a number of other health issues before the Accident including long term asthma, Grave's disease that resulted in thyroid surgery, bowel issues or irritable bowel syndrome, and insomnia, some or all of which were treated with medications. Ms. Borgford described her thyroid condition as well managed. She said her bowel issues would come and go but they included episodes of diverticulosis. Clinical records from Langley Memorial Hospital show, for example, indicate she had attended at the emergency department in June 2016 with abdominal pain, nausea, and fever and ongoing symptoms in September 2016.

The Accident

- [120] Again, the Accident occurred at approximately 6:40 p.m. on August 7, 2017, which was a Monday. Firefighter Jordan Hall was among the first emergency responders to arrive on the scene. His incident report shows that a dispatch message was received at 18:41 that evening. He and his crew arrived at 18:48:48, shortly before the first ambulance and police. Tasked with getting inside the vehicle, assessing Ms. Borgford and assisting in getting her out, Mr. Hall found her unconscious and estimated that she regained consciousness but was very incoherent about ten minutes later.

- [121] The ambulance report shows Glasgow Coma Scores ("GCS") of 13 for Ms. Borgford at 19:30 and 19:35. The report refers to her as combative, confused and oriented in person but not place or time. It also states she presented with "constant repetition and moderate combativeness". At 19:22 and 19:31, Ms. Borgford was treated with Ketamine. Describing her response to the medication, the report reads: "Ketamine down arrow agitation/ combativeness, pt LOC worsened to 13 from initial assessment of 14 while in care".
- [122] Transported by air ambulance to VGH, Ms. Borgford remained there until August 10, 2017 when she was transferred to Royal Columbia Hospital ("RCH").

Substance Use before the Accident

- [123] Shortly after her arrival at VGH, a blood sample taken from Ms. Borgford was found to contain less than 2 mmol/L of ethanol. Urine sample testing detected the presence of THC, cocaine and opiates. In his report, Mr. Jeffery explained that the alcohol result usually indicates no ethyl alcohol was found or it was less than .008 mg%. Writing that cocaine can be detected in urine for up to three to five days and TCH for weeks after a single usage, Mr. Jeffery opined that the only conclusion that can be drawn from the results is that Ms. Borgford used THC, cocaine and opiates prior to the Accident.
- [124] Although her recollections were unclear, Ms. Borgford testified that she probably drank quite heavily with Ms. Chevalier-Cook in the evenings of the weekend before the Accident, but she had no alcohol on the day of the Accident. Ms. Chevalier-Cook, whose memory for the period seemed much better, recalled having several drinks with Ms. Borgford on the Friday night but then just a glass of wine with dinner on Saturday and Sunday, and no alcohol on Monday. Mr. Borgford's evidence was that he thought Ms. Borgford was drinking vodka on Sunday, which is her preferred drink.
- [125] Ms. Borgford also testified to trying a marijuana lollipop for the first time that weekend, which she bought on the Saturday. Ms. Chevalier-Cook described smoking a joint of marijuana on her own and not being aware of the popsicle. She also testified that she had not known Ms. Borgford to use marijuana. Mr. Borgford gave similar evidence, indicating very occasional she would take a toke from a marijuana joint in a social situation.
- [126] Mr. Borgford gave some unusual evidence about a small baggie of cocaine that he received on the Saturday. Mr. Borgford said he had been helping a friend move some things and repair his motorcycle that day. He described being very surprised when the friend gave him a "small little amount" of cocaine "for Chantale" as a form of thanks. Referring to the friend as a former biker and "not someone you say no to", Mr. Borgford said he took the baggie and left it on the bench in their garage because that is where he went when he arrived at home. Both cigarette smokers at the time, the garage was the Borgford's smoking area. Mr. Borgford testified to not thinking much about the cocaine until after the Accident when he learned that testing results showed cocaine in Ms. Borgford's system. He also testified to later finding the baggie opened up and a little bit there. Mr. Borgford denied ever

discussing the cocaine with Ms. Borgford before or after the Accident. He also denied ever using cocaine himself except when he was 15, or being aware that she had used it previously.

[127] Ms. Borgford said she remembered finding the baggie or "half a gram" of cocaine in the garage, dipping the marijuana lollipop into it, and the cocaine tasting awful but nothing more. Asked what happened to the rest of the cocaine, she testified initially that Mr. Borgford used it, but later on it became evident she assumed rather than observed this. In contrast to Mr. Borgford's evidence, she also said she talked with Mr. Borgford about the cocaine recently. Ms. Borgford acknowledged using it before but very rarely, if not only once before, and denied it was something she and Mr. Borgford had ever used together. Ms. Chevalier-Cook denied seeing or knowing about the baggie of cocaine at all, also stating cocaine was not something she had ever used with Ms. Borgford.

[128] Again, I have not been asked to find that Ms. Borgford was impaired by drugs or alcohol at the time of Accident and I make no such finding.

Acute Injuries

[129] Again, there is no dispute that Ms. Borgford suffered complex, multiple orthopedic injuries in the Accident. The agreed statement of facts identifies them as follows:

Multiple rib fractures bilaterally: Right 1st and 2nd, left 1st, 2nd, 4th, 5th, and 6th;

T10 endplate fracture;

L1 wedge fracture;

Left scapular fracture.

[130] This articulation reflects the causation findings of orthopedic surgeon Dr. Thompson in his report of March 2, 2022.

[131] Physiatrist Dr. Anton defined Ms. Borgford's acute injuries more comprehensively:

Chest injuries, including a left pneumothorax and multiple bilateral rib fractures resulting in a "flail chest", a severe and potentially life-threatening injury "in which multiple rib fractures separate part of the rib cage from the rest of the chest wall, compromising respiratory function".

Injuries to the low back including an acute wedge compression fracture of the L1 vertebral body with associated soft tissue injury.

Injuries to the upper and mid back including an undisplaced fracture of the left T1 transverse process; a probable compression fracture involving the superior endplate of the T10 vertebral body; and associated soft tissue injuries.

A left-sided facial injury from blunt force trauma producing a soft tissue defect in the left outer face and a probable left infraorbital nerve injury (a sensory nerve in the face).

Trauma to the left temporomandibular joint ("TMJ").

A head injury associated with a soft tissue hematoma over the left vertex and left parietal bone and a TBI.

A minimally displaced left scapula fracture.

[132] In his response report, Dr. Thompson did not dispute Dr. Anton's diagnoses and in cross-examination he agreed that Ms. Borgford suffered a left pneumothorax.

[133] As I stated, Ms. Ball agrees that Ms. Borgford also suffered TBI in the Accident, although there is a significant disagreement about its severity or how it should be categorized, and whether it is causing ongoing symptoms.

[134] Mr. Borgford recalled Ms. Borgford as "not conscious at all" when he arrived at VGH on the evening of August 7, 2017. Hooked up to tubes and wires, she was also intubated. Photographs he took early on August 8, 2017 still show her intubated. They and others also show extensive bruising around her left eye, deep linear bruising from the base of her neck that extended down her spine, bruising around her left jaw and a large abrasion below her left collar bone. He also noticed lots of cuts.

[135] Indicating Ms. Murphy and her children also visited Ms. Borgford on August 8, 2017, Mr. Borgford said she did not recognize anybody. He asked her a few times if she remembered his name and her response was, "you're funny". He said it was three days before she used his name, although she called him Freddie instead of Fred, something she had not done before.

[136] On August 10, 2017, after learning her first language was French a speech therapist suggested someone speak to Ms. Borgford in French, which Ms. Murphy did. She described Ms. Borgford speaking back to her in a really "mixed bag" of incoherent and coherent sentences. She also used words "out of left field" and "it was evident" her thought processes were affected.

[137] Videos taken by Mr. Borgford of Ms. Borgford in hospital show her really struggling to communicate. An August 10th video shows her having a lot of trouble finding words, speaking very slowly and stuttering at times.

[138] Ms. Borgford testified to having no memory of anything after the Accident until several days later when she was at RCH and Ms. Murphy was speaking to her in French. She remembered feeling as she described it "pain, pain, pain", having trouble speaking and eating, not being able to open her mouth and everything being mixed up.

[139] The nursing assessment records contained in the Joint Book of Documents for August 8, 2017, refer to Ms. Borgford being sedated and receiving a range of medications that included Ketamine, Dilaudid, and Propofol. Records for August 11 and 13, 2017, show her receiving hydromorphone for pain. The nursing assessment records also refer to her becoming extremely agitated, continuing to have difficulty expressing herself, making

repetitive noises and movements and "still" being confused. Special care nursing assessment records for August 9, 2017 identify her GCS as 13 and 14 and describe her as confused. One of the records also describes her as "agitated, oriented to name only, difficulty finding words/expressing herself". The nursing notes for that same day describe Ms. Borgford as extremely agitated, combative and oriented to name only. She was unable to explain the location or severity of her pain, although she was able to follow instructions.

- [140] In a consultation report dated August 10, 2017, psychiatrist Dr. P. Rezazadeh-Azar wrote that Ms. Borgford was disoriented, could not recall the events related to her admission and was surprised to be told she had been involved in a motor vehicle accident and was in hospital, adding that she could not sustain a conversation. The consultation report also indicated that pain management had been a challenge. By then Ms. Borgford was receiving hydromorphone, but she remained extremely uncomfortable. The transfer of care record from RCH also dated August 10, 2017 shows a GCS of 13-14.

Early Recovery

- [141] Ms. Borgford was discharged on August 16, 2017. At home she was cared for by agency caregivers, Mr. Borgford recalled, six to eight hours each day, four or five days per week. Mr. Borgford did not return to work until October 2017. He described Ms. Borgford's condition as not having changed that much by then, but he felt more comfortable leaving her alone with the caregivers.
- [142] Ms. Baker began providing Ms. Borgford with occupational therapy on August 18, 2017.
- [143] Unfortunately, arranging for Ms. Borgford's primary medical care took longer. It was Ms. Baker who was able to find Dr. Crompton, Ms. Borgford's family doctor since November 2017. Both of them have been extensively involved with Ms. Borgford since then, also collaborating with each other.
- [144] During her involvement Ms. Baker has completed many reports that set out her observations, ongoing assessments of all aspects of Ms. Borgford's functioning, as well as various interventions aimed at improving that functioning.
- [145] Initially, when Ms. Borgford was limited by pain as well as symptoms of dizziness/vertigo and poor balance, the sessions focused on physical mobility. The focus then shifted to providing her with cognitive and memory strategies. A typical session, testified Ms. Baker, starts with an update, then they identify the "imminent" issues, review Ms. Borgford's appointments since they last met, look ahead at her calendar and establish goals. Ms. Baker has also attended medical appointments with Ms. Borgford and supported her in many other ways such as arranging other services and with driving licensing issues.

- [146] In February 2018, Ms. Borgford gradually resumed driving short distances in familiar areas during the day. Later in 2020 and 2021, she was required to complete some driving tests which she found really distressing, including a functional driving assessment that involves a clinical assessment. As a result however, she qualified to drive vehicles with a manual transmission, which includes Mr. Borgford's vehicle.
- [147] Ms. Baker arranged for physiotherapy, kinesiology and speech therapy. Later on, she involved a rehabilitation assistant ("RA") to work under her direction. More recently the RA has been focusing on implementing cognitive strategies that require more repetition, in part to relieve the burden on Mr. Borgford.
- [148] Ms. Baker indicated that she used to meet with him very often too, given his role as the "primary caregiver". Over time she included him less often, realizing how taxing this was for him. Now generally she will contact him after a session if there is something important to communicate.
- [149] Before the Accident Ms. Borgford received chiropractic treatments, when as she said, she was "all out of wack", although since the Accident she has not been able to afford them regularly. Other evidence indicates there have been no post-Accident chiropractic treatments because the cost has not been covered. Since the Accident, but not before, Ms. Borgford has attended acupuncture which she said she finds helps her low back pain.
- [150] Addressing how she was when she first went home from the hospital, Mr. Borgford said she was speaking in five- or six-word sentences although her English remained "messed up". She had also started to stutter really badly and still did not know why she had been in the hospital. Ms. Borgford's pain he said was "overriding everything" and her breathing was laboured from the "lung collapse".
- [151] Ms. Borgford testified to not remembering much about her early recovery. Although she had trouble providing a chronological or comprehensive account of her condition, she did recall being in a lot of pain, not being able to take a deep breath due to all the broken ribs. She also remembered not being able to open her mouth and being treated by oral surgeon Dr. Ben Kang. After finding her jaw was displaced, she said, he put her to sleep and "replaced" her jaw, or put it back in place, which helped a bit.
- [152] Ms. Borgford recalled using a cane for about six months because she was dizzy all the time and unbalanced. She described retching when she put her head down or in different positions. She also said her brain was not working, she would forget, kept repeating herself and needed help with everything. At a certain point, Ms. Borgford realized her sense of smell and taste were almost gone.

