
CANADA / JUDGMENT

Dennis v. Fothergill

2012 BCSC 1510

COURT

Supreme Court of British Columbia

DECIDED

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2012 BCSC 1510 Dennis v. Fothergill

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Dennis v. Fothergill,

2012 BCSC 1510

Date: 20121012

Docket: M093365

Registry: Vancouver

Between:

Julia Ellen Dennis

Plaintiff

And

Peter Fothergill

Defendant

Before: The Honourable Madam Justice Bruce

Reasons for Judgment

Counsel for the Plaintiff:

Marc Kazimirski

David J. Gomel

Counsel for the Defendant:

Andrea Jones

Place and Date of Trial:

Vancouver, B.C.

August 7-10, 13-17, 29 and 30, 2012

Place and Date of Judgment:

Vancouver, B.C.

October 12, 2012

INTRODUCTION

- [1] This is an action for damages for personal injuries that arises out of a motor vehicle accident that occurred on October 2, 2007, while the plaintiff was operating her Subaru Impreza on the highway between Whistler and Squamish. The defendant, who rear-ended the plaintiff's vehicle with his truck, admits liability. The plaintiff seeks damages for pain and suffering caused by the injuries she sustained to her neck, shoulders and back. In addition, the plaintiff seeks damages for the secondary emotional harm caused by the accident related injuries, which include depression and alcohol dependence. Due to the injuries caused by the accident, the plaintiff seeks compensation for out-of-pocket expenses, the cost of future care, past wage loss, and loss of future earning capacity.
- [2] The issues in dispute concern the nature of the injuries suffered by the plaintiff due to the accident and the extent to which the plaintiff's pre-existing injuries are causally related to her current physical impairments. In addition, the defendant disputes the claim for past wage loss, loss of future earning capacity, and future care costs on the ground that the minor injuries caused by the accident do not continue to impede the plaintiff's ability to work in her pre-accident job as a hair stylist.
- [3] At the time of the accident, the plaintiff was working as a hair stylist at a salon in Squamish called Divas. She had only recently started working at this salon in September 2007 as an independent contractor. Essentially she rented a chair from Divas and covered her own expenses. The plaintiff had worked as a hair stylist since 1985. At the time of the accident she was 42 years old.

CHRONOLOGY OF EVENTS

- [4] On October 2, 2007, the plaintiff was stopped on the highway for road construction when she was rear ended by the defendant who was driving a pickup truck and towing a boat. The impact of the collision was sufficient to cause the plaintiff's seat to break and force her into a prone position while she pressed heavily on the brakes. The windows in the rear of the plaintiff's vehicle also shattered and the rear end of the vehicle was crushed and forced towards the front seat area. The plaintiff's vehicle was thrust forward several hundred feet

until it came to a stop. The plaintiff did not lose consciousness and did not strike her head during impact. Her left knee struck the dashboard.

- [5] Immediately after the collision, the plaintiff experienced neck pain and headache along with a sense of weakness, dizziness and blurred vision. She managed to extricate herself from the vehicle slowly by rolling over on her side and stepping out of the driver's door. Police and ambulance attended the scene. Because the plaintiff had a dog in the vehicle, she was not able to go to the hospital in the ambulance. Instead, the police drove her to the hospital after dropping the dog off at the plaintiff's apartment in Squamish. The plaintiff was released from the hospital after a brief examination by an emergency physician. He recommended that the plaintiff stay active by exercising and attend physiotherapy after five days. She walked home, which was a short distance away.
- [6] The plaintiff rested during her two days off immediately after the accident but returned to work at Divas on the third day, October 5, 2007. She appears to have worked fewer hours on this day and for the next few days. While the hours worked are not noted on the calendars filed as evidence of her earnings loss, the monies earned on these days in October are less than the monies the plaintiff earned each day worked in September 2007. Towards the end of the month of October it appears that the plaintiff earned similar daily totals to September; however, there continue to be days where her earnings are half of those earned in September. The plaintiff also acknowledged in cross-examination that she worked some full days in October. There is no evidence that the plaintiff missed any days at work during this period immediately after the accident.
- [7] The plaintiff testified that within the first week after the accident she began resorting to alcohol to reduce her pain and help her sleep. Before the accident she drank very little alcohol and often abstained during a body cleanse. However, the plaintiff's evidence as to how she began drinking after the accident and how much she consumed is inconsistent. In direct examination, the plaintiff testified that she consumed two glasses of wine every day starting the first week after the accident. While she testified in cross-examination that during the first two weeks after the accident she consumed one or two glasses of wine or beer, in discovery she said it was at least that much or more since the accident. While she testified that her consumption gradually increased over time and was up to three glasses of wine per day on a regular basis within one or two years after the accident, in December 2009 the plaintiff told Dr. Zentner that she had only recently begun consuming more alcohol and stated that her consumption was two to three drinks per day. This evidence is also inconsistent with her testimony in direct examination that she was drinking a bottle of wine or six beers per day by early 2010.
- [8] The plaintiff began attending physiotherapy on October 9, 2007. Her complaints included tingling in her hands, sleep problems, right-sided neck pain, shoulder pain, upper back pain, low back pain, and left-sided knee pain. On October 11, 2007, she attended the Whistler Medical Clinic to consult with a physician about her injuries. At that time she reported to the attending physician that her condition had improved significantly, but she

still had dizziness, nausea, and neck pain. She did not mention low back pain or tingling in her hands. Thereafter the plaintiff continued to attend for various therapies.

- [9] On October 26, 2007, the plaintiff reported to Tantalus Chiropractic that she had bilateral arm numbness, headaches and neck pains. She did not mention low back pain. The plaintiff saw her family doctor again in October; however, it was for an unrelated matter. She did not return to her general practitioner at the Squamish medical clinic for an accident related consultation until November 19, 2007. On that date she reported increased pain, reduced work hours to four per day, and regular attendances for chiropractic and massage therapy. (The November 2007 calendar records indicate that on most days the plaintiff earned over half of her average daily earnings in September 2007) On examination, flexion and extension in her neck was normal and rotation was 45 degrees bilaterally. The physician noted tenderness and spasm in the right more than left trapezius. She recommended reduced work hours and a continuation of chiropractic and massage therapy along with yoga. A November 20, 2007 attendance for physiotherapy indicates symptoms of headaches, neck pains, upper back pains, and numbness and tingling in her hands.

- [10] When the plaintiff returned to the medical clinic on December 10, 2007, she had not been to chiropractic or massage therapy in the interim but had been to a single appointment with a new physiotherapist. That session had helped; however, her headaches were now getting worse, two months after the accident. On January 9, 2008, the plaintiff reported to the physician daily headaches relieved with Advil. She had not been to physiotherapy due to transportation problems but had sought chiropractic and massage therapy. This treatment appeared to be helping her neck pain. On January 11, 2008, the CL 19 form completed by the attending physician noted her initial complaints were:

Nausea, dizziness, neck pain and decreased range of motion and the objective findings were decreased neck range of motion. On the CL 19 form the current complaints included daily headaches, fatigue, neck pain and decreased range of motion, nausea, dizziness, left knee pain and pelvic pain. On examination there was tenderness on right and left C-spine rotation and lateral flexion.