Dizziness

- [153] Mr. Borgford testified that Ms. Borgford continued to experience vertigo or dizziness after the Accident, if she turned or got out of bed too quickly. He said her eyeballs would shake back and forth and she would lose all balance. Following some vestibular therapy, however, in late 2017 or early 2018 her vertigo or dizziness dropped off dramatically.
- [154] Ms. Borgford testified to experiencing bouts of dizziness again after two flights to Mexico in 2018 and 2020 and becoming dizzy and retching during the flights. She explained as did Mr. Borgford that he attends work related conferences in Mexico every year. After she got home from the 2018 trip she could not drive for a month because of dizziness. Ms. Borgford stated she had no issues with flying before the Accident, "but now it affects my head so bad". She also referred to bursting her eardrum on the 2020 flight.
- [155] Mr. Borgford confirmed that Ms. Borgford came with him to work conferences in February 2018 and May 2020. Before the first trip they conferred with her family doctor and neurologist. He described Ms. Borgford being thrown into a "tailspin" and her brain not liking the descent on a flight in February 2018. She needed a wheelchair to get off the plane, spending all of her time in their hotel room, and being right back to how she was before he returned to work in October 2017. The following year he arranged for Ms. Chevalier-Cook to stay with Ms. Borgford while he attended another conference. When she joined him again in May 2020, he recalled the flight going well until the descent. This time she had a problem with her ears not clearing.
- [156] During her evidence, Dr. Crompton referred to a clinical record for March 5, 2018, which indicates Ms. Borgford reported struggling with an ear issue on the 2018 flight. She also appeared somewhat unsteady on her feet.
- [157] Dr. Ramsden's records show that in March 2018, Ms. Borgford told him she had been fine on the trip to Mexico in February. Cross-examined on this point, she testified that she was referring to her joints, which were fine, because the weather was nice and warm.
- [158] Mr. Borgford referred to Ms. Borgford experiencing another bout of vertigo at the end of 2018 that lasted two or three months and recurring bouts since then that start and stop for "no rhyme or reason". Her balance is poor when she has them. Mr. Borgford said that during those times he follows her around the house and advises caregivers to pay particular attention to her, concerned about her tripping and falling.

Recent Eye Injury

- [159] Not long before the trial, in April 2022, Ms. Borgford fell as she was getting out of her bed. Mr. Borgford testified that she landed on her face and was knocked unconscious briefly, although after he sat her up she lapsed into unconsciousness over and over again, by his count 26 times. Ms. Borgford's eye was seriously injured in the fall. She has lost all vision in that eye, which is likely permanent, and has returned to using a cane and is not able to drive, because she has trouble with depth perception.

Ongoing Symptoms

- [160] Ms. Borgford really struggled to focus when describing her ongoing symptoms. Asked about pain symptoms, Ms. Borgford said her pain is amplified or exaggerated in comparison to before the Accident. Mr. Borgford commented that in contrast to before the Accident, she actually complains of pain and pain is evident in her "very vivid" facial expressions.
- [161] Ms. Borgford did refer to constant daily headaches, accompanied by nausea and retching, which she also attributed to being in certain positions. Ms. Borgford said she deals with the nausea by taking Gravol "all the time". Botox injections, which neurologist Dr. Diggle administers every three months, improve her headaches for about two months. Describing the injections as taking a "loud concert down to a whisper", Ms. Borgford stated they help her to function. Mr. Borgford gave very similar evidence, indicating she also seems a little happier, stops constantly holding her head, and her face displays less pain during that two-month period.
- [162] Dr. Diggle specified that he has been treating Ms. Borgford for daily headaches since January 2018, although he saw her initially at a stroke clinic because of speech difficulties. Other treatments for her headaches were not effective. In November 2018, he administered Botox injections for the first time. She reported a reduction in the duration and intensity of her headaches. Since then the injections have continued. Dr. Diggle modifies the dose and injection sites based on the areas of tenderness she reports and his observations. For example, after noting abnormal tone in her jaw muscles and abnormal clenching of the left jaw, he injected a higher dose into that area.
- [163] Referred by Dr. Kang for treatment of her TMJ disorder and related myofascial pain, dentist Dr. Sam Ng testified that the treatment plan is for her to continue to receive Botox injections and use a mouthguard.
- [164] When asked about her personality or emotional functioning since the Accident and at various points during her evidence, Ms. Borgford cried about losing her polite filter, blurting out whatever she is thinking, and being very volatile. Stating she can be happy, sad and angry in the space of five minutes, she described having angry outbursts if she feels someone is "getting in my face". Ms. Borgford said she has also become very sensitive to noises and startles or jumps at everything. Mr. Borgford and others confirmed all of this.

She recalled screaming at a little girl in a store because she was screaming. Intensely distressed by her behaviour, Ms. Borgford felt like vomiting and cried in her car.

- [165] Asked about her memory, which she referred to as fantastic and nearly photographic before the Accident, Ms. Borgford complained of significant ongoing memory problems since. She has to make a note or a list for everything, she leaves food cooking on the stove, forgets to close the garage door, forgets where she is going while driving to an appointment, and forgets where she parked and thinks her car has been stolen.
- [166] Ms. Borgford gave evidence that Ms. Baker has given her many helpful memory strategies. She relies, for example, on a chore check list she has on her phone, that dings to remind her to water the plants etc.
- [167] Regarding changes in her speech, Ms. Borgford said she stutters especially when she is anxious. Stuttering also makes her flustered and then she stutters even more. Ms. Borgford finds it very embarrassing. She also stated that she struggles to find words, forgets what she said and repeats herself because she forgets, all of which was displayed throughout her testimony.
- [168] Addressing some of her other previous medical issues, Ms. Borgford described her bowel issues or IBS as much worse since the Accident, triggered by stress and anxiety. She said she experiences either constant diarrhea and cramping, which prevents her from going out, or constipation, although a new antidepressant medication is helping, unless she is "really worked up". Related to this, Ms. Borgford identified appointments with doctors and lawyers as triggering her anxiety. The mere mention of the name ICBC is enough to "send me over the edge". Ms. Borgford and various others identified her intense mistrust and dislike of ICBC, arising from previous litigation and the use of counselling records that discussed childhood trauma.
- [169] Always thin, Ms. Borgford has gained 50 pounds since the Accident. She and others testified about her distress and embarrassment over the change in her appearance, as well as her condition. Taken to photographs of the two of them looking happy and relaxed on a trip to Mexico a few months before the Accident, Ms. Borgford gave very poignant disinhibited testimony:

My life has changed. I can't smell him anymore. I feel awful. I hate this body, it's really affected us, when I realized how bad my head injury was, I wanted to leave him because he didn't marry this, what he married is gone. Thank god for Naomi. She said by leaving him you're not giving him a choice and I didn't want to do that to him, but I have him the out, I wanted to leave him because I didn't want him to have to deal with this, everything stopped working, I can't smell I can't taste, my button's broke it hasn't worked for years and he's such a good man. I haven't been coping so well at all, I've been relying on him so much and that's why he's had a heart attack, I know it's from all the stress from going everywhere trying to find doctors.

I thought if he dies, I can't remember anything like the combination to get important documents, and then this stuttering too, now people look at me and think I'm a dummy, it's been horrendous .

[170] The heart attack she refers to, occurred in 2020. In terms of not coping, Ms. Borgford readily acknowledged drinking vodka more than she should.

[171] All of her evidence about changes in her personality, cognitive function and speech as well as the impact of her condition on Mr. Borgford were corroborated by him, Ms. Murphy and Ms. Chevalier-Cook.

[172] Mr. Borgford indicated that although her physical injuries resolved, there has not been much improvement in her "mental status" since the Accident. He described her as having no short-term memory. As a result, he went to all of her medical appointments for three years. Now she is completely dependent on her cell phone for information. Her lack of memory continues to pose real challenges, with tasks like cooking, which she forgets about and walks away from. He also said although they have conversations for the most part she does not retain what they discussed. For example, while he was attending court, Ms. Borgford had called worried about where he was, forgetting he was testifying. That evening, although he told her he would be, she asked repeatedly if he was going to court the next day.

[173] Like Ms. Borgford, he identified her as having emotional outbursts, getting volatile and lashing out verbally at people all of a sudden. Mr. Borgford referred to her exploding on their roommates, family members including his children and strangers, but that he takes the brunt of it. Ms. Borgford cries and apologizes when she has these outbursts. But she also cries all the time, something she never did in front of him before the Accident. Mr. Borgford said his wife has more bad than good days. He also spoke about how isolated Ms. Borgford has become as a result. She has lost many friends, acquaintances and connections with family members. Her rich social life has been reduced to a handful of people.

[174] Asked about the big picture, he said the joy is gone. Apparently emotionally exhausted, he credited Ms. Baker with helping him manage the stress of dealing with Ms. Borgford. At the same time, Mr. Borgford expressed a certain amount of desperation about how much longer he can "carry on" without "big time" help, stating they need someone in the house on a regular basis and Ms. Borgford needs speech therapy and physiotherapy, along with a program to get her physically active.

[175] Addressing the changes she has seen in Ms. Borgford since the Accident, Ms. Murphy testified that she feels like she has lost her sister. Especially when they go out, Ms. Murphy feels more like a caregiver. Ms. Murphy said Ms. Borgford is all over the map emotionally - happy and laughing at jokes and then crying or angry within a short period of time. Her behaviour is impulsive and she will say inappropriate things. She is not able to manage herself in different settings and misperceives what is happening, which Ms. Murphy finds particularly disturbing. She offered an example of Ms. Borgford becoming very upset with a cashier and telling her she was accusing her of stealing. In fact, the cashier was simply

trying to help her with pricing. Ms. Borgford has also become more animated and her gestures are exaggerated when she tells a story. Strangers notice her behaviour. Describing her sister as ashamed and embarrassed by how she is, like Mr. Borgford, Ms. Murphy said that Ms. Borgford has become reclusive and introverted. Ms. Murphy has to try very hard to get her out of the house.

- [176] Ms. Murphy also testified that Ms. Borgford forgets things, including for example what she has just ordered at a restaurant. She repeats herself constantly and feels the need to act on any immediate memory in case she forgets. Ms. Murphy recalled Ms. Borgford disappearing during a visit at her home. Ms. Murphy found her in the laundry room folding clothes. When she asked her what she was doing, Ms. Borgford said she just remembered she had to fold the laundry. Ms. Murphy has also noticed she is quick to put information into her phone and keeps papers to help her remember.
- [177] Ms. Chevalier-Cook gave similar although less detailed evidence about Ms. Borgford since the Accident. Describing the overall change in her as like night and day, Ms. Chevalier-Cook referred to Ms. Borgford's cognitive skills as "not there". In addition to forgetting everything and repeating herself all the time, it takes her quite a while to process information. Ms. Borgford often has to read things over and over again. An "A 1" speller before the Accident, now she asks how to spell words. Ms. Borgford is less articulate and uses foul language, something she did not do before.
- [178] Ms. Chevalier-Cook also described significant personality and or emotional changes. In addition to losing her special demeanour, Ms. Borgford is very quick to anger and has no emotional filter. Ms. Chevalier-Cook finds herself biting her tongue, after more than 30 years of friendship without a fight. She also testified they no longer have back and forth conversations, because "there is no comprehension on the other side". Aware that Ms. Borgford has lost many friends, like Ms. Murphy, Ms. Chevalier-Cook has observed that other people are not able to handle her angry outbursts and her lack of reciprocity.
- [179] Dr. Ramsden also gave evidence about Ms. Borgford displaying cognitive and speech difficulties during appointments since the Accident. They include trouble expressing herself, stuttering, pressured speech, difficulty focusing and jumping from topic to topic, as well as memory issues, although these were partly based on what she told him, none of which he had observed before the Accident.
- [180] Although she did not know Ms. Borgford before the Accident, Ms. Baker gave entirely consistent evidence regarding her cognitive, psychological and emotional condition since the Accident. Ms. Baker testified that Ms. Borgford displays many ongoing problems with attention, memory, information processing and executive functioning. Ms. Borgford is very tangential, meaning she jumps from one topic to another constantly, but she also perseverates, is hard to re-direct and interrupts. Similarly, Ms. Borgford has difficulty focusing on the flow of a conversation and loses track of the topic. She has problems multitasking, planning, and problem solving.