- [11] This is the first reference to knee and pelvic pain contained in the medical records. There is no reference to low back pain or shoulder pain.
- [12] In March 2008, the plaintiff began a return-to-work program with Squamish physiotherapy. This program consisted of two workout sessions, two physiotherapy sessions and one massage each week. At this time the plaintiff reported to her physiotherapist that she was very busy at work and working six hours per day. (She informed Dr. Swope that she was working five hours per day.) On March 17, 2008, the plaintiff reported to Dr. Swope persistent headaches and tingling in the right and left thumb and second finger when lying down and that she was waking up during the night. This is the first reference to sleep problems in the medical records. On examination, there were few indications of pain or functional limitation. Neck flexion and extension was normal, lateral rotation 70 degrees bilaterally

and lateral flexion was normal. There was no tenderness or spasm in her neck and back range of motion was normal. There were normal reflexes with slight decrease in the left thumb strength. Dr. Swope ordered C-spine X-rays but these were normal with minor spondylosis at C4-6. She recommended carpal tunnel splints for the tingling in the plaintiff's fingers.

- [13] On April 14, 2008, Dr. Swope reviewed the X-ray results with the plaintiff. The plaintiff said that she had not yet purchased splints but the tingling was less evident at that time. On examination, the plaintiff had slight pain on the left C1-2 area and was tender on the right para-cervical muscles but neck rotation was improved. Due to persistent loss of sensation in her thumb and forearm, a CT scan was ordered. The scan was normal apart from the slight narrowing of the disc at C4-6.
- [14] The plaintiff did not return to see Dr. Swope until July 21, 2008; however, she continued to have physiotherapy treatments consistently between April and July 2008. She also had regular massage therapy treatments during this period. The plaintiff advised Dr. Swope that the tingling had extended to her four left hand digits and the border of her hand. On examination, there was reduced sensation in these areas and slightly reduced sensation in the right hand fingers. Dr. Swope referred the plaintiff to Dr. Johnston, who is a neurologist, for possible brachial plexus pathology.
- [15] At the end of August 2008, Jennifer Paddock, who is a kinesiologist, reported that the plaintiff had concluded the three month return-to-work program. It was Ms. Paddock's opinion that the plaintiff's busy work schedule had impaired her physical improvement due to lack of time to do the required exercises. While the plaintiff's strength improved and her headaches and dizziness decreased, she did not achieve maximum function due to soreness from her job. Ms. Paddock gave the plaintiff a home exercise program and recommended that she reduce her workload to give her more time for rehabilitation.
- [16] On October 8, 2008, the plaintiff was examined by Dr. Johnston. Because she could not tolerate EMG studies, he could not confirm a diagnosis. He felt that she probably had a medium neuropathy at the wrist and mild brachial plexus was possible. Dr. Johnston believed that most of the plaintiff's symptoms were muscular or ligamentous in origin. He recommended that the plaintiff see a physiatrist for chronic neck pain. Because the plaintiff would not take medication for her neck pain, he could only recommend strengthening and stretching exercises. Dr. Johnston also commented that as a hair stylist the plaintiff was at risk for chronic neck problems, but there was no evidence of neurological damage. The plaintiff did not advise Dr. Johnston that she suffered from pre-accident neck and back pain as well as tingling and numbness in her hands. She related the tingling and numbness exclusively to the accident. The plaintiff did not mention her alcohol consumption for pain and sleep disturbance.

- [17] On October 20, 2008, the plaintiff saw Dr. Swope. On examination, she had tenderness in her right neck and pain on right rotation and left lateral flexion was normal. The lumbar spine had a limitation of movement on left rotation, right lateral flexion and pain on extension. The thoracic spine had pain on left rotation and right lateral flexion. There were some persisting sensory deficits in the left and right arm. The headaches and tingling in her fingers along with neck pain continued. This is the first reference to lumbar and thoracic back pain and shoulder fatigue to Dr. Swope. Sleep was also mentioned as a problem as Dr. Swope recommended Nortriptyline at bedtime. On December 9, 2008, the plaintiff said she tried this medication twice but did not feel her sleep was any better and she felt "hung over". She did not attempt a retry of this medication.
- [18] On December 12, 2008, the plaintiff saw Dr. Travlos, who is a physiatrist, for neck pain with upper extremity symptoms and lower back pain due to the motor vehicle accident. During this consultation, the plaintiff told Dr. Travlos that prior to the accident she had no back or neck pain. Her current symptoms were described to Dr. Travlos as follows:
1. Headaches: located in the lower occipital region, occasionally radiating to the right temporal area. The headaches are daily and are aggravated by therapy and exercise. Advil relieves her symptoms.
 2. Dizziness and nausea: on occasion she loses balance and feels dizzy. She feels nausea when lying down with her head propped up.
 3. Neck pain: pain is just below occipital that radiates down to the upper thoracic spine. The pain is worse on the right side. The pain is aggravated by work, massage, lifting her arms over her head, neck flexion, and especially with the use of right upper extremity. There is general fatigue in her shoulders.
 4. Upper extremities: tingling and occasional numbness in bilateral upper extremities. It radiates down the medial aspect of the arm and forearm into the fourth and fifth digits. She wakes at night due to neck pain and sensory symptoms.
 5. Back pain: in the mid to lower back more on the right side. Worse while driving or lying down. Her feet are numb.
- [19] On examination, the plaintiff had normal range of motion in her neck with discomfort in the upper neck with flexion and lateral flexion. There were no radicular symptoms and range of motion in her shoulders was symmetrical. She had full strength in her upper extremities and mildly altered sensation in the dorsum of her hands and forearms. She was tender over the occipital condyles and the right side of C2 and palpation of these areas increased her headaches. Dr. Travlos found that there was essentially a subjective description of pain with no underlying abnormalities. Dr. Travlos opined myofascial pain with referral of symptoms into the upper extremities. There were no focal neurological or musculoskeletal impairments. Dr. Travlos opined that sleep disturbance was a major factor in the plaintiff's recovery and prescribed Nortriptyline at bedtime. He felt that her previous attempts with

this drug were too short to be of any assistance.

- [20] It is significant that the plaintiff did not advise Dr. Travlos of her pre-accident history of neck and back problems, as well as tingling and numbness in her hands, headaches and dizziness. In cross-examination, the plaintiff explained that she did not believe these were injuries; they were only aches and pains. In addition, the plaintiff testified that the area of her neck that was painful was now different and the headaches were different than before the accident. When confronted with her evidence in discovery that the tingling after the accident was of the same nature as before the accident but worse, the plaintiff testified that she had been bullied into giving this answer. She testified that the tingling currently is far different than the symptoms she had prior to the accident. However, the plaintiff also said in discovery that she had numbness in both hands now, just like before the accident.
- [21] The plaintiff did not advise Dr. Travlos about her alcohol consumption. Nor did she mention any of the stresses that were affecting her mood at the time. In particular, she did not disclose a \$65,000 debt she owed for repairs to the leaks in her condominium, a lawsuit by Visa for a \$6,000 debt and her action against a car dealer who sold her the vehicle giving rise to the Visa debt. The plaintiff did not advise Dr. Travlos that she was having difficulty coping at work.
- [22] On February 15, 2009, the plaintiff left her position as a hair stylist with Divas and began working out of her home at a vastly reduced schedule of hours. The plaintiff testified that she was not able to work as well or as fast as before the accident and she could not afford the chair rental only working half-time to three-quarter-time. Her injuries were not improving and she needed more time to work on rehabilitation. She testified that it was intended to be a six month leave of absence. However, as of the trial date she had not returned to the salon. In April 2009, she set up a room in her home to see clients, but only saw two or three per week. Currently, she is up to seven clients per week. None of the plaintiff's medical practitioners recommended that she leave work entirely. However, Dr. Swope testified that she agreed with the plaintiff's decision in retrospect. Dr. Travlos was told of the decision after the fact and his recommendations appear to have been for the plaintiff to increase her work hours rather than decrease them.
- [23] On February 25, 2009, the plaintiff was assessed by Dr. McPherson, who is an orthopaedic surgeon, for the purpose of instructing the insurer regarding the need for further treatment and therapies. The plaintiff advised Dr. McPherson that she had no health problems prior to the accident. She also advised Dr. McPherson that her family doctor had recommended that she leave work in mid-February 2009. Despite the list of complaints provided by the plaintiff and her expressions of pain, Dr. McPherson's examination of the plaintiff revealed that her neck had full range of motion when she was distracted. Further, he noted that she had a powerful shrug in her shoulders and there was no response to pressure on her neck and trapezius areas when she was distracted. Her hips had full range of motion and leg raising was normal. She had no restrictions in her knees. There was very full extension, lateral flexion and rotation of the spine from a standing position. There was no spasm or

tenderness in the spine.

- [24] Dr. McPherson concluded there was no objective evidence of a continuing disability related to the accident and that the plaintiff was voluntarily restricting her neck movements. While he concluded she must have suffered a neck strain during the accident, he could not provide an opinion as to its severity without a review of the clinical records.
- [25] On March 7, 2009, the plaintiff reported to Dr. Swope that she had discontinued the Nortriptyline two weeks previously due to side effects. The plaintiff reported to Dr. Swope that she had left work in February 2009 but noted that her yoga now increased her neck pain. She also had a reduced range of motion in her neck generally on this occasion.
- [26] In July 2009, the plaintiff returned to see Dr. Travlos. She continued to report headaches, neck pain, low back pain, and numbness and tingling in both arms. Even though she had quit work and had attended physiotherapy and massage therapy, there was no great difference in her pain. The plaintiff also reported that she was going to the gym three times a week for 90 minutes and trying to hike. She was not taking any medications even though her sleep remained a problem. The plaintiff told Dr. Travlos that, apart from her symptoms and her inability to work, she had no other major stresses. On examination, there was no muscle wasting and weight was normal. Range of motion and mobility in her neck was reasonably full. Her complaints of pain were mostly on the left side when stretching. Loading the neck did not bring on symptoms. She was more tender on the left than on the right side of the lower neck, trapezius, rhomboids, and infraspinatus muscles. Neurological functioning was normal except some subjective reduction in pinprick in the left side fourth and fifth finger and medial forearm. The lower back examination revealed discomfort with flexion and extension.
- [27] The plaintiff advised Dr. Travlos that while she continued to exercise, she did not work on her upper body because it caused her pain and headaches. Dr. Travlos told the plaintiff that she had to continue exercising these areas even if it did cause pain. He said that the less she did, the harder it would be to return to work. She had to strengthen the neck and shoulder muscles to increase her function. Dr. Travlos also continued to recommend a sleep medication as insomnia was a major factor in the plaintiff's treatment. He recommended several drugs that ultimately the plaintiff refused to take due to the side effects. Overall, Dr. Travlos felt the plaintiff had improved since the last examination but that she was still very symptomatic. He recommended that she increase her work hours to at least 0.6 to 0.8 full-time equivalency. In his testimony, Dr. Travlos clarified that he meant close to full-time hours in a variety of occupations and not exclusively hair styling.
- [28] The plaintiff did not disclose her alcohol consumption to Dr. Travlos. The plaintiff did not advise Dr. Travlos of the financial stresses she was experiencing including the Visa action, the large debt for leaks in her condominium, and the monies she owed for income tax and GST.

- [29] On October 28, 2009, the plaintiff reviewed her current symptoms with Dr. Swope. For the first time, the plaintiff reported that she had had lower back pain since the accident and a new pain in her groin from speed walking. Her range of motion in the back and hips was normal on examination and there was no tenderness except on the right side of the SI joint. She reported that there was an increase in her neck pain due to more hours working as a stylist; however, at this time she was working no more than a few hours per week in this capacity.
- [30] On December 10, 2009, Dr. Swope recommended Trazadone for the plaintiff's sleep problems that were now primarily due to lower back pain and hand tingling. In January 2010, the plaintiff reported an increase in low back pain and sleep disturbance and Dr. Swope recommended a bone scan. The bone scan was normal.
- [31] On December 30, 2009, the plaintiff saw Dr. Zentner for heart palpitations. She first experienced these palpitations in August 2006. Significantly, for the first time the plaintiff reported to Dr. Zentner that she had recently increased her consumption of alcohol to two to three glasses per day. He diagnosed her with borderline pulmonary hypertension.
- [32] Dr. Swope reviewed her alcohol consumption in January 2010, but at that time the plaintiff reported she no longer was consuming alcohol. In March and April 2010, Dr. Swope gave the plaintiff trigger point injections in her neck and scapular muscles and these injections gave her some temporary improvement. In July 2010, the trigger point injections were continued in the shoulders but not the neck due to lack of effectiveness in the neck area.
- [33] In November 2010, an associate of Dr. Swope's diagnosed thoracic outlet syndrome in the plaintiff's shoulders and upper extremities. As a consequence, she was referred back to Dr. Travlos for an assessment. On November 26, 2010, the plaintiff was examined by Dr. Travlos for the purpose of an independent medical assessment. This is the first opportunity that Dr. Travlos had to review the plaintiff's medical history from clinical records. Contrary to the plaintiff's earlier statements that she had not suffered any pain in her neck or back prior to the accident, Dr. Travlos concluded there had been a significant history of such complaints, which included the following:

In March 2000 the Whistler Medical Clinic records indicated a two year history of bilateral shoulder pains and right elbow pains that were attributed to the claimant's work as a hair stylist. The Peak Performance Physiotherapy records from May 2000 indicated a 15 year history of bilateral shoulder symptoms and a history of low back pains in August 2000 and October 2002. The shoulder symptoms returned in 2005 and it was noted then that they had been symptomatic for six years.

The Whistler Medical Clinic records also indicated a history of headaches, chest pains and shortness of breath intermittently over the years and in 2004 the claimant was placed on Celexa for depression. She was still depressed in June 2005 in a follow up but had discontinued the Celexa.

Dr. Zentner's clinical records from September 2006 indicated that the claimant had complained of dizziness for several years, headaches, fatigue, shortness of breath, chest pain and palpitations. She also had tingling episodes in her hands and feet. An MRI of the complainant's brain was normal. The Squamish Physiotherapy records from September 2006 indicated that the claimant complained of mid back pain, chest pains for the past few weeks. She also had numbness or tingling in her hands and a past history of rib pains, tailbone pains, and low back pain.