- [181] Ms. Baker has observed that Ms. Borgford has a very strong startle in response to every day sounds like the phone ringing and is very sensitive to noise, which Mr. Borgford also noted. Referring to her low tolerance for frustration, emotional lability and volatility, Ms. Baker said during many appointments Ms. Borgford's emotions have fluctuated from crying to being fine to being really angry and sort of yelling and then laughing. Ms. Baker also found that Ms. Borgford displayed more anger and irritation as her awareness and understanding of her limitations increased. Like the other witnesses Ms. Baker described Ms. Borgford as disinhibited in the sense that she blurts out inappropriate and sometimes hurtful comments.
- [182] Identifying the same speech issues as other witnesses, Ms. Baker also said there were some improvements in Ms. Borgford's speech in response to the speech language therapy in 2019, which have not been sustained.
- [183] In terms of dizziness and balance issues, Ms. Baker observed that Ms. Borgford's balance decreased and she was using a cane after the May 2020 trip. Ms. Baker also noted worsened dizziness and several falls at that time. She testified that during appointments Ms. Borgford dry heaves very often, induced by head down positions. As she recovers she grasps for a chair or something to steady herself with.
- [184] Ms. Baker also observed that Ms. Borgford tends to overestimate her ability to mobilize and therefore tends to make decisions that place her at risk of falling.
- [185] Ms. Baker commented that at a certain point, Ms. Borgford wanted to take on more household chores and try having no homemaking support. The attempt did not go well. Instead it resulted in a significant aggravation of Ms. Borgford's physical and "mental health" symptoms.
- [186] Addressing the "big picture" that emerges from looking back on her work with Ms. Borgford over several years, Ms. Baker identified some significant improvements generally. When they first met Ms. Borgford needed help with all of her personal care, and she was not driving, grocery shopping or making meals. She returned to cooking most meals, grocery shopping and doing some housekeeping. Receptive to all of the strategies Ms. Baker has suggested, Ms. Borgford has been able to attend medical appointments on her own because she writes things down. At the same time, Ms. Baker identified Ms. Borgford's memory problems as her biggest ongoing challenge.
- [187] I note at this stage the observations of Ms. Chow, an occupational therapist, during two in-home sessions with Ms. Borgford, discussed in her report dated March 4, 2022. In addition to stuttering, Ms. Borgford's speech was extremely pressured and her volume fluctuated. Sometimes she was almost yelling and Mr. Borgford would remind her to speak softly. Ms. Borgford appeared anxious, pacing from side to side and moving around. She was also extremely tearful and very emotional at times, requiring Mr. Borgford to calm her. She displayed signs of disinhibition or lack of impulse control, some of them extreme. Ms. Chow offered as an example, Ms. Borgford reaching into the freezer and pouring herself a

shot of vodka, when she became upset at one point. Another involved Ms. Borgford "flipping up" her dress to show Ms. Chow the weight gain in her abdominal area and a hernia she said was developing from retching, something she did during their sessions.

[188] Ms. Chow also observed that Ms. Borgford was extremely distractible and tangential on both assessment days and required frequent re-direction to stay on topic.

[189] Ms. Chow's report includes a list of current medications that was reviewed with Ms. Borgford during her testimony. They are: Venlafaxine XR, which is an antidepressant that Ms. Borgford said she was not prescribed for depression; Dicyclomine for abdominal cramping related to anxiety, which Ms. Borgford said helps with sleep; Lyrica 150 mg for pain management, something she also took before the Accident; Oxycodone 10 mg twice daily for pain management, and 5 mg as needed for break through pain, also a form of medication she took before the Accident; Aleve (Naproxen) twice daily for pain management related to rheumatoid arthritis; Ativan (Lorazepam) .5 mg for anxiety, which she took before the Accident although Ms. Borgford said it was prescribed for sleep; Botox injections every three months for headaches and jaw pain; and Voltaren cream three times/day for musculoskeletal pain.

[190] Ms. Borgford also reported that she has been using CBD oil and approximately 10 grams of cannabis every two to three weeks to decrease her reliance on Oxycodone. She testified it helps with body pain a "little bit" but anxiety "a lot".

Expert Evidence

[191] A number of the expert witnesses, including Dr. Anton and the two psychiatrists provided opinion evidence about Ms. Borgford's TBI. Dr. Anton and Dr. Thompson, as I have already indicated opined on her orthopedic injuries and pain symptoms as well as her current versus post-Accident condition.

Dr. H.A. Aton

[192] Turning first to physiatrist Dr. Anton, I note that his clinical practice has included the medical and rehabilitation management of patients with neurological injuries due to acquired brain injury, as well as spinal cord injury and stroke, in addition to those with multiple injuries due to trauma. I have already identified the orthopedic injuries he found were caused by the Accident. His report includes a long and detailed list of facts and assumptions derived from his assessment of Ms. Borgford and his review of pre and post accident medical records.

[193] In opining about the nature of her TBI, Dr. Anton explained that generally speaking the consequences depend on injury related factors that include severity as measured by post-traumatic amnesia, the GCS and imaging findings, and patient related factors such as age, risk factors for prolonged recovery and medical status. He referred to Ms. Borgford's first post Accident GCS score of 13 as consistent with a more severe form of mild TBI. He also

suggested that her report of prolonged amnesia after the Accident and hospital records documenting confusion early on in her admission would suggest at least a moderate TBI, if the amnesia arose only from the effects of the TBI. He commented that medication and delirium secondary to her acute medical condition also could have contributed to her confusion and amnesia. Dr. Anton noted that an initial CT scan of the head, showing evidence of head trauma including soft tissue hematoma over the left vertex and left parietal bone, did not show any intracranial abnormality. However, a negative result does not rule out a clinically significant TBI.

- [194] Dr. Anton also identified the reported results of an MRI scan and an MR angiogram done on March 10, 2018, showing chronic small vessel disease or changes within the small blood vessels, that likely predated the Accident, and two possible concussions in 1990 and childhood, could have pre-disposed Ms. Borgford to prolonged recovery and a poorer outcome from a TBI.
- [195] In addition, he considered a number of post-Accident symptoms reported by Ms. Borgford including dizziness and balance problems, diminished sense of smell and taste, cognitive and speech problems, changes in personality and increased anxiety. Identifying dizziness as common after head trauma but also having many possible causes, Dr. Anton expressed the view that Ms. Borgford's TBI could have contributed to her dizziness and imbalance.
- [196] Dr. Anton similarly identified diminished sense of smell as a possible consequence, although it may also have been caused by the deviation of her nasal septum, a complication of the facial injuries she suffered in the Accident.
- [197] Addressing cognitive problems and changes in her speech with reference to the hospital records, Dr. Anton opined that their acute onset after the Accident makes it probable the Accident contributed. In his report and during his testimony, he expressed uncertainty about the cause of Ms. Borgford's ongoing cognitive symptoms, indicating they may be in part caused by residual effects of the TBI, but other factors are also probably contributing, identifying pain and headaches, anxiety, depressed mood, side effects from medications such as opioids and fatigue from disrupted sleep. In his report, Dr. Anton also noted the score of 26 out of 30 on the Montreal Cognitive Assessment ("MoCA") test she completed during his assessment, significantly better than the score of 20 when she was first tested in hospital, does not rule out the possibility of subtle impairment of cognitive and language function. He emphasized this point during his testimony highlighting the limitations of the MoCA which is a screening test. Dr. Anton clarified the memory part of the MoCA test is a very basic test of short-term memory. Ms. Borgford lost two points on delayed recall, receiving a subscore of three out of five. He also clarified that a score of 26 is borderline or just barely normal. I would note that Dr. Crompton's evidence and records indicates Ms. Borgford scored 24 on December 5, 2019.

- [198] With respect to personality changes and increased anxiety, Dr. Anton noted that TBI can cause changes in mood, emotional regulation and behaviour, but they can also arise from depression or a general medical condition. Describing Ms. Borgford as a poor historian, Dr. Anton identified collateral information from family and friends as helpful in assessing these changes along with those related to her cognitive function. Along with this, he expressed the view that her pain, headaches and fatigue may make it difficult for her to participate in neuropsychological testing and limit the reliability of the results. Agreeing in cross-examination that neurocognitive testing can clarify whether persistent symptoms are the result of a TBI, he maintained his view that it was not a realistic option for Ms. Borgford but collateral information would be helpful in determining the extent to which her current symptoms are more severe than they were before the Accident.
- [199] In cross-examination, he disagreed with the suggestion that 90% of patients with a mild TBI fully recover within one year, specifying 15% of them do not recover completely although the category is so broad it includes some who have such mild symptoms they never seek medical attention.
- [200] Considering Ms. Borgford's post-Accident pain symptoms in light of her pre-Accident history of chronic pain, he opined that her lower back pain is mainly a non-specific activity related mechanical back pain and partly discogenic, meaning pain exacerbated by activities that increase pressure within the intervertebral column, such as prolonged sitting. Dr. Anton diagnosed her mid and upper back pain as myofascial, which can develop after soft tissue injuries.
- [201] With respect to causation, he concluded, at a minimum Ms. Borgford had a prolonged increase in her pre-existing lower back pain after the Accident, although the extent to which her current low back pain is worse than before was unclear. He also expressed the view that although she would have continued to experience fluctuating soft tissue and joint pain absent the Accident, the Accident exacerbated her pre-existing fibromyalgia.
- [202] Noting the migraine features of the daily constant headaches Ms. Borgford reported, Dr. Anton specified a diagnosis of migraine headaches was confirmed by her positive response to the Botox injections, although some of her headaches may be analgesic rebound headaches given her regular use of pain medication. Aware that Ms. Borgford experienced headaches before the Accident including some migraine headaches, in terms of causation, he concluded her post-Accident headaches as more severe than those she had before the Accident.
- [203] Addressing prognosis, Dr. Anton anticipated little improvement in Ms. Borgford's residual TBI symptoms and impairments, given the recognized two-year period of recovery. To the extent that other factors are contributing that can be effectively treated, however, he added it was possible that her cognitive function could improve.

[204] In cross-examination, Dr. Anton was taken through a number of documents in the Disability Records and some more recent pre-Accident clinical records. Many of the records dealt with chronic pain issues but there were also some references to migraine headaches, acute anxiety, sleep issues and in very dated records: alcohol misuse, depression and in one instance decreased concentration and memory, along with other mental health diagnoses up to 2003. Dr. Anton indicated he was generally aware or not surprised by much of the chronic pain related history, including Ms. Borgford's long-term use of opiate medication, chronic fatigue, past depression and past alcohol misuse. Agreeing the records indicated Ms. Borgford experiences issues with disruption of cognitive function, anxiety, depression, chronic fatigue to varying degrees before the Accident, he emphasized again the importance of collateral information provided by those who knew her before and after the Accident to determine if her ongoing symptoms are worse. Also agreeing that opioids can result in dizziness, he clarified the side effect is not true vertigo but instead more of a light headedness. Dr. Anton identified the most common side effect for opioids as constipation. He also identified the side effects as less problematic for long-term opioid users who have adapted physiologically.

[205] Dr. Anton's report included many recommendations. Several were directed at Ms. Borgford herself. For example, he recommended she minimize her use of alcohol and in collaboration with her treating physicians her use of medications that may be adversely affecting her cognition. Similarly, he recommended regular exercise for her general health mood, cognitive function and activity tolerance. In terms of services, Dr. Anton recommended:

¾ Ms. Borgford continue to receive occupational therapy "in the short and medium term", noting she may also require it occasionally in the longer-term during transitions, and she may benefit from case management by an occupational therapist to help her access community resources and medical services in future;

¾ if she finds chiropractic, massage, physiotherapy or acupuncture helpful, up to 12 sessions per year of whatever treatment is most effective to manage pain flare-ups;

¾ she may benefit from equipment and homemaking assistance;

¾ related to this, once her improvements have plateaued, an updated occupational therapy home assessment to quantify her needs; and

¾ she may benefit from counselling by a registered psychologist and should be offered up to 12 sessions and possibly more.

[206] In cross-examination, he maintained that he would not have made some of these recommendations prior to the Accident.

Ms. Nazneen Chow

- [207] I turn now to the assessment component of Ms. Chow's cost of future care report. Ms. Chow's assessment included two meetings with Ms. Borgford in her home. Ms. Chow also consulted with Dr. Crompton, Ms. Baker, Ms. Borgford's previous speech and language pathologist, her acupuncturist, her optometrist, a pharmacist, Mr. Borgford, and her niece. Further Ms. Chow reviewed the reports of Drs. Anton and Spivak, some clinical records and five years of PharmaNet printouts.
- [208] Ms. Chow's opinions rest on assuming that Ms. Borgford's Accident related injuries include most notably a TBI and the orthopedic injuries I have already outlined. Ms. Chow also assumed that Ms. Borgford had a pre-existing history of fibromyalgia, ankylosing spondylitis, a right eye injury, chondritis of the right hip, L1 - S1 back injuries with disc issues and herniations, and she took numerous medications that included Synthroid, Lyrica and Oxycodone. Ms. Chow made other assumptions about Ms. Borgford's pre-Accident history such as prior motor vehicle accidents and her receipt of long-term disability benefits since she stopped working as a nurse in 1993.
- [209] I have already discussed Ms. Chow's observations of Ms. Borgford during their interviews.
- [210] Ms. Chow administered several questionnaires related to Ms. Borgford's emotional functioning, how her anxiety impacts on her functioning, her perceived pain level compared to observations of her function and movement, the impact of headaches on her day to day functioning and ongoing symptoms related to her brain injury. Ms. Chow commented that her scores were consistent with a diagnosis of minor, chronic or major depression - mild; the highest range for extreme anxiety or panic; somewhat strong overall pain at the time, but pain that ranged from moderate to very strong in the 30 days prior, and severe headaches that occur more than once per week. Ms. Borgford also rated many post-concussion symptoms as severe including for example: feelings of dizziness, nausea, noise and light sensitivity, sleep disturbance, fatigue, irritability, easily angered, feeling frustrated or impatient, forgetfulness, poor memory, poor concentration, taking longer to think and restlessness.
- [211] In discussing Ms. Borgford's physical status, Ms. Chow noted that her left knee was scabbed and scarred, reportedly from frequent falls. However, Ms. Borgford demonstrated the ability to safely access all the rooms in her four-bedroom rental rancher. She could also access all the appliances, although she retched every time she bent forward to reach into the fridge or the washer and dryer. Ms. Chow observed that Ms. Borgford is independent with respect to all aspects of her personal care. She is also independent with grocery shopping. In terms of housekeeping, she demonstrated an ability to prepare meals for herself and Mr. Borgford, although she was easily distracted. Consequently, Ms. Chow concluded she requires some oversight when using the stove. Ms. Chow also noted Ms. Borgford's reliance on an app called "chore checklist", which provides her with reminders for a multitude of chores as well as medication etc.

- [212] At the time of the assessment Ms. Borgford was receiving home support for heavier household tasks, such as cleaning the bathrooms, floors and windows and vacuuming.
- [213] Based on her interviews with Ms. Borgford, Mr. Borgford and others along with her review of medical records, Ms. Chow concluded the Accident has significantly disrupted Ms. Borgford's functioning. Her care and cost of care recommendations are discussed below under the damages heading "Cost of Future Care". At this point, I would note that Ms. Chow makes recommendations about a number of items and services and their costs, including medications that either increased or have been taken since the Accident, ongoing occupational therapy, the involvement of a RA or community support worker to assist Ms. Borgford in following through on weekly tasks and activities, counselling sessions, kinesiology services, medical/rehabilitation equipment and expense needs, chiropractic/massage/acupuncture care, and home maintenance.
- [214] Significantly, Ms. Chow was not cross-examined about any of her care or cost of care recommendations.

Dr. J.P. Thompson

- [215] I have already identified Dr. Thompson diagnoses of Ms. Borgford's orthopedic injuries, along with his apparent concurrence with Dr. Anton's broader diagnoses of her acute injuries and his express agreement that she also suffered a left pneumothorax. His original report, his response report and his testimony do not undermine or materially add to Dr. Anton's opinions regarding the effects of her physical injuries on her pre-Accident condition as well as her current versus post-Accident condition, so I will not discuss them in detail.
- [216] Dr. Thompson accepted Ms. Borgford may have experienced some exacerbation of her pre-existing musculoskeletal conditions (fibromyalgia, rheumatoid arthritis and low back pain) from the fractures and soft tissue injuries caused by the Accident, and some "residual stiffness and tightness" from the fractures. He concluded however that her pre-existing conditions were not accelerated or aggravated, based on comparing Ms. Borgford's subjective complaints, pain behaviours and objective findings before the Accident and after the acute phase of recovery as discussed in the clinical records, including those of Dr. Ramsden. Dr. Thompson reached the same conclusion about Ms. Borgford's "objective physical functioning" based again on comparing clinical assessments pre- and post-Accident. In cross-examination, he clarified that he had considered for example range of motion findings. He agreed he was not suggesting her subjective baseline status had been achieved.
- [217] In his original report, Dr. Thompson commented that Ms. Borgford's subjective presentation made quantifying the extent of her recovery difficult because both before and after the Accident it was exaggerated and incongruous. In his response report, he similarly referred to her subjective complaints as greater than expected. During his testimony he

acknowledged this is actually quite common with fibromyalgia (and other conditions). Asked to agree that Ms. Borgford's recovery and current condition are complicated by her brain injury, Dr. Thompson indicated he lacked the expertise to comment.

[218] Dr. Thompson's original report did not include specific recommendations apart from suggesting the focus of Ms. Borgford's treatment should be on chronic pain management, ideally using a biopsychosocial approach. He also wrote that biologic treatment should consist of active rehabilitation to address her physical deficiencies; and psychosocial treatment should address her emotional needs and pain concerns.

[219] His response report addressed the recommendations of Dr. Anton and others. Dr. Thompson commented that passive modalities beyond the acute phase are generally of limited utility and any flare-ups in physical symptoms for Ms. Borgford probably would have been necessary without the Accident. Dr. Thompson also commented that no objective physical barrier to her usual household and recreational activity had been identified, referring presumably to Dr. Anton's recommendation that Ms. Borgford may benefit from equipment and household assistance as determined by an updated occupational home assessment.

[220] I turn now to the opinion evidence of the expert psychiatrists.

Dr. Mitchell Spivak

[221] Dr. Spivak assessed Ms. Borgford on February 15, 2022 and prepared a report dated February 22, 2022. Qualified to provide expert opinion evidence regarding the diagnosis and prognosis of TBI, as well as psychiatric injury, he expressed the opinion that Ms. Borgford's TBI may have been as significant as moderate or potentially even severe. He based his conclusion on the overall changes in her functioning, her ongoing post-concussive symptoms, and "the potential that she likely had", at a minimum, several days of post-Accident amnesia. Ms. Borgford described to him weeks of memory loss and no memory of her time in hospital. Dr. Spivak commented the duration of her amnesia was difficult to evaluate, given the potential impact of intubation and pain medication. In his report, he also indicated that it is largely understood that the more severe a TBI, the more likely it is the injured person will have longer-term symptoms.

[222] During cross-examination, Dr. Spivak clarified that Ms. Borgford's TBI should be categorized as moderate, noting that a TBI involving post-Accident amnesia from one to seven days falls into that category. He identified Ms. Borgford's absence of memory for a week as a significant finding and specified that patchy memory as opposed to no memory might occur with lots of medication that cloud memory. Although he acknowledged that 90 to 95% of patients with mild TBI fully recover within six months, Dr. Spivak made the point that categorizing a TBI is most useful for prognosticating although the exercise is also quite academic because there can be "really good" and "really bad" outcomes with both mild and moderate TBI. Here a few years after the Accident, he indicated, we can see the outcome.

- [223] In preparing his report, Dr. Spivak reviewed redacted clinical records from the Amari Clinic from 1994 onward and MSP and Pharmanet records for several years prior to the Accident, as well as much more comprehensive post-Accident records. Aware of her pre-existing and long-term history of pain, Dr. Spivak did not receive records of any prior psychiatric evaluations. Ms. Borgford told him she saw a psychiatrist many years ago related to past trauma, which they did not discuss, but otherwise she denied past treatment by mental health professionals. He highlighted that he did not explore her past personal history in detail, based on her concerns about privacy.
- [224] Much of his description of his interview with Ms. Borgford mirrors how she presented during her testimony. She stuttered intermittently, although her stuttering seemed to dissipate when she was distracted. Throughout the interview, she was agitated and gesticulated wildly. Her behaviour and manner were also disinhibited. For example, she referred to her breasts at least three times, actually picking them up and describing the burden they were causing. Twice during the interview, she left the room with little acknowledgment. Ms. Borgford also struggled with staying on topic and would frequently go off on tangents. Her affect was labile. She frequently burst into tears, which she sometimes struggled to recover from. At other times they seemed more superficial. Sometimes Ms. Borgford said her lack of memory prevented her from answering questions, particularly in relation to details from the last few years. Her memory of events from the more remote past was better.
- [225] Dr. Spivak emphasized it was difficult to be certain about which, or to what extent, Ms. Borgford's symptoms are due to psychological factors as opposed to secondary to a TBI, although he identified her intermittent stuttering as psychosomatic and her persistent disinhibition as more consistent with TBI. In considering the influence of psychological factors, Dr. Spivak identified the most appropriate diagnosis as an unspecified somatic symptom and related disorder, given Ms. Borgford has somatoform-like symptoms that do not fit any particular diagnostic heading. Dr. Spivak also identified Ms. Borgford as displaying symptoms of post-traumatic stress disorder ("PTSD"), although she did not meet the criteria for a diagnosis of PTSD. Noting Ms. Borgford's report of a significant change in personality, Dr. Spivak opined that if the change was confirmed by collateral information, personality change due to another condition would be the appropriate diagnosis.
- [226] Questioned about not administering the PHQ-9 or the GAD-7 standardized questionnaires during his assessment, Dr. Spivak said he did not use them because he views them as having no value in this context. In addition to having no internal validity markers, he explained they provide a rating score related to DSM criteria that is relevant to measuring improvement or deterioration but not helpful when diagnosing one condition as opposed to another. In other words, they have much more purpose when treating a patient over time.

- [227] Addressing causation, Dr. Spivak opined that absent the Accident, there were no other factors that could account for Ms. Borgford's full complement of psychological and cognitive symptoms, which followed logically and temporally from the Accident.
- [228] During cross-examination, Dr. Spivak was taken through a multitude of Disability Records mostly from the 1990s and a few in the early 2000s, including some that referred most significantly to diagnoses of depression, alcohol abuse, psychosis, schizophrenia, some psychiatric symptoms and chronic pain/pain conditions. Acknowledging the records demonstrated Ms. Borgford had a psychological history, Dr. Spivak agreed she would have met the criteria for a diagnosis of a somatoform disorder "of some type" before the Accident. He would not agree that his opinion about causation was therefore inaccurate. Dr. Spivak stated a significant part of his opinion still held although the issue of causation was more complicated and nuanced. Characterizing the records as showing vulnerability and risk of reoccurrence, he noted that for whatever reason, Ms. Borgford's psychological issues dissipated and she no longer had a psychiatrist involved in her care for many years prior to the Accident. In re-examination, Dr. Spivak was taken to Disability Records from 2005 onward which showed her ongoing disability claims were not based on a psychiatric diagnosis. He testified that when a person's history is relevant, immediately prior to an accident is generally speaking the most important timeframe.
- [229] In discussing issues of disability, prognosis and recommendations, Dr. Spivak characterized Ms. Borgford's psychological and cognitive symptoms as severe based on his understanding that all aspects of her life have been affected, which he catalogued. He also identified her prognosis as guarded to poor, given how long it's been since the Accident and her minimal improvement despite occupational therapy, physical treatments and attempts to manage her symptoms with medication. He did not recommend psychotherapy and made no specific recommendations about medications. Aware she was already receiving antidepressants which have calmed her to some degree, Dr. Spivak opined that adjusting them may potentially provide some relief, but medications would not significantly improve the level of disorganization and distress that she demonstrated during the interview. He seemed to suggest that further occupational therapy would provide more benefit. At best, he predicted, was the possibility of some improvement in her ability to maintain herself day to day and more stability in her relationships and her executive task completion.

Dr. Derryck Smith

- [230] Dr. Smith prepared three reports dated February 15, 2022, March 27, 2022 and May 30, 2022, the day before the trial started. He interviewed Ms. Borgford once on February 2, 2022. As I have indicated his second report is critical of Dr. Spivak's report, but it also considered the reports of Dr. Anton, Dr. Thompson and Ms. Chow as well as Dr. Elliot. In his third report, Dr. Smith reviewed and addressed the impact of the Disability Records on his previous opinions.

- [231] In his first report, Dr. Smith discussed his interview with Ms. Borgford at some length yet said very little about her presentation, other than she appeared to have a hard time focusing, was frequently in distress and tearful, and had trouble with word finding and mispronounced words. Expressing the view a complicated psychiatric history was likely, Dr. Smith noted that she refused to discuss "these" issues with him.
- [232] Ms. Borgford completed a number of screening tests during Dr. Smith's assessment, including the Somatic Symptom Scale-8, the PTSD checklist (PCL-5), the GAD-7 and the PHQ-9, which showed severe symptoms of anxiety and significant problems initiating and maintaining sleep. He concluded Ms. Borgford did not qualify for a diagnosis of PTSD, based on the "A criteria", explaining that people with no memory of the trauma usually do not develop PTSD. He also stated that her high scores for certain PTSD symptoms could be accounted for by a brain injury.
- [233] Identifying her "pre-existing" diagnoses as including fibromyalgia, rheumatoid arthritis, possible ankylosing spondylitis, hypothyroidism, Graves' disease, chronic low back pain, asthma and "possible psychiatric disturbance, possible bipolar disorder", Dr. Smith opined that before the Accident, Ms. Borgford probably would have qualified for a diagnosis of somatic symptom disorder ("SSD") with predominant pain. He opined that her current psychiatric diagnoses include: insomnia disorder; SSD with predominant pain; generalized anxiety disorder; major depressive disorder; mild TBI; and possible mild neurocognitive disorder.
- [234] Dr. Smith's many recommendations included referring Ms. Borgford to a psychiatrist for management of her current diagnosis. He also recommended a gradual increase in the dose of Effexor XR, one of the medications she was taking at that time to treat anxiety as well as depression, explaining the current dosage as ineffective for managing her anxiety. In addition, he recommended a sedating antidepressant to help with sleep, opining that she will not improve until her sleep normalized. Unlike Dr. Spivak he suggested Ms. Borgford may benefit from cognitive behavioural therapy.
- [235] Regarding causation, Dr. Smith wrote it was probable Ms. Borgford was at significantly increased risk for psychiatric illness over her lifetime given her "likely exposure to physical and/or sexual abuse as a child" and some type of psychiatric crisis about 10 years prior to the Accident. In order to determine whether the diagnoses of generalized anxiety disorder and major depressive disorder are attributable to the Accident, Dr. Smith said he would need to review a full set of Ms. Borgford's psychiatric records going back to this crisis. He also identified the Accident as causing a mild TBI and possible mild neurocognitive disorder, which would require neurocognitive testing to determine.
- [236] In his second report, Dr. Smith strongly disagreed with what he referred to as Dr. Spivak's diagnosis of a moderate to severe TBI based on several days of post-Accident amnesia, reiterating his view that Ms. Borgford's TBI was mild. Much of the report discussed TBI generally including the criteria for mild, moderate and severe TBI. Commenting that those

with mild TBI appear to be at much less risk of cognitive impairment and psychiatric illness, Dr. Smith acknowledged that the outcome from brain injury is highly variable and some persons with mild TBI can be severely impaired. He emphasized that the accuracy of the diagnosis of TBI and post-TBI symptoms depends on the reliability of the evidence, and contemporaneous objective data is necessary, also stating that retrospectively constructing the length of post-traumatic amnesia at the time of the Accident is not based in science. Ms. Borgford reported to him that she had no memory after turning right to take a shortcut home until she "woke up" in RCH. Because there was no attempt to establish the length of her post-Accident amnesia "at the time of the accident", and she was intubated and on pain medication, he opined, the period of time she reports cannot be attributed to her brain injury.