The Emergency Room records from the Squamish General Hospital indicated that on the day of the accident the claimant reported a six month history of neck pains.

- [34] At the time of Dr. Travlos' assessment, the plaintiff reported essentially the same ongoing symptoms affecting her neck, back, upper extremities, right shoulder and hip. While Dr. Travlos acknowledged that the plaintiff had had pre-accident symptoms in all of these areas, he noted they were not sufficiently severe to preclude her from working full-time as a hair stylist. Accordingly, he concluded that prior to the accident she was functioning quite well despite these physical problems.
- [35] This conclusion formed the basis for Dr. Travlos' opinion that all of these pre-existing symptoms were aggravated by the accident and, further, due to her inability to work full-time since the accident, these symptoms continued to be aggravated. Dr. Travlos also opined that some of the plaintiff's current symptoms were not accident related. The only accident related symptoms were neck pain, headaches, dizziness, nausea and bilateral arm numbness or tingling in her hands and fingers.
- [36] Curiously, Dr. Travlos' examination of the plaintiff on November 26th revealed a "paucity" of findings despite substantial regions of reported pain. She had good flexibility and mobility of the entire spine, including in her neck and lower back. She had a mild finding of thoracic outlet obstruction on the left side and other than that there were no areas of concern.
- [37] Dr. Travlos' diagnosis included myofascial soft tissue pain in the neck and shoulder girdle; non-specific mechanical back pains; myofascial pain in the right buttock; numbness and tingling in the hands referred from myofascial pain, thoracic outlet syndrome or carpal tunnel syndrome; and sleep disorder with mental health difficulties. He recommended further investigations by MRI for nerve issues and further treatment for her sleep problems. It was seen as imperative that the plaintiff improve her sleep in order to see improvement in her chronic pain condition. He again recommended another medication for sleep. Dr. Travlos recommended counseling for depression associated with the chronic pain and an anti-depressant.
- [38] Dr. Travlos was not in favour of more passive therapies but he was adamant that the plaintiff improve her upper body conditioning with exercise in the gym under the supervision of a trainer if necessary. She did not appear to have been improving in this area since the last assessment in 2009. Regardless of further treatment however, Dr. Travlos felt the plaintiff's condition had reached a plateau and would not be expected to improve. While Dr. Travlos did not notice any pain behaviours, he agreed that the plaintiff's inability to squat during the

examination was inconsistent with her statement that she went to the gym regularly and worked out for 90 minutes. The fact that the plaintiff sat on a pillow for neck pain was also regarded as unusual given the normal range of motion in her neck and shoulders. Dr. Travlos also recommended the plaintiff seek psychological counselling because there were few objective findings to support her subjective assessment of pain. He worried there were other issues affecting her mental health.

- [39] Lastly, Dr. Travlos made recommendations concerning the plaintiff's physical activities and work. First, he was of the opinion that the plaintiff could do any of her pre-accident activities such as cycling, swimming, hiking, shopping and travelling. She was encouraged to be as active as she could tolerate with pain symptoms. Second, he felt the plaintiff was capable of doing home chores and activities without assistance, with the exception of the heavier work in and outside of the home. Third, Dr. Travlos opined at p. 11, that the plaintiff could work longer hours:

In my opinion, Ms. Dennis is capable of working longer hours and there is no reason for her not to be able to be working at least 0.6 to 0.8 full time equivalency. Given her complaints, it is unlikely that she could work full time hours on a daily basis. The only limiting factor for her is her subjective pain experience and the numbness that she has at night. It is possible that with the above noted treatment recommendations, that things may improve, allowing her to work full time. She has to determine what that balance is in her life that allows her to work the longest possible hours, allows her to still be active, exercise and partake in recreational and home activities.

- [40] Although the plaintiff agreed to start Gabapentin for sleep as recommended by Dr. Travlos, she had not started this medication by December 15, 2010 when she next saw Dr. Swope. At this point in time it was the plaintiff's mental health issues that dominated her consultations with Dr. Swope. The plaintiff reported that she had started smoking again due to an increase in her stress level. She had decreased exercise due to depressed mood. The plaintiff reported again that she was not consuming alcohol at this time but still noted increased anxiety due to financial stress, the uncertainty of her career, a credit card dispute that had resurfaced and the fact that she was not socializing with friends and family. Dr. Swope reviewed with the plaintiff her significant family history of mental illness; her maternal uncle committed suicide due to depression, her mother had depression and anxiety, and her maternal aunt was in a psychiatric facility suffering from depression and anxiety.
- [41] Dr. Swope administered to the plaintiff certain psychological tests that suggested she was severely depressed and severely anxious. As of December 22, 2010, the plaintiff was taking Trazadone for depression and was sleeping seven hours each night and in January 2011, she began seeing a counsellor. The plaintiff advised Dr. Swope that improved sleep was lessening her lower back pain. Her only exercise at this time was walking. By February 2011, the plaintiff was taking Sertraline for depression and anxiety and there was some improvement in her symptoms. She was also abstaining from alcohol consumption again.

- [42] The plaintiff saw a mental health counsellor from January 2011 until April 2012; however, she missed many of the scheduled sessions. During these sessions the plaintiff discussed with the counsellor the financial stress she was experiencing at the present time and in the past and how this caused her to become depressed. She discussed the problems in her childhood and problems she had concerning the sale of her condominium in Squamish and a future move to Victoria or the Sunshine Coast. She also talked about her alcohol consumption and relationships. Although there is a reference to pain management through yoga in February 2011, there is no reference to pain as a cause of her depression or alcoholism. There is no reference to the accident in the counselling records.
- [43] In March 2011, Dr. Swope diagnosed major depressive disorder, generalized anxiety disorder, alcohol abuse, and chronic pain, with causal factors including financial stress and career uncertainty. From March to June 2011, her mood issues remained slightly improved but her underlying neck and back pain continued to be reportedly unchanged. It was in July 2011, however, that the plaintiff's alcohol consumption surfaced as a problem related to the accident. On July 14, 2011, the plaintiff reported to Dr. Swope that she was consuming one to one and a half bottles of wine or six to eight beers per day and had been drinking this heavily for the past three to four months. She was not interested in detoxification or Alcoholics Anonymous ("AA").
- [44] Immediately prior to this consultation with Dr. Swope, the plaintiff was seen by Dr. Lu, who is a psychiatrist specializing in alcohol-related mental health conditions, for an independent medical assessment. Dr. Lu opined that the plaintiff's chronic pain condition had led to secondary mental health problems, including her ability to focus and concentrate as well as her ability to cope with internal and external stressors. He opined that chronic pain increased her risk of developing major depression. At the time, June 2011, she was diagnosed with major depression precipitated by chronic pain and associated physical limitations. The depression was interfering with the plaintiff's sleep, attention, concentration, energy level, and general interest in life. The severity of her depression was moderate. Despite a bout of depression in 2004 and a family history of depression, Dr. Lu opined there was no indication that without the accident in 2007 and the resulting chronic pain, the plaintiff would have relapsed.
- [45] Dr. Lu also opined that the plaintiff's alcohol dependence was a major factor in her depression and mood symptoms. She reported an increase in drinking over the past two years and demonstrated a tolerance to alcohol. The alcohol dependence was likely causing some of the depression symptoms and was related to chronic pain; however, it must be treated as an independent medical condition. It was Dr. Lu's opinion that as long as the plaintiff continued to drink, the treatment for depression would not be successful. At this time the plaintiff was only contemplating treatment for her alcoholism; she had not made a commitment to seek any form of treatment. Dr. Lu recommended withdrawal from alcohol under medical supervision and thereafter treatment through publicly funded resources such as AA or privately funded programs which could address her other mental health issues and

her chronic pain as well as the alcoholism.