[237] Dr. Smith was also critical of Dr. Spivak's psychiatric diagnosis because he did not quantify Ms. Borgford's psychiatric symptoms using standardized screening tests, although Dr. Smith also diagnosed her with a form of SSD. Noting the "normal" MoCA score of 26 reported by Dr. Anton, Dr. Smith reiterated that neuropsychological testing was needed to quantify any cognitive impairment. He also stated he could not provide an adequate opinion on causation absent a review of a full set of her past medical records, broadening the scope from his first report.

[238] In his third report, Dr. Smith referred to Ms. Borgford's "rich" history of psychiatric illness based on a review of the Disability Records. Referring to the diagnoses of paranoid psychosis, alcohol abuse, paranoid schizophrenia, and depression as a basis for her disability benefits, along with a hospitalization and treatment by two psychiatrists up to 1998, depression as a main reason for her disability benefits in 1999, and a reference to possible bipolar disorder in 2000, Dr. Smith also noted very few references to psychiatric diagnoses from 2003 onward. Despite this, he added schizophrenia as well as major depressive disorder and SSD with predominant pain, insomnia disorder and possible bipolar disorder, to the list of pre-existing diagnoses set out in his first report. He also wrote that it was unclear to him why Ms. Borgford did not have significant psychotic symptoms of either schizophrenia or bipolar disorder at the time of his assessment, because they are considered chronic life long diagnoses. In cross-examination, however, he acknowledged that he did not believe she had schizophrenia. At the same time, he continued to identify schizophrenia, as part of the "rich history of her pre-existing diagnoses" that he had to consider in assessing how she was functioning before the Accident, along with a psychiatric crisis from about ten years ago, which he clarified was in fact Ms. Borgford's hospitalization in 1996. Dr. Smith resisted the suggestion that her history in the decade before the Accident was much more important in determining the baseline of her function.

[239] Dr. Smith was cross-examined at length about a range of other issues related to Ms. Borgford's TBI and ongoing symptoms. He maintained that post-Accident amnesia must be assessed objectively and contemporaneously, meaning while in hospital in this case and

many, but he agreed that many of the symptoms Ms. Borgford described can be or are associated with TBI, and are frequently assessed clinically. He also agreed that collateral information could be helpful in understanding how she functioned before and after the Accident and the assessment of her TBI, but focused repeatedly on the importance of neuropsychological testing.

- [240] Ms. Borgford's counsel argues Dr. Smith's reports are replete with advocacy and therefore should be treated with caution. Certainly, I was troubled by the arc of his opinion evidence. To be clear I found central aspects of it unreasonable, including his approach to Ms. Borgford's psychiatric history and the Disability Records and his apparent reluctance to consider the cause of her current symptoms, beyond proposing neurocognitive testing. On this last point, I would highlight the discrepancy between Dr. Smith's discussion of Ms. Borgford's mental status examined and the entirely consistent and detailed observations of Dr. Spivak, Ms. Chow and treating professionals including most significantly Ms. Baker, all of which align with how she presented during her testimony. In my view, it is unlikely Ms. Borgford presented any differently when she was interviewed by Dr. Smith. I was also concerned that his insistence on contemporaneous objective questioning to evaluate post-trauma amnesia operates as a means of minimizing the seriousness of this symptom, although this is tied to the explanatory weakness of the criteria for the categories of TBI.

Other Expert Evidence

- [241] Dr. Elliot's report dated March 4, 2022 provides opinions regarding Ms. Borgford's life expectancy. A specialist in internal medicine and endocrinology, Dr. Elliot's qualifications relating to life expectancy derive from certification in mortality, statistics and actuarial methods and his related work experience.
- [242] Identifying the average life expectancy for a BC woman of Ms. Borgford's age (57.4 years) as 29.7 years (age 87.1 years), Dr. Elliot concluded her life expectancy is 18.8 years (age 76.2 years) or 10.9 years less, based on his assumptions about negative factors or life risks and his estimation of their influence on her mortality.
- [243] In terms of methodology, his report explained that he starts with a standardized mortality or relative risk ratio ("SMR") of 1.0, which is the ratio of the individual mortality rate to that of the general population at the same age ("GP"). The SMR for a specific person results from adding excess mortality ratios ("EMR") to the SMR of 1.0 for the "extra mortality" that apply to specific life risks.
- [244] Dr. Elliot identified Ms. Borgford's life risks based on his assumptions that she has depression, anxiety, wide spread chronic pain complaints and an active polysubstance use disorder involving alcohol, cocaine and cigarettes, although she reported that she quit smoking more than a year ago, moderate alcohol use and no cocaine use. Dr. Elliot described Ms. Borgford's use of alcohol as worrisome given her "pre-Accident reported alcohol challenges", and testified that alcoholics cannot drink. He also stated her report of

abstinence from cocaine was of limited value, without regular urine tests, expressing the view that cocaine is highly addictive. Similarly, during his testimony he expressed skepticism about recreational cocaine use. Dr. Elliot indicated his understanding of substance misuse is based on his role as a board member for a large recovery house.

[245] Although Ms. Borgford acknowledged during her testimony that she has been drinking more than moderately, there is no opinion evidence from a qualified expert diagnosing her with a substance use disorder, let alone a polysubstance disorder, or addressing the addictiveness of cocaine. Nor is there any fact evidence that she ever used cocaine more than rarely.

[246] Dr. Elliot's assumptions about Ms. Borgford's psychiatric history and his discussion of her "current psychiatric" status show a similar approach. In his report, he refers to her medical history as notable for "longstanding undetermined psychiatric disease". After setting out the mortality risks associated with depression, he commented that her case appeared "particularly severe, raising concern about her "long-term prognosis". During cross-examination, he said he was confident Ms. Borgford had a long psychiatric history in part because she refused to discuss her history with a psychiatrist referring to Dr. Smith's report.

[247] Dr. Elliot's report discusses a meta-analysis based on 16 studies with respect to cocaine abuse that showed an average EMR of 5.13. Estimating Ms. Borgford's overall SMR at 4, his report indicated that "but for" an EMR of 1.0 related to chronic pain and mood disorder, he would have considered an EMR of 3.0 appropriate for her "history" of polysubstance use. To avoid double counting however, he reduced his estimate. An SMR of 4 would mean that Ms. Borgford is four times as likely to die in any one year than a BC woman of her same age, and at greater risk than a heavy smoker who suffered a recent heart attack.

[248] Critical of Dr. Elliot's assessment and estimation of Ms. Borgford's, life risks and noting the case law requires the courts to be "optimistic and not pessimistic" about life expectancy, Ms. Borgford suggests her life expectancy should be estimated applying an EMR of 1.0, which equates to an SMR of 2.0 and using a median figure of 25 years. This represents a doubling of the risk that Ms. Borgford will die in any one year than the average BC woman of the same age. Based on my own concerns about Dr. Elliot's evidence, and in the absence of any submissions from Ms. Ball, I agree.

Credibility and Reliability

[249] Ms. Ball challenges the reliability of Ms. Borgford's evidence, and as I understand it, to a lesser extent her credibility, as well as Mr. Borgford's credibility. She seems to assert both of them minimized the seriousness of Ms. Borgford's pre-Accident condition and exaggerated her functioning. Ms. Ball also suggests there was a marked difference in how Mr. Borgford testified during direct and cross-examination that should be carefully considered. Finally, she argues the assessment of Ms. Borgford's evidence should be

impacted by the fact that she did not testify first.

[250] Credibility or truthfulness and reliability or accuracy are related but distinct concepts. A truthful witness, for example, can be honestly mistaken about what they recall and observed. Further, credibility and reliability are not all-or-nothing concepts. A trial judge may believe some, all, or none of a witness's evidence and attach different weights to different parts of their evidence, based on an assessment in light of the evidence as a whole: *R. v. R. (D.)*, [1996] 2 S.C.R. 291 at para. 93.

[251] *Bradshaw v. Stenner*, 2010 BCSC 1398, discussed the proper approach to assessing the reliability and credibility of a witness and also identified a number of factors that play a role in the assessment. Those factors include:

- the witness's ability to remember;
- the ability of the witness to resist being influenced by their interest in recalling those events;
- inconsistency in the witness's evidence, meaning did their testimony change between direct and cross-examination (internal inconsistency), or inconsistencies between prior statements, discovery evidence and their evidence at trial (external inconsistency);
- whether the witness's evidence harmonizes with or is contradicted by other evidence, particularly independent or undisputed evidence;
- whether their evidence seems unreasonable, improbable or unlikely, bearing in mind the probabilities affecting the case; and
- the witness's demeanour, meaning the way they presented while testifying.

[252] Regarding the last factor, *Faryna v. Chorny*, [1952] 2 D.L.R. 354 (B.C.C.A.) and other authorities have discussed the dangers of relying too heavily on demeanour to determine credibility, recognizing there is a risk of misinterpreting the testimony of the better actor as truthful, and conversely, the poor presentation of an honest witness as deceptive: see *R. v. Jeng*, 2004 BCCA 464 at para. 54 and *R. v. Tyers*, 2015 BCCA 507 at para. 18.

[253] I begin with what is plain. Ms. Borgford displayed a poor memory of what has occurred since the Accident and very poor short-term memory, both of which significantly undermine the reliability of her post-Accident evidence. At the same time, in cross-examination, she and several other witnesses were also asked to recall a multitude of circumstances related to her pre-Accident medical history and condition up to thirty years ago. This would be an impossible task for all but the most exceptional witness. In my view, Ms. Borgford's memory for circumstances prior to the Accident was reasonably good.

[254] Further there were no material inconsistencies, either internal or external, in her evidence or Mr. Borgford's. Ms. Borgford also readily acknowledged some circumstances that were not in her interest. I might have had some concern that she and Mr. Borgford were influenced by her interest when testifying about her condition and functioning,

particularly before the Accident. Certainly aspects of Mr. Borgford's evidence, or lack of evidence, but more so his demeanour seemed to reflect a desire to protect Ms. Borgford. For example, although Ms. Borgford offered that she has been drinking more than she should, Mr. Borgford did not provide this evidence although he gave detailed evidence about a number of negative changes in Ms. Borgford since the Accident.

- [255] Any meaningful concern was dispelled however, by the remarkably consistent and corroborative evidence of Ms. Murphy, Ms. Chevalier-Cook, Mr. Beaulieu, Ms. Baker, Dr. Crompton whose testimony I have not summarized, Dr. Ramsden to a more limited extent, along with the observations of Dr. Spivak and Ms. Chow. Significantly, I had no concerns about the credibility of any of these witnesses. Among Ms. Borgford's friends and family members, I was particularly impressed by Ms. Murphy who displayed a better memory and gave careful, factual and more detailed evidence than the other two.
- [256] The consistency and depth of the evidence regarding the cognitive, behavioural and emotional changes in Ms. Borgford was frankly striking. The evidence is further supported, as I have indicated, by how Ms. Borgford testified. Although she presented as alert and intelligent and her nursing knowledge was apparent, she really struggled to remember and to focus and concentrate on what she was being asked. In addition, she was easily and often distressed, agitated, and disinhibited, her gestures were exaggerated and displayed the speech difficulties both she and her witnesses described. Quite restless she also regularly changed her position from sitting to standing. I did not observe however the exaggerated pain behaviour that Dr. Thompson identified.

Causation Findings

- [257] As I have indicated Ms. Ball does not dispute that Ms. Borgford sustained significant and complex orthopedic injuries and a TBI in the Accident. There is a dispute about Ms. Borgford's pre-Accident condition, the nature and severity of her ongoing symptoms, and the extent to which her current symptoms and condition differ from her pre-Accident condition.
- [258] In light of my assessment of the evidence, I accept the account of Ms. Borgford's pre-Accident condition and functioning that she and Mr. Borgford provided, as corroborated by other witnesses and Ms. Borgford's presentation during her testimony.
- [259] Consequently, I find that before the Accident Ms. Borgford was as she, Mr. Borgford, Ms. Murphy and others described. Outgoing, warm, fun-loving, meticulous, articulate and smart, Ms. Borgford also had a very good if not excellent memory. Someone who loved spending time with people, she had an active social life, many close relationships and was a committed and insightful friend and sibling. Her relationship with Mr. Borgford was an especially happy and fulfilling one.

- [260] Ms. Borgford suffered from quite severe complex chronic pain due to fibromyalgia, rheumatoid arthritis or pain symptoms consistent with rheumatoid arthritis and low back pain for many years before the Accident. She also experienced neck pain and ongoing sleep issues. In addition to widespread complex pain, Ms. Borgford experienced a range of other relevant symptoms at times including bowel issues related to IBS, some dizziness and headaches that at times were migraines or had migraine features, and fatigue.
- [261] It was chronic pain, however, that prevented Ms. Borgford from working and formed the primary basis for her permanent disability benefits for more than a decade before the Accident.
- [262] Despite her chronic pain condition, Ms. Borgford lived quite a normal life. She travelled regularly. While vacationing she was able to participate in some physical activities, such as swimming and lots of walking. She also enjoyed motorcycle rides, camping trips and a range of other activities with Mr. Borgford. At home, she was able to manage all of the housekeeping to a high standard, some gardening, grocery shopping and meal preparation, along with some less physical renovation tasks. Her life style was a busy one. She entertained friends and family, quite often making large and elaborate meals.
- [263] Ms. Borgford was also able to fulfill the administrative and communication responsibilities required of a president of a fairly large strata before she and Mr. Borgford began living together. Although the hours were limited, Ms. Borgford went on to assist Mr. Borgford with his business.
- [264] In light of Ms. Borgford's chronic pain condition and Mr. Borgford's evidence that Ms. Borgford never complained of pain or cried in front of him, along with other evidence about her need to pace herself while doing housework, change her position, stretch, take breaks and lie down for long periods sometimes due to intense pain, I infer that she was stoic before the Accident.
- [265] I also accept that after Ms. Borgford's long-term family doctor retired and other physicians began changing her prescriptions for opioid pain medication, however, her pain symptoms were less well managed and her experience of her pain intensified.
- [266] There is no question that Ms. Borgford's chronic pain would have continued absent the Accident, along with other relevant symptoms such as poor sleep, fatigue, and some headaches including some migraine headaches.
- [267] Given her long-term opioid use and the weight of the expert opinion evidence about potential side effects and her dosages, along with the fact evidence, I do not accept Ms. Borgford's cognition was materially affected prior to the Accident.

- [268] In terms of her mental health, the evidence does not support a finding that her original position was impacted by a mental health condition. Although she experienced a serious mental health crisis in or about 1996 and serious depression both then and at other times, there is no evidence that Ms. Borgford suffered from any significant mental health issues or symptoms for more than 10 years before the Accident. I accept her pre-Accident prescriptions for Ativan were primarily related to sleep issues.
- [269] Turning now to the injuries caused by the Accident, I refer and accept Dr. Anton's diagnoses of Ms. Borgford's physical injuries and their trajectory. Dr. Anton impressed me as particularly and refreshingly objective, careful, and thoughtful medical specialist. His report was both comprehensive and well explained. In contrast, I found Dr. Thompson's opinion evidence constrained and minimizing. For example, although he emphasized his diagnoses were limited to Ms. Borgford's musculoskeletal injuries, he did not diagnose Ms. Borgford's acute injuries as including the soft tissue injuries associated with her orthopedic injuries, the soft tissue and nerve injury associated with her left sided facial injury, trauma to the left TMJ and the most serious aspects of her chest injury, that Dr. Anton identified.
- [270] During the acute phase of her recovery, Ms. Borgford's physical symptoms included overwhelming pain but also dizziness, nausea, retching, balance issues and daily severe headaches, that initially limited her mobility and prevented her from performing any aspects of her own care.
- [271] Addressing her TBI, Ms. Borgford was rendered unconscious for at least 20 minutes after the Accident. I accept Ms. Borgford's consistent evidence that she has no memory from some moments prior to the Accident until after she was in RCH, three or more days later. Her evidence is consistent with the ambulance and hospital records documenting her confusion and disorientation.
- [272] Since the Accident, Ms. Borgford has experienced significant and/or severe ongoing cognitive, emotional and behavioural symptoms and speech difficulties that were not part of her original position. In summary, they include poor concentration and attention, very poor short-term memory, irritability, emotional volatility, impulsivity and disinhibition. I find all of these symptoms were caused by the Accident, along with her speech difficulties which include significant stuttering and difficulties with word finding.
- [273] The Accident also caused psychiatric injuries that manifest as significant, if not severe, anxiety and symptoms of depression although Ms. Borgford denies feeling depressed, as well as post-traumatic stress symptoms.
- [274] Turning now to whether Ms. Borgford's cognitive, emotional and behavioural changes are the result of her brain injury and or depression, anxiety and disrupted sleep, based on the fact and opinion evidence of Dr. Spivak and Dr. Anton regarding symptoms that are probably or more likely attributable to a TBI, I am satisfied that Ms. Borgford's profound change in personality, deficits in her executive function and impaired short-term memory since the Accident are at least partly if not mostly attributable to her TBI. I say this also

because she never experienced this constellation of deficits and impairments before the Accident even though poor sleep and fatigue plagued her for many years before the Accident, and they have remained consistent since the Accident.

- [275] Ms. Borgford submits and I agree that the dispute about how to categorize her TBI, is largely a "red herring" given the consensus that ongoing and severe symptoms can result from a mild TBI.
- [276] To the extent the moderate as opposed to mild TBI category requires more than 24 hours of amnesia (but less than seven days) unrelated to pain medication or delirium, the distinction becomes rather meaningless for all of those who require immediate and ongoing pain medication after a TBI. Based on the criterion and the evidence that Ms. Borgford received pain medication almost immediately after emergency responders arrive at the scene of the Accident and throughout her hospitalization, however, it would appear her TBI is appropriately categorized as the severe form of mild TBI identified by Dr. Anton, despite her various ongoing significant or severe cognitive, emotional and behavioural symptoms.
- [277] Accepting Dr. Anton's evidence regarding Ms. Borgford's ongoing migraine headaches, her evidence that they are daily and intense but mitigated by Botox injections for two out of every three months, I find that Ms. Borgford's post-Accident headaches are much more frequent and more severe than her pre-Accident headaches.
- [278] Regarding her ongoing pain symptoms, again accepting Dr. Anton's evidence, I find the Accident at least exacerbated her fibromyalgia and increased her lower back pain. It also caused mid and upper back pain.
- [279] It is difficult to determine the extent to which Ms. Borgford's current pain symptoms are worse than before the Accident. Accepting that Ms. Borgford perceives them as worse or more amplified, I put some but limited weight on this evidence because I am concerned it may be affected by her more severe, daily post-Accident headaches. I am also reluctant to draw an inference that Ms. Borgford's pain has worsened based on Mr. Borgford's evidence that her expressions of pain have greatly increased although I accept that is true, because Ms. Borgford has lost the stoicism she had before the Accident. At the same time however, for reasons I will come to, I am satisfied that Ms. Borgford's ongoing pain symptoms as opposed to her headaches, are being treated with a somewhat higher dose of Oxycodone. Considered together with her evidence her pain symptoms remain worse than they were before the Accident, I accept Ms. Borgford continues to experience some although not a substantial increase in her chronic pain symptoms.
- [280] I also find that her IBS symptoms since the Accident have been at least occasionally disabling. For example, at times they have prevented her from leaving the home to do a variety of activities.

- [281] Ms. Ball argues that any dizziness Ms. Borgford has experienced since the flight to Mexico can not be attributed to the Accident, characterizing the flight(s) and or the ruptured eardrum Ms. Borgford described as intervening events, which also raises the spectre of a divisible injury. As I indicated, Ms. Ball took this position for the first time in closing submissions without discussing the applicable legal principles, resulting in an unfairness to Ms. Borgford.
- [282] The evidence of Ms. Borgford and Mr. Borgford indicates that her symptoms of dizziness and vertigo resolved in late 2017 or early 2017 following vestibular therapy, but returned during a flight to Mexico in February 2018. Since then Mr. Borgford testified Ms. Borgford has experienced bouts of dizziness for varying lengths of time. Ms. Baker and others testified to their observations consistent with symptoms of dizziness and loss of balance such as Ms. Borgford using a cane, not driving and grabbing a hold of things to steady herself.
- [283] More recent case law is not explicit about whether the defendant or the plaintiff bears the burden of proving that an intervening act has resulted in a divisible injury. However, *Hussack v. School District No. 33 (Chilliwack)*, 2009 BCSC 852, var'd on other grounds in 2011 BCCA 258 includes:
- [189] The defendant has not succeeded in demonstrating that Hussack Sr.'s actions amount to a new intervening act. Hussack Sr.'s over-bearing, over-protective tendencies were well-known to the defendant prior to the field hockey incident. Moreover, as held in *Nader and Malcolm*, it is not "beyond the range of reasonable anticipation" to foresee that a parent would react strongly to their child suffering an injury. That this reaction was extreme in this case was foreseeable, and it does not break the chain of causation.
- [Emphasis added.]
- [284] There is some older case law that explicitly states the defendant has the burden of proving an intervening event has broken the chain of causation: see *Madonia v. Stevens*, 2008 CanLII 70461 (O.N.S.C.) at para. 85; *Lee v. O'Farrell* (1988), 30 B.C.L.R. (2d) 130 (B.C.S.C.); and *Liu v. Hansen*, [1996] B.C.J. No. 591 (B.C.S.C.).
- [285] The two-part test for causation was summarized most recently in *Borgford*, the test is as follows: (1) the plaintiff must establish the damage was caused in fact by the conduct of the defendant (*Hussack* at para. 54); and (2) the plaintiff must establish causation in law. This has been described as proving the defendant was a proximate cause of the loss, the damage was not too remote from the factual cause, or the damage suffered was reasonably foreseeable (*Hussack* at para. 54).

- [286] The intervening event analysis (or the "novus actus interveniens" analysis) forms part of the proximate cause analysis: *Maingot v. Wankowicz*, 2021 BCSC 1596 at para. 59. The question of whether a subsequent act breaks the chain of causation is a question of fact, and may depend on whether the plaintiff acted unreasonably: see *Safdari v. Buckland*, 2020 BCSC 769 at para. 136; *Woloschuk v. Neuman*, 2021 BCSC 940 at para 87.
- [287] The treatment of intervening events was recently summarized in *Ho v. Eccles*, 2021 BCSC 244:
- [101] I must consider whether the intervening events were sufficient to break the chain of causation, often referred to as the principle of novus actus interveniens. In the words of T.W.N.A. at para. 36, I must determine whether the subsequent events "would have affected the plaintiff's original position adversely in any event."
- [288] Although the evidence indicates that Ms. Borgford experienced both intense pain in her head and a re-emergence of severe dizziness during and after the first flight to Mexico in February 2018, similar symptoms during a second flight in 2020 and she identified her eardrum "bursting" on one of the flights, there is no medical evidence suggesting either flight was the cause. Having "cleared" the first trip in advance with Dr. Crompton, taking the trip was certainly reasonable. Furthermore, since the first trip, which occurred approximately two months after her initial dizziness resolved, Ms. Borgford has continued to experience bouts of dizziness that come and go without warning. Accordingly, I accept that Ms. Borgford's increased dizziness and problems with balance since the Accident are attributable to the Accident, excepting the balance difficulties that she has experienced since she seriously injured her eye in April 2022.
- [289] I also find that related to both dizziness and her daily headaches, Ms. Borgford experiences frequent nausea. Coupled with certain postures, as identified by Ms. Chow, this results in frequent retching.
- [290] Given the duration of her ongoing Accident related symptoms, all of the treatment she has received, and based on the opinions of Dr. Anton and Dr. Spivak, I accept Ms. Borgford's prognosis is guarded to poor.
- [291] Turning to Ms. Borgford's functioning, I find that her Accident-related injuries and ongoing symptoms have impacted her functioning quite significantly, although she returned to grocery shopping, what I infer is simple meal preparation and some housekeeping, as well as driving locally for short distances (before her eye injury). Her very poor short-term memory, poor concentration and focus, other cognitive, emotional and behavioural symptoms, severe headaches, somewhat increased pain, nausea and retching, and bouts of dizziness all play a role in undermining her capacity to function as she did before the Accident.

[292] I will have more to say about Ms. Borgford's related care needs in discussing her claim for cost of future care. At this stage, I find that she requires ongoing support and services to manage her daily activities and ongoing symptoms.

Non-pecuniary Damages

[293] Ms. Borgford seeks an award of \$275,000 in non-pecuniary damages. Ms. Ball suggests the amount of \$210,000 is appropriate.

[294] Non-pecuniary damages are awarded to compensate a plaintiff for the pain and suffering, loss of enjoyment of life and loss of amenities caused by a defendant's negligent conduct.