- [46] Between May and August 2011, the plaintiff worked with a personal trainer. They met at the gym and the plaintiff did exercises under supervision. After she could no longer afford the cost (\$25 per session) the plaintiff tried to do the exercises at home; however, without the machines at the gym and the supervision she was unable to recreate the same beneficial effects on her injuries as she had with the personal trainer.
- [47] In July 2011, the plaintiff reviewed with Dr. Swope her options regarding treatment for alcoholism. They discussed her sessions with a counsellor and programs such as Changeways and Smart for addiction issues. The plaintiff was not interested in detoxing and made excuses for her refusal to accept any of Dr. Swope's recommendations. However, on and off throughout the fall of 2011, the plaintiff had periods of abstinence. She also reported the same physical symptoms. Throughout the balance of 2011 and 2012 until trial, there were few references to the physical complaints; the sessions with Dr. Swope primarily concerned medications for sleep and depression and non-accident related medical problems.
- [48] On April 26, 2012, the plaintiff again saw Dr. Travlos for an update to his first independent medical report. On this occasion he had the benefit of clinical records from the plaintiff's counsellor, Dr. Swope's clinical records and reports, Dr. Lu's report, a functional capacity report, and additional physiotherapy and chiropractic records. At this time Dr. Travlos found that the plaintiff's physical symptoms had not changed except for right shoulder pain and left knee pain which were not present on the previous assessments. Although Dr. Travlos noted additional pre-accident issues related to her head, neck, chest, shoulders and back, he remained convinced that the accident had aggravated these injuries due to the decrease in function subsequent to the date of the accident. The one change to his opinion concerned the aggravation of lower back pain as accident related. Having examined new physiotherapy records from October 2007, it became apparent that the plaintiff complained of low back pain a week after the accident. Thus Dr. Travlos concluded that this pre-existing problem was probably aggravated by the accident.
- [49] While Dr. Travlos believed the plaintiff's functional capacity had improved over the past year, because she was working more hours, she continued to be more restricted physically than she was before the accident. Dr. Travlos says at p. 9 of his report:

It is my opinion that Ms. Dennis' level of function has improved despite a lack of change in symptoms, but she is yet to return back to her pre-accident level of activity. Her current global presentation is not out of keeping with her pre-accident presentation, but just the level of functioning is different and the degree of pain that she experiences is more.

- [50] Dr. Travlos continued to opine that the plaintiff's upper body symptoms were primarily soft tissue and muscular pain; she had no significant evidence of mechanical dysfunction of the neck and upper body. While the plaintiff probably had a mild thoracic outlet syndrome on the left side given her left hand tingling, it was felt that the symptoms were not significant

particularly because they were intermittent. The right hand numbness was related to carpal tunnel syndrome; however, Dr. Travlos opined this was not related to the accident. Although the plaintiff presented with a right shoulder impingement on the day of the assessment, Dr. Travlos opined that this was a new symptom and therefore not accident related. The mid to low back symptoms remained relatively unchanged. The left knee pain was not believed to be accident related. Dr. Travlos did not provide an opinion regarding the causal connection between chronic pain and alcohol dependence; however, he stated that alcohol abuse causes a reduction in a person's pain tolerance and sleep functioning. In cross-examination, Dr. Travlos agreed that while the plaintiff's subjective assessment of her pain was significant, he could find no areas of tenderness on examination. Dr. Travlos also agreed that it was unusual for the plaintiff's functional capacity to improve while her pain experience worsened. He agreed that his findings were highly dependent upon the plaintiff's truthfulness because pain cannot be measured.

- [51] Dr. Lu saw the plaintiff again on April 12, 2012, which led to his second report of the same date. At this time it was noted that the plaintiff's mood had improved to the point where she was observed as having only mild depressive symptoms. The improvement in her mood did not improve her functional capacity. Alcohol abuse worsened over the past year since the first assessment. She showed cognitive deficits in memory and concentration. She was now drinking six alcoholic beverages per day. Despite the worsening of her condition, the plaintiff was still only contemplating alcohol treatment.

PRE-ACCIDENT FUNCTIONING

- [52] The plaintiff's pre-accident level of functioning at work and socially is a very important aspect of her case. All of the pain symptoms she has experienced since the accident appear to be aggravations of pre-existing problems or injuries according to the plaintiff's expert witness, Dr. Travlos. Thus what she was able to do before the accident is critical to a determination of which, if any, of her post-accident symptoms were caused by the accident. Indeed, it is the comparison of her functional capacities that provides the underlying foundation of Dr. Travlos' opinion that the aggravation of the pre-existing injuries is causally related to the accident and is ongoing.
- [53] The plaintiff called witnesses to establish her pre-accident functional capacity. She also testified about her pre-accident work history and social activities. The plaintiff's mother, Ms. Hicks, testified that as a young girl and a teenager the plaintiff was very active. She loved to ride horses; cycled, skated, jogged, swam, and did aerobic exercise. She had lots of friends and always had a job in high school. She saved her money and was financially responsible. Ms. Hicks testified that she rarely saw her daughter drink alcohol. The plaintiff lived with her mother until she was 29 and at that point she purchased her own home. In those years she worked full-time in a hair salon and part-time at a Subway shop. Ms. Hicks testified that her daughter remained active physically and socially during these years after high school. In 1999, the plaintiff moved to Whistler and her mother remained living in Ontario. Thereafter

they had very little contact prior to the accident and, indeed, in the first four years after the accident. The plaintiff visited her mother for short periods once each year up to 2006 and they talked over the telephone. It was not until Ms. Hicks came to B.C. in May 2011 that she saw the change in the plaintiff's health and demeanour. She was shocked by her daughter's drinking, dramatic weight gain, and slovenly appearance. The plaintiff appeared very depressed and, while she was easygoing before, was now short tempered. The plaintiff was no longer happy and outgoing and did not appear to have friends.

- [54] Ms. Pino has known the plaintiff for eight years. They worked together at the Bee Hive hair salon commencing in 2003 or 2004. They worked five days per week together and during this time Ms. Pino had an opportunity to observe the plaintiff and how she worked. Ms. Pino testified that the plaintiff was a good worker; she was a hard worker and punctual. She did not notice that the plaintiff had complaints of physical pain or injury. Ms. Pino agreed that the job of a stylist is physically demanding because the stylist must stand most of the day and has to lift her arms above her shoulders while performing services for clients. She occasionally attended a chiropractor and a massage therapist for general fatigue in her shoulders, neck, back, feet and legs. From her perspective, the plaintiff had no difficulty with the physical demands of the job. The plaintiff left the salon shortly before the accident but Ms. Pino did not know why. The only time they socialized outside of work was during a cruise in 2005 when they went to Mexico. On the cruise the plaintiff had an occasional glass of wine at dinner but was never seen drunk. The plaintiff never came to work hung over. In cross-examination, Ms. Pino acknowledged that she knew nothing of the plaintiff's drinking habits. While she never noticed that the plaintiff was tired at work, Ms. Pino agreed she was busy at work with her own customers.
- [55] Ms. White testified that she owns the Bee Hive salon and met the plaintiff in 2003 when she came to work for her as a stylist. She started out working on commission (50% of her billings) and two years later she began renting a chair and working independently. She agreed that the job was physically demanding. Ms. White testified that the work bothered her back, neck and shoulders. She did "maintenance" with a chiropractor and a massage therapist to prevent problems developing in these areas.
- [56] Ms. White testified that the plaintiff was an excellent stylist who had amazing skills. She had a great many clients who always returned, which is a good sign that the stylist has talent. When the plaintiff left her salon in 2007, she was working full-time and had a long cancellation list. She was always punctual and rarely absent due to illness. Ms. White regarded the plaintiff as hardworking. She was oriented to making money and did not take much time off. She never came to work hung over and led a healthy lifestyle; she had good eating habits and set an example for others. While working at the Bee Hive, Ms. White observed that the plaintiff was very fit, did yoga, looked much younger than her age at 41, and was trim. She took care of her appearance. She did not observe any physical limitations regarding work. The only time they socialized together was during the 2005 cruise. Ms. White only saw the plaintiff have the occasional glass of wine on the cruise. Ms. White

testified that she had problems with the way that the plaintiff treated customers and that this problem ultimately led to the plaintiff leaving the salon. Ms. White had warned her about the way she treated customers on a couple of occasions and when the issue arose again she decided to terminate the plaintiff's arrangement. Termination ultimately did not become necessary because before Ms. White had a chance to meet with the plaintiff, she resigned voluntarily. Although Ms. White did not believe the plaintiff was more moody than other stylists, Ms. White agreed that the plaintiff's behaviour with clients was potentially damaging to her business.

- [57] Ms. Evans is the owner of Divas salon in Squamish. She rented the plaintiff a chair in her salon commencing in September 2007. In this first month before the accident, she observed the plaintiff was an excellent stylist; that she immediately had a full load of clients and worked a full day, five days per week. In that month Ms. Evans did not notice any physical limitations regarding her work. After the accident, Ms. Evans could tell that the plaintiff was in pain, which showed on her face. She walked slower and shuffled along. She hunched over. It appeared that her pain got worse over time and she began to lose her concentration. She forgot to lock the salon twice and forgot to close the window when she left. The plaintiff began to rest between clients and take time off to go to physiotherapy. She had difficulty with certain treatments and worked more slowly. She had more headaches and Ms. Evans had to be careful when talking to the plaintiff about problems in her work or behaviour. She became very sensitive and had little patience. The plaintiff decided to leave work in mid-February 2009, just after Ms. Evans moved her salon location. The plaintiff said she could not do the work anymore due to her injuries. While the plaintiff testified it was a leave of absence, Ms. Evans testified it was a permanent departure. The plaintiff gave Ms. Evans her client indexes and indicated she was no longer able to work as a stylist. Ms. Evans has only seen the plaintiff once since she left the salon and their contact was brief. She noticed a weight gain and loss of her healthy appearance. Ms. Evans agreed the job of a stylist was physically demanding and she also did maintenance work with a chiropractor, acupuncturist and massage therapist to address any problems with her shoulders, neck and back.
- [58] The plaintiff testified that she was very active while attending school. She played softball, worked out in the gym, swam, cycled, played squash, tennis and badminton, and went rollerblading. She also had part-time jobs from the age of 12 and worked every summer. After attending hairdressing school in Hamilton, Ontario, she worked as a stylist and also had part-time jobs to earn extra money. The plaintiff kept two jobs until she was 27 and at that point she worked exclusively as a stylist. During this period she remained physically active with jogging, yoga, skiing and aerobics. At 29 she purchased a home and renovated it. She had substantial savings and was able to loan money to her mother and stepfather when they went bankrupt.

- [59] In 1999, the plaintiff moved to Whistler and obtained work as a stylist. She also worked part-time at a snowboard shop. The move to Whistler was prompted by a desire to participate in the winter sports offered there such as skiing and snowboarding. While living in Whistler, she met many skiers and snowboarders and enjoyed a very active social life. She continued to participate in all types of sports, including skiing; she also did yoga, boxing and aerobics. The plaintiff became a Vegan and took natural supplements. She was fit and healthy. The plaintiff drank only the occasional glass of wine and three times per year she did a "cleanse" which meant abstaining from alcohol, sugar, fat, caffeine and dairy products.
- [60] In 2004, the plaintiff began working part-time at the Bee Hive salon in Squamish while she worked full-time in Whistler. It was her plan to move to Squamish and rent a chair at the Bee Hive rather than continue to be employed by the salon. In January 2006, she moved to Squamish and began working at the Bee Hive full-time as an employee. In 2007, she began renting a chair and worked independently.
- [61] The plaintiff testified that she felt the physical demands of the job were minimal and she enjoyed the mental aspects of the work; it was easy for her to talk to people and she made friends quickly. Many of her clients became personal friends. While she agreed the job was physically demanding for most stylists, the plaintiff testified that she was so fit prior to the accident that she hardly noticed any stress on her upper body. The plaintiff also testified that she went to see a physiotherapist or a massage therapist for maintenance of her neck and shoulders; however, there were no specific problems apart from a rib that caused her pain in the chest area and between her shoulder blades. She never lost time at work or missed out on sports and exercise due to any problems with her upper body prior to the accident.
- [62] The clinical records filed as exhibits in the trial do not support the plaintiff's evidence that the physical demands of her work only required occasional maintenance therapies. In October 2006, the plaintiff sought physiotherapy treatments for a tight neck and upper back that she attributed to work. The only physical activities she identified at this time were hiking and yoga. She returned to this clinic in March 2007 and September 2007 with further back and neck problems.
- [63] In May 2007, the plaintiff saw Dr. Broker, who is a chiropractor, for problems with her neck, tailbone, right side SI joint, headaches, dizziness, and jaw clicking. The plaintiff advised Dr. Broker that she had neck and upper back pain, as well as headaches, nausea and insomnia. She attended for chiropractic treatment 28 times between May 1 and September 25, 2007. In her history, the plaintiff disclosed that she had fallen off a horse five years previously and landed on her mid-back. The injury she suffered had gotten worse over the years. In addition, the plaintiff disclosed that ten years previously she fell while snowboarding and injured her pelvis, coccyx and hip. Further, at the time she was doing less exercise; biking and hiking with no mention of upper body work. Her sleep was poor and she woke up a number of times in the night. Dr. Broker's overall assessment included a nerve system imbalance associated with faulty posture; loss of normal range of motion in the neck, mid and low back; tenderness upon palpation in upper and mid neck, upper back, the base of

the ribs, low back and pelvis. She recommended a four and a half month program of therapy to deal with these overall problems and not just a "patch to the system". The plaintiff agreed and undertook this program which ended a week before the accident.