[295] The amount of the award is not determined by the nature or seriousness of the plaintiff's injuries alone. A non-exhaustive list of additional factors includes the plaintiff's age; the severity and duration of the pain; disability; emotional suffering; impairment of family, marital and social relationships; impairment of physical and mental abilities; loss of lifestyle; and the plaintiff's stoicism: *Stapley v. Hejslet*, 2006 BCCA 34 at para. 46. An appreciation of the plaintiff's loss is the key: *Lindal v. Lindal*, [1981] 2 S.C.R. 629 at 637.

[296] Compensation for non-pecuniary losses must also be fair and reasonable to both parties. Fairness is measured against awards made in comparable cases, recognizing they offer rough guidance only because no two cases will ever be identical. In other words each plaintiff's circumstances have unique aspects: see *Trites v. Penner*, 2010 BCSC 882 at para. 189.

[297] Addressing the *Stapley* factors, Ms. Borgford suffered serious, complex and very painful acute injuries including many orthopedic injuries, soft tissue injuries and a brain injury in the Accident. Her pre-existing pain condition was aggravated for a significant period of time, although it is difficult to determine the extent to which her ongoing pain symptoms are significantly worse than before. She has also been left with severe daily headaches that are reduced but far from resolved by Botox injections, and much worse than before the Accident. Her post-Accident headaches are also accompanied by nausea that causes her to retch. Bouts of dizziness, very unpleasant in themselves also cause retching. Most impactful are the constellation of significant and/or severe ongoing cognitive, emotional and behavioural symptoms, coupled with ongoing speech difficulties and psychiatric injuries or symptoms namely anxiety and symptoms of depression.

[298] Simply put Ms. Borgford's pain and suffering and her loss of enjoyment of life have been and will continue to be quite profound. She is very far from the positive, independent, outgoing, busy, very competent and fully engaged person that she was before the Accident. Volatile, disinhibited, without a filter to guide what she says and plagued by a very poor memory and no longer cognitively and emotionally capable of insight and reciprocity, her once large and vibrant social circle is now very small. Aware and embarrassed by her condition she has become quite reclusive. Previously a dynamic and highly supportive spouse, Ms. Borgford is now extremely dependent on Mr. Borgford, which in turn causes

her great distress. She is also no longer able to participate in the various activities and travel they enjoyed together. Her other close relationships have been similarly impacted. Ms. Murphy and Ms. Chevalier-Cook, much like Mr. Borgford fulfill caregiving roles.

[299] Ms. Borgford relies on a number of cases in support on her position:

- a. *Gilbert v. Bottle*, 2011 BCSC 1389: The 30-year-old plaintiff sustained numerous injuries including a complicated mild TBI which resulted in significant and permanent symptoms, fractured clavicle, head laceration and soft tissue injuries. Indigenous, the plaintiff's parents were Indian residential school survivors. Prior to the accident the plaintiff struggled with substance abuse, anxiety, depression and several physical health challenges. At the same time, she had strong social and cultural connections and worked part-time for a personal healing, growth and development program for First Nations persons. The trial judge found her mental, emotional and physical condition and all aspects of her functioning had changed significantly since the accident. Her substance abuse worsened as a result of her brain injury symptoms and she lost the capacity to abstain, a choice the trial judge was satisfied she would have made in time. Forgetfulness, irritability and increased emotional disturbance meant she could no longer work or enjoy her personal relationships. Headaches and pain interfered with her ability to cook and clean. Non-pecuniary damages of \$200,000 (\$250,000 currently) were awarded.
- b. *Harrington v. Sangha*, 2011 BCSC 1035: The 45-year-old plaintiff sustained a TBI that resulted in cognitive deficits and poor memory and concentration that significantly impacted her behaviour. She was also affected by chronic pain and headaches. Pain medication further impacted her intellectual functioning and emotional state. A brachial plexus injury permanently limited her left arm function. As a consequence, the plaintiff was unemployable and there were significant limitations in her physical activities. However, she remained capable in other ways and largely independent. The Court awarded \$210,000 (\$262,587 currently) in non-pecuniary damages.
- c. *Jarmson v. Jacobsen*, 2012 BCSC 64: The 56-year-old plaintiff was awarded \$230,000 (\$282,000 currently). Healthy, extremely fit and active before the accident, he sustained a TBI along with multiple orthopedic injuries including fractures to his right femur, left wrist and right foot, as well as chest trauma and collapsed lung. The cognitive, behavioral and emotional consequences of the TBI had a severe effect on the plaintiff's life and his relationships. Although the fractures healed, he was left with chronic pain in his right knee, foot and shoulder and other knee issues, which restricted his participation in recreational and home-based activities. An international teacher and a part-time photographer before the accident, he was unsuccessful in returning to teaching after the accident.

- d. Young v. Anderson, 2008 BCSC 1306: The 51-year-old plaintiff received \$200,000 (\$264,000 currently) in non-pecuniary damages. The accident resulted in chronic pain, depression, headaches, personality changes, a cognitive disorder, tinnitus, dizziness, and loss of balance, along with other issues. Similar to Ms. Borgford the plaintiff had a pre-existing chronic neck pain.
- [300] Distinctly at odds with her assertions about Ms. Borgford's TBI, recovery and return to pre-Accident functioning, Ms. Ball also relies on Harrington, as well as two other cases involving plaintiffs that suffered TBIs and significant if not severe ongoing symptoms and impairments. Just as in Harrington, each was awarded \$210,000 in non-pecuniary damages (without accounting for inflation). They include:
- a. Kirilenko v. Bowie, 2017 BCSC 2048: The young adult plaintiff suffered severe complex injuries including internal injuries, nerve damage to his left leg, multiple rib fractures, soft tissue injuries and a TBI that impaired his frontal lobe function. His ongoing symptoms included double vision, headaches, dizziness, severe cognitive, mood and anxiety issues, major depression, lack of concentration a soft tissue injuries. The non-pecuniary damages award was substantially reduced to account for the range of possible long-term outcomes arising from the plaintiff's pre-accident cocaine addiction, which had severely impaired his functioning.
- b. Ngo v. Fong, 2020 BCSC 624: The 27-year-old plaintiff sustained a moderate TBI that left her with cognitive, emotional and behavioural impairments that profoundly compromised her personal and working life. In contrast, other physical injuries that resulted in some ongoing knee pain, headaches and dizziness did not significantly impair her functioning.
- [301] There are several unique aspects to Ms. Borgford's circumstances, including her pre-existing condition, which limit the guidance provided by each of the cases I have been asked to consider. Viewing Gilbert as the most comparable, based on my findings and consideration of the Stapley factors, and in light of the positions of the parties, I am satisfied an award of \$250,000 is fair and reasonable.

Cost of Future Care

- [302] Ms. Borgford relies on Ms. Chow's cost of future care report in seeking a total award of \$1,051,833 for cost of care items and services that fall, as I have stated, into a number of categories including medications, rehabilitation/therapies, medical/equipment/expenses, chiropractic/massage/acupuncture, and home maintenance. Ms. Ball opposes any award, based on her position that Ms. Borgford's accident-related injuries have essentially resolved and the assertion that the Ms. Chow's treatment recommendations relate to Ms. Borgford's chronic and complex pre-existing condition.

Legal Principles

- [303] A plaintiff is entitled to compensation for the cost of future care based on what is reasonably necessary to restore them to their "pre-accident" condition, insofar as that is possible, and to preserve and promote their mental and physical health: see *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.) at para. 182, aff'd (1987), 49 B.C.L.R. (2d) 99 (C.A.); *Spehar v. Beazley*, 2002 BCSC 1104 at para. 55, aff'd 2004 BCCA 290; and *Gignac v. Insurance Corporation of British Columbia*, 2012 BCCA 351 at paras. 29-30.
- [304] The test is an objective one, based on the medical evidence. A future care service or item must be reasonable and medically justified, not medically necessary, to be recoverable: *Milina* at para. 211. An evidentiary link between the "physician's" assessment of pain, disability and recommended treatment and the care recommendations of a qualified health care professional is required: *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para. 39. Assessing reasonableness depends on whether a reasonably-minded person of ample means would be ready to incur a particular expense: *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 22.

Discussion

- [305] Turning to Ms. Chow's report, I would note the thoroughness of the investigation that underlines her assessment. In contrast to the other medical experts, Ms. Chow interviewed and assessed Ms. Borgford twice in her home and conducted several collateral interviews with Dr. Crompton, Ms. Baker, Ms. Borgford's previous speech and language pathologist, her acupuncturist, her optometrist, a pharmacist, Mr. Borgford, her niece. Ms. Chow also reviewed the reports of Drs. Anton and Spivak, the clinical records of several treating physicians, specialists and therapists from 2015 to 2021, and five years of PharmaNet printouts.
- [306] Again, Ms. Chow was not challenged in cross-examination on any of her care or cost of care recommendations. In opposing the proposed awards for particular care items, Ms. Ball relied instead on aspects of Drs. Smith and Thompson's evidence and assertions about fact evidence, which I have not accepted. She also overstated some of the evidence of Drs. Anton and Spivak regarding Ms. Borgford's condition or care needs before the Accident.
- [307] Ms. Borgford's calculations of the cost of various items and services rely on a life expectancy of 25 years, a multiplier of 2% and discount rate of 19.5.
- [308] Neither party made submissions about contingencies affecting the proposed awards.

Medications

- [309] Ms. Chow recommends a number of medications, identifying which of those, and or the dosage that Ms. Borgford was taking before the Accident.

[310] Including many but not all of the medications Ms. Chow recommended, Ms. Borgford's claim for this item includes the following:

Medication

Cost

Frequency

Venlafaxine XR 75mg daily

\$149.65

Yearly

Dicyclomine 20mg

\$354.05

Yearly

Rabeprazole 20mg

\$127.75

Yearly

Oxycodone

\$1,051.20

Yearly

Botox Injections

\$3,226.52

Yearly

Voltaren Cream

\$302.28

Yearly

Medical Cannabis

\$2,200.00

Yearly

Total

\$7,411.45

Yearly

- [311] Ms. Borgford calculates the cumulative cost of the medication expenses at \$144,523.
- [312] Ms. Borgford testified to taking Venlafaxine, which is an antidepressant, to help with cramping, although other medications, discussed below, have also been prescribed for IBS symptoms. Dr. Anton identified Venlafaxine as an SSRI that is used primarily to treat depression and anxiety. He testified it can also have a positive effect on pain. Dr. Smith referred to Effexor as the anti-depressant Ms. Borgford was taking when he assessed her. Dr. Crompton's clinical records mention other antidepressants.
- [313] Ms. Ball argues the medication is not compensable because Ms. Borgford was diagnosed with depression before the Accident. I have found that depression was not part of her original position although Ms. Borgford was suffered depression and treated for it many years before the Accident.
- [314] The question is whether the medication is to treat an Accident-related symptom or condition. Certainly it is not a medication, or type of medication she was taking at the time of the Accident. I have found the Accident caused Ms. Borgford to suffer anxiety, symptoms of depression and some ongoing increase in her chronic pain. Accepting Ms. Borgford requires an antidepressant medication to treat her Accident related anxiety and depression symptoms and Ms. Chow's cost estimate, I conclude this item is medically justified and the cost reasonable.
- [315] I agree with Ms. Ball's submission that neither Dicyclomine nor Rabeprazole are compensable because they are prescribed to treat abdominal cramping and acid reflux, conditions or symptoms not causally related to the Accident.
- [316] Ms. Ball opposes an award for Oxycodone because Ms. Borgford has taken it in varying doses for decades to alleviate chronic pain. Ms. Borgford states the proposed award reflects the increase in her dosage since the Accident. The pre-Accident Pharmacare records show prescriptions for 45 Supeudol (a form of Oxycodone) 5 mg on July 18 and August 8, 2017. Dr. Crompton's clinical records show the most recent prescription for Oxycodone 5mg, at a dose of one tablet every four hours PRN, as well as OxyNeo 10 mg every 12 hours. The most recent Pharmacare records, which end in January 2022, show prescriptions for 40 Supeudol 5 mg, as well as 60 OxyNeo 10 mg (one tablet every 12 hours) approximately once per month.
- [317] Again, I have found some ongoing increase in Ms. Borgford's chronic pain symptoms post-Accident. I have also found that Ms. Borgford's chronic pain symptom were not well managed in the year or two before the Accident, meaning she may have been somewhat undermedicated. Accepting, there is an overall increase in her prescriptions for opioid medication, in all the circumstances, I conclude 30% of the proposed cost for Oxycodone is fair and reasonable.