- [64] In addition to chiropractic therapy, the plaintiff was also attending physiotherapy during this period. While the plaintiff sought therapy for the chronic rib problem, on September 11, 2007, she also advised the therapist that she was having pain in her mid back, dizziness, sleep problems, and tingling in the hands. Her past history included rib pain, tailbone pain, and low back pain. The emergency department records from the date of the accident also indicate that the plaintiff advised the physician that she had a six month history of right-sided neck pain.
- [65] Dr. Travlos' summary of the clinical records in his November 26, 2010 report also indicates a significant history of pre-accident neck, shoulder and back pain. In March 2000, the plaintiff reported a two-year history of bilateral shoulder pains and right elbow pains to the Whistler Medical Clinic. She attributed these problems to her work as a stylist. Physiotherapy records from 2000, 2002 and 2005 indicate a history of low back pains and shoulder symptoms going back for six years. When the plaintiff saw Dr. Zentner in September 2006 for heart palpitations, she complained of dizziness for several years, headaches, fatigue, shortness of breath, chest pain, and tingling in her hands and feet. In October 2009, the plaintiff saw Dr. Johnston and advised him that she had a history of tendonitis in her right shoulder which was related to work. In October 2007, the plaintiff advised Tantalus Chiropractic that she had a past history of tailbone pain for eight years.
- [66] The plaintiff acknowledged that in 2004/2005, she had a bout of depression and was on medication for six months. She testified that her recovery was complete after eight months. The cause of her depression was limited to a relationship problem and a dispute over a car purchase. She purchased a used car that turned out to be a "lemon". When she attempted to stop payment on the Visa cheque, she was not successful and Visa sued her on the debt. The Whistler Medical Clinic records indicate that the plaintiff was prescribed Celexa in 2004 and that she had a follow-up in June 2005, at which time she had gone off this medication.

POST-ACCIDENT FUNCTIONING

- [67] The plaintiff testified that at the time of the accident she was fit and weighed 130 pounds. At the present time her weight is 170 pounds. She stated that the weight gain is due to her alcohol consumption, lack of exercise, poor eating habits and insomnia. She is now drinking 12 to 18 beers per day. Today she is left with right-sided neck pain that travels down into the shoulders; headaches in the occipital region that are constant and vary in their intensity; mid and low back pain, hip pain and left knee pain. The pain experienced precludes the plaintiff from working full-time hours as a hair stylist or in any other occupation. The numbness in her hands and left arm continues to interfere with sleep and work. The chronic pain has led to mood changes and bouts of irritability. She became depressed within six months of the accident and continues to be severely affected by depression. She has become

a recluse and no longer sees her friends. She is anxious, afraid to drive, and is very emotional. The plaintiff stopped caring about her appearance and how she dressed. She is alcohol dependent.

- [68] The plaintiff no longer enjoys any of the sports she did prior to the accident. She does some yoga for pain management and she hikes with dogs that she looks after. Her work as a stylist is reduced to five or six clients per week and she has recently obtained work walking dogs and looking after horses. She can also board a dog in her home. If she increases her hair clients then she experiences more neck pain and other symptoms.
- [69] Mr. Shew, who is an occupational therapist, performed a functional work capacity evaluation on the plaintiff as of April 2011 and updated this assessment as of April 2012. During the first assessment, Mr. Shew observed no abnormal pain behaviours and the plaintiff's statement of her capacities generally matched his examination findings while she showed good effort throughout the testing. Overall, Mr. Shew concluded that the plaintiff met the physical demands for the job of hair stylist; however, due to problems with extended or repetitive standing, forward reaching and overhead reaching, as well as bending and stooping, it was doubtful that she could sustain the ability to function competitively on a full-time basis in this job. It was his opinion that the plaintiff was capable of working part-time in this capacity with accommodations such as periodic rest breaks. During the second assessment in April 2012, Mr. Shew observed clinically significant reductions in the plaintiff's cervical and shoulder mobility, upper extremity strength, lower extremity strength, bilateral grip strength, her capacity to tolerate activities requiring standing, overhead reaching, forward reaching, bending, stooping, crouching and squatting. Her cardiovascular fitness had declined along with her capacity for two hand lifting. However, these changes did not appear to affect his original conclusions concerning the plaintiff's work capacity.
- [70] Mr. Nordin, who is a vocational evaluator, assessed the plaintiff in June 2011 and updated this assessment in April 2012. Mr. Nordin concluded that while the plaintiff was a very intelligent person who could have considered careers requiring a university education, at the age of 46 and having worked her entire adult life as a hair stylist, she could not be expected to pursue alternate work as long as she could still continue as a stylist in some capacity. Further, he concluded that her ongoing problems with chronic pain and depression would interfere with her ability to work full-time as a stylist and would likely prevent her from increasing her hours beyond the five to six hours per week she now works in this capacity. Other occupations for the plaintiff were limited by her lack of education, age, and her residence in a small community. During the second assessment in April 2012, Mr. Nordin noted that the plaintiff had significantly increased her hours of work through dog walking and horse care. Her stylist work hours remained the same. Further, Mr. Nordin opined that in light of the plaintiff's chronic pain, alcoholism and depression, retraining was not a viable option. Until these problems were addressed, he did not see any improvement in her vocational outlook.

- [71] The plaintiff has not yet committed to detoxing from her alcohol addiction and has not attended any form of therapy for this addiction. The plaintiff is concerned about her alcohol consumption but appears to believe she can deal with this problem on her own. She has considered residential therapy and has investigated this option on the internet. The plaintiff does not wish to attend AA or other group therapies in Squamish because of a fear of meeting someone she knows. She has not attended AA in North Vancouver or elsewhere.

DISCUSSION

A. General Damages for Pain and Suffering

- [72] The plaintiff argues that the accident has had a dramatic and devastating impact on her physical and mental health; she now suffers from chronic pain, major depression and alcoholism. She has consistently experienced pain from her neck, shoulders, and back since the accident and this pain remains with her today. The consistent medical prognosis for the future is poor. She is not expected to improve her current condition. The plaintiff says she has not only lost the ability to earn a living in her chosen profession, but she has also lost the ability to engage in the many sports she did before the accident. She has lost all her friends and has no social life. She has gained weight and is no longer interested in her personal appearance. The plaintiff argues that since the accident, the financial stress has led to a loss of self-esteem, depression and alcoholism. Citing *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229; *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.); *Dikey v. Samieian*, 2008 BCSC 604; and *Stapley v. Hejslet*, 2006 BCCA 34, the plaintiff says in light of her age, the nature of her injuries, their severity and pain, her emotional suffering and impairment of work and social life, she is entitled to damages of \$180,000 for pain and suffering. Further, the plaintiff says this range of damages is supported by the similar circumstances found in *Felix v. Hearne*, 2011 BCSC 1236; *Zawadzki v. Calimoso*, 2011 BCSC 45; *Cantin v. Petersen*, 2012 BCSC 549; *Eccleston v. Dresen*, 2009 BCSC 332; *Williamson v. Suna*, 2009 BCSC 576; and *Shapiro v. Dailey*, 2010 BCSC 770.
- [73] The defendant argues that while the plaintiff suffered a neck strain as a result of the accident, it was a mild strain that would have been fully rehabilitated in a few months at most. The defendant says there are no objective signs of continuing injury and further, that the plaintiff has shown a paucity of real symptoms since late 2008. Due to her lack of credibility, the defendant argues the underlying basis for the medical opinions supporting chronic pain cannot be accepted as accurate. The defendant argues there is no credible evidence that the plaintiff's alcoholism is related to the accident and further, says that the evidence supports a conclusion that the plaintiff had an alcohol problem before the accident. The defendant says the plaintiff may have developed new problems that impacted her ability to work; however, these are not related to the accident. Lastly, the defendant argues the plaintiff's case for an aggravation of existing injuries depends entirely on evidence that she was fully functional prior to the accident. In this regard, the defendant says no witnesses were called to corroborate the plaintiff's description of her pre-accident

social life and her sports. In support of an adverse inference, the defendant cites *McTavish v. MacGillivray* (1997), 38 B.C.L.R. (3d) 306 (S.C.) and *Hodgins v. Street*, 2009 BCSC 673.

- [74] The defendant says general damages should be no more than \$40,000 and argues for a range of \$30,000 to \$35,000. In support of this figure, the defendant relies upon *Korliuk v. Miller*, [1984] B.C.J. No. 702 (S.C.); *Sharma v. Didiuk*, 2010 BCSC 280; *Eng v. Titov*, 2012 BCSC 300; *Paradis v. Gill*, 2011 BCSC 1414; *Wepryk v. Juraschka*, 2012 BCSC 974; and *St. Germain v. Jemmott*, 2012 BCSC 1041.
- [75] To properly assess general damages in this case, the court must distinguish between those injuries caused by the accident and those injuries or illnesses that are unrelated to the accident. Dr. Travlos' expert medical evidence supports a conclusion that the plaintiff suffered an aggravation of pre-existing neck, shoulder and back injuries that were likely caused by her work as a hair stylist. The pre-accident clinical records are consistent with pre-existing significant pain and injury to the plaintiff's neck, shoulders and back with all of the same consequential symptoms including headaches, dizziness, nausea, numbness and tingling in her hands and arms. Superimposed upon these areas of chronic pain are the illnesses of depression and alcoholism diagnosed by Dr. Swope and Dr. Lu.
- [76] Dr. Travlos testified that, in terms of the chronic pain symptoms, the plaintiff's pre and post-accident condition is the same except that since the accident she has had a greater pain experience from her injuries and a reduction in her functional capacities. The basis for his opinion that the plaintiff continues to experience an aggravation of her pre-existing injuries caused by the accident is that she is not capable of working full-time as a hair stylist, when before the accident she was completely functional at work. This conclusion is entirely dependent upon the credibility of the plaintiff's subjective assessment of her pain and the evidence surrounding her functional capacity prior to the accident.
- [77] I have serious reservations about the credibility of the plaintiff's evidence overall. The plaintiff was clearly untruthful with her physicians regarding her past history of injuries and the symptoms she experienced as a result of those injuries. The fact that she completely denied any prior injuries to her neck, shoulders and back undermines the credibility of her evidence as a whole due to the significance of these injuries and their role in the formulation of Dr. Travlos' opinions. These injuries were not minor problems that resolved long before the accident. The plaintiff experienced serious and ongoing neck, shoulder and back problems immediately prior to the accident. Indeed, she completed a four and a half month program of chiropractic treatment a week before the accident. Further, there were no new injuries caused by the accident. Dr. Travlos could only go so far as to say her pre-existing injuries were aggravated by the accident. Thus this misstatement of the truth is fundamental to my assessment of the strength of the claim. It is also important to note that the plaintiff continued to minimize the nature of her pre-accident injuries during her testimony in spite of Dr. Travlos' conclusions and offered explanations for her failure to be candid with her doctors that lacked credibility.

- [78] In addition to this serious credibility issue, the plaintiff's subjective assessment of her pain experience has often been inconsistent with the physical examination findings of her own physicians and the insurer's physician, Dr. McPherson. Dr. Travlos referred to a paucity of symptoms and to a lack of tenderness in areas where the plaintiff expressed significant pain during his examinations of the plaintiff. Further, Dr. Swope, who examined the plaintiff regularly in the first two years after the accident, noted variations in range of motion and other objective signs of injury. Sometimes the plaintiff's cervical range of motion was far more restricted than at other times when it was deemed to be normal. While this variation could be explained by activities that aggravated her condition at various times, the plaintiff advised her physicians that her neck pain and restricted functioning had not changed over time and that it was always a problem. Moreover, it is logical to conclude that the plaintiff would be visiting her family doctor when her injuries were problematic rather than when they were improving or non-symptomatic.
- [79] The plaintiff's description of constant severe pain and limited function is inconsistent with her initial reports to her doctor and to her therapists in October 2007 that the neck pain was improving. The hospital records clearly indicated a minor injury to the neck that is inconsistent with the plaintiff's description of her pain and functional limitations. Further, indications in the April and May 2008 physiotherapist's records that there was some sustained improvement in her pain symptoms were denied by the plaintiff or minimized.
- [80] The plaintiff testified that her functional capacity was limited in two specific ways. First, she could no longer participate in her pre-accident sports and activities due to the pain she suffered and the physical limitations placed on her by these injuries. Apart from the plaintiff's testimony, however, there is no cogent evidence to corroborate her description of pre-accident activities outside work. Ms. Hicks had no recent personal knowledge of her daughter's sports and activities. None of her work colleagues socialized with the plaintiff outside of the salon. No witness was called to testify about the plaintiff's skiing, snowboarding and jogging activities prior to October 2007. In addition, the number and frequency of these activities, as described by the plaintiff, appear to be greatly exaggerated in light of her evidence that up until 2006 she was essentially working seven days per week. The plaintiff's description of her pre-accident activities is also inconsistent with her history of therapies for back, shoulder, chest and neck problems. I note, in particular, that her description of activities in the various therapy records is far more restricted than the plaintiff's testimony concerning her pre-accident activities. It is also significant that Dr. Travlos did not consider the plaintiff was disabled from her usual recreational activities. He recommended that she become more active and return to sports and other activities. Thus it is difficult to accept that either there was such a rigorous recreational life before the accident or that the plaintiff was precluded from these activities after the collision.

- [81] Second, the plaintiff testified that she was completely functional at work before the accident and this changed drastically thereafter. The evidence of Ms. Pino, Ms. White, and to a lesser extent, Ms. Evans, supports the plaintiff's testimony that she had no difficulty with her work prior to the accident despite ongoing injuries to her neck, back and shoulders. However, the plaintiff's income pre and post-accident up until the end of 2008 does not support a drastic change in her earnings consistent with a loss of functional capacity.
- [82] Annual income must be regarded as the key determinant because there is no clear evidence of the number of hours the plaintiff worked each day before or after the accident. The calendars entered as evidence of wage loss indicate the hours the plaintiff was in the salon, but do not indicate the hours spent actually working with clients. Significantly, the plaintiff