- [318] Regarding Botox, Ms. Ball suggests there is no admissible opinion evidence capable of justifying the cost of this treatment, although again Ms. Chow was not challenged on her cost estimates. Based on my previous findings about Ms. Borgford's Accident-related headaches and Dr. Diggle's treatment of them with Botox injections, I am satisfied this cost item is medically justified and reasonable. I make no deduction to account for pre-Accident headaches because there is no suggestion her pre-Accident headaches were severe enough to warrant this treatment or that this treatment was ever proposed.
- [319] Regarding Voltaren Cream, which Ms. Chow describes Ms. Borgford as using three times per day for musculoskeletal pain, this is an over the counter topical medication. I do not recall any evidence that it has been recommended or used only since the Accident. Absent this evidence, I am not able to find the cost justified.
- [320] Turning lastly to medical cannabis, the only direct evidence in support of this item is Ms. Borgford's testimony that she finds it useful in addressing symptoms of anxiety and less so pain. Although Ms. Chow writes that Ms. Borgford uses medical cannabis prescribed by Dr. Crompton, in combination with other prescribed and over the counter pain medications to reduce her use of Oxycodone, Dr. Crompton did not indicate she prescribed or recommended it. Recognizing the law does not require a doctor's recommendation for all care items to be medically justified, with respect to medication this will most often be necessary. Here absent a medical recommendation in the face of opinion evidence that cannabis combined with opioid medication could affect cognition and increased sedation, I am not able to conclude there is a medical justification for this item.

Rehabilitation/ Services

- [321] Ms. Borgford seeks the cost of some but not all of the services under this heading that Ms. Chow recommends.

Item

Cost

Occupational Therapy/Case Management

\$69,575

Community Support Worker

\$617,760

Psychological Support

\$10,125

Kinesiology

\$2,160

Physiotherapy

\$1,905

Vision Therapy

\$4,000

Total

\$705,523

[322] Most significant are the cost of occupational case management ("OCM") and a RA or community support worker.

[323] Regarding the OCM, Ms. Chow recommends 68 hours in the first year (\$8,024), 48 hours in years two through four (\$16,992) and 24 hours per year in year five and onward (\$44,557). Ms. Borgford calculates the total cost at \$69,573.

[324] Regarding the RA, Ms. Chow recommends four two-hour sessions per week. At a rate of \$165 per session, the annual cost is \$31,680 and the present value of the total cost would be \$617,760.

[325] There is no question that Ms. Baker's occupational therapy has played a critical role in helping Ms. Borgford manage and or deal with the activities of daily life. Ms. Baker's assistance has been multifaceted. In addition to teaching, implementing and reinforcing memory and coping strategies, she has connected Ms. Borgford with a range of other services, assisted her in dealing with many stressful events and circumstances such as driving tests, and liaised very effectively with her family doctor.

[326] I note Dr. Spivak indicated further occupational therapy would be beneficial. Dr. Anton recommended that Ms. Borgford continue to receive occupational therapy "in the short and medium term", and occasionally in the longer-term during transitions, along with case management to help her access community resources and medical services in future.

[327] Ms. Chow explains the purpose of RA services is to assist Ms. Borgford in following through with weekly tasks and activities, to replace the support Mr. Borgford has been providing between OT visits, and to ensure she follows through with "gentle activation" and leisure interests in to prevent further declines in her physical functioning and increases in her dependence of opioid medications.

[328] Ms. Borgford emphasizes that RA services are particularly important because Mr. Borgford cannot sustain the level of support he has been providing. I fully accept that Mr. Borgford has been overburdened by Ms. Borgford's Accident related cognitive, emotional and behavioural needs, along with the demands of working full-time and his household responsibilities. Certainly, without Mr. Borgford, the care Ms. Borgford would require would increase significantly.

[329] As I indicated earlier, Ms. Baker has involved an RA to fulfill much the same role in between her own visits, given the RA's lower cost and Ms. Borgford's needs.

[330] I note that in her last progress report dated April 11, 2022, Ms. Baker recommended the same services to fulfill the same role but much less frequently:

¾ OT visits [approximately] every four weeks - to monitor/adjust care/supports in place, reassess functioning, provide additional strategy/training education to client and/or family/caregivers, with intermittent communication with client, caregivers and medical/rehab team to support client's participation and quality of life; and

¾ RA services for up to two hours twice per week to support community-based activity, decreased caregiver burden and/or support strategy integration and participation in leisure activities to improve quality of life.

[331] The evidence of Ms. Chow and Ms. Baker along with my findings of fact satisfy me that RA services are medically justified. Bearing in mind Ms. Baker's long-term in-depth involvement with Ms. Borgford and the requirement for a cost of care award to be reasonable, I am satisfied the level of service she recommends is appropriate and award \$300,000 for this item.

[332] I have no difficulty accepting that Ms. Borgford will continue to need ongoing occupational support to maximize her functioning.

[333] Assuming future services would be provided by a different occupational therapist, I accept that additional hours will initially be required for the therapist to assess Ms. Borgford's needs and functioning. I estimate 10 hours as sufficient. After that and until the end of year two, I accept that 48 hours is medically justified and reasonable. I agree with Ms. Chow's estimate of 24 hours per year starting in year three and continuing.

[334] Ms. Ball opposes an award for kinesiology services, suggesting Dr. Anton agreed she would have benefited from them before the Accident. I note Dr. Anton recommended regular exercise for Ms. Borgford's general health mood, cognitive function and activity tolerance. Ms. Baker recommended a referral to "KIN" for assessment/implementation of exercise-focused activities.

[335] There is no question Ms. Borgford has been inactive since the Accident. Despite the significance of her chronic pain before the Accident, she was comparatively active. Mr. Borgford testified that she used to go to the gym without being more specific. She also walked regularly and engaged in some physical activities with him.

- [336] Unlike prior to the Accident, Ms. Borgford now requires assistance to implement an appropriate exercise program. Her short-term memory and other cognitive, as well as emotional, symptoms would prevent her from accomplishing this on her own. Given Ms. Borgford has been awarded the cost of RA services twice a week and their role in assisting her to participate in activities, I conclude that the cost of 12 sessions is medically justified and reasonable.
- [337] The physiotherapy Ms. Chow recommends under this heading is for a vestibular therapy assessment and 12 treatment sessions. Ms. Ball's opposition to this item targets regular physiotherapy. Ms. Borgford and Mr. Borgford gave unchallenged evidence that previous sessions of vestibular therapy in late 2017 were helpful in resolving her symptoms of dizziness/vertigo. I have found the subsequent bouts of dizziness are also a result of the Accident. Noting that Ms. Chow's report pre-dates Ms. Borgford's April 2022 eye injury and the onset of significant balance issues, I accept that this recommendation is both medically justified and reasonable.
- [338] Regarding counselling services or psychological intervention, Ms. Chow recommends two sessions per month for the first six months and then monthly sessions for the next 18 months, followed by a lifetime allowance of 12-18 sessions. Ms. Ball opposes any award although Dr. Smith recommended cognitive behavioural therapy and Dr. Anton recommended up to 12 sessions of counselling by a registered psychologist and possibly more. She relies on his other evidence that he may have made the same recommendation before the Accident. I have found, however, that the Accident caused significant if not severe anxiety, symptoms of depression and post-traumatic stress symptoms. I am satisfied that psychological services are medically justified.
- [339] Ms. Chow explains that she recommended more than 12 sessions based on her assessment of Ms. Borgford's functioning, and in consultation with Dr. Crompton who predicted Ms. Borgford would utilize 12 sessions in six months due to her trauma response to the Accident. Balancing Ms. Chow's recommendation with Dr. Anton's in the context of my findings, I conclude that an award for the cost of 30 sessions is reasonable.
- [340] There is no basis for awarding the cost of vision therapy.

Medical/Rehabilitation Equipment/Expense Needs

- [341] Ms. Chow recommends the cost of a facility pass, because Ms. Borgford attended the gym before the Accident, and attending now with the kinesiologist and then the RA would facilitate her regular participation in an exercise program, which I accept. Ms. Chow estimates the cost at approximately \$524 per year to age 60 and thereafter \$393. Ms. Chow also makes other various recommendations under this heading that Ms. Borgford does not appear to be claiming. Using the lower figure for the facility pass, she estimates the present value of the total cost at \$7,664. Ms. Ball does not dispute this item. Accordingly, I grant the amount sought by Ms. Borgford.

Chiropractic Care/Massage Therapy/Acupuncture

[342] Acknowledging she attended chiropractic treatment and massage therapy within the allowances provided by her health care plan before the Accident, Ms. Borgford argues she will require more passive therapies because her pain is now greater. Since, but not before, the Accident she has been receiving acupuncture which she testified to finding helpful with pain relief. Dr. Anton recommended an allowance of 12 session per year for whichever treatment she finds the most beneficial, if Ms. Borgford finds passive modalities helpful for managing pain flare-ups. Again, I have found that Ms. Borgford's ongoing pain symptoms have increased although not substantially. Coupled with the reality she would have continued to attend some passive therapies to address her chronic pain symptoms in any event, I award the cost of three sessions per year.

Home Maintenance

[343] Ms. Chow found that Ms. Borgford had increased difficulty managing household tasks that she was able to manage before the Accident, which I accept, and recommends weekly housekeeping to perform the heavier household tasks, such as cleaning the bathrooms, floors and windows and vacuuming, at a cost of \$145 per week, an annual cost of \$7,540 and a total cost (present valued) of \$147,030. Again at the time of her assessment, Ms. Borgford was receiving assistance with those same tasks. In her last report, Ms. Baker recommended more - four hours per week of homemaking services - to assist with mopping, sweeping, cleaning tub/toilet, dusting, blinds, vacuuming, changing bed linens and assisting with laundry. Ms. Baker's recommendation accounts for the impact of nausea, retching and dizziness on Ms. Borgford's need for housekeeping assistance, which based on my findings is medically justified. Although, I accept the weekly and annual amounts are reasonable, in my view, the award must be reduced by 30% to account for the combined effects of aging and Ms. Borgford's pre-existing pain conditions on her housekeeping abilities.

[344] Given my findings with respect to Ms. Borgford's Accident-related injuries and ongoing symptoms and her poor to guarded to prognosis, I should clarify that all of the cost of care items are awarded for the primary purpose of maximizing her functioning and enjoyment of life, as opposed to aiding in rehabilitation.

[345] Where I have not accepted Ms. Borgford's calculations and granted a different award, I leave it to counsel to calculate the correct present value amounts, based on Ms. Borgford's approach.

In-Trust Claim

[346] Ms. Borgford brings an in-trust claim on behalf of Mr. Borgford in the amount of \$50,000, based on an estimate of \$10,000 per year since the Accident, characterizing his role as that of a caregiver since the Accident. Ms. Ball opposes any award, submitting Mr. Borgford provided the same level of care that any "ordinary and loving" spouse would if presented with the circumstances.

[347] The Court may compensate a plaintiff for the care and other services provided by a spouse or family member, over and above what would be expected from the relationship: *Hans v. Volvo Trucks North America Inc.*, 2016 BCSC 1155 at paras. 529-555.

[348] The factors and principles that govern in-trust awards are as follows:

- (a) the services provided must replace services necessary for the care of the plaintiff as a result of a plaintiff's injuries;
- (b) if the services are rendered by a family member, they must be over and above what would be expected from the family relationship;
- (c) the maximum value of such services is the cost of obtaining the services outside the family;
- (d) where the opportunity cost to the care-giving family member is lower than the cost of obtaining the services independently, the court will award the lower amount;
- (e) quantification should reflect the true and reasonable value of the services performed taking into account the time, quality and nature of those services. In this regard, the damages should reflect the wage of a substitute caregiver. There should not be a discounting or undervaluation of such services because of the nature of the relationship; and,
- (f) the family members providing the services need not forego other income and there need not be payment for the services rendered.

See *Bystedt v. Hay*, 2001 BCSC 1735 at para. 180.

[349] After her discharge from hospital, Ms. Borgford was assisted by in home caregivers for a period of time. There is no clear evidence about the caregivers' schedule. I infer from Mr. Borgford's evidence that they provided daily care even after he returned to work in October 2017, although before that it was never 24-hour care. I accept that during and after his return to work, Mr. Borgford also assisted Ms. Borgford's physically during the first few months of her recovery, and since then in response to severe headaches, bouts of dizziness and pain flare-ups. More significant, however, is the ongoing support he has provided related to her significant and severe cognitive, emotional and behavioural symptoms. Until Ms. Borgford was able to use the cognitive strategies provided by Ms. Baker, he attended all of her medical appointments with her. It is readily apparent that he has had to spend a significant amount of time and energy assisting her with, monitoring and mitigating the impacts of her short-term memory loss, for example: leaving the stove unattended and

reminding her of what appointment she is driving to. I accept that managing her intense and frequent emotional and behavioural symptoms has also formed an important part of his daily "caregiving role" with Ms. Borgford. As a small example, I note his interventions with Ms. Borgford during Ms. Chow's two in home assessment sessions.

[350] The award Ms. Borgford proposes begins with her estimate of the annual cost of an RA providing two hours of support four times per week, or \$31,680, which she reduces to \$10,000 per year. Given my award for ongoing RA services which will serve to replace Mr. Borgford's role in part, and the principles that apply to valuing an in-trust claim, I am satisfied that \$50,000 is entirely fair and reasonable and award that amount.

Special Damages

[351] The parties have agreed on an award of \$18,653.53.

Costs

[352] Ms. Borgford is entitled to her party to party costs. If there are other circumstances I am unaware of, and the parties are unable to agree on her costs, a short hearing may be scheduled before me.

"Fleming J."

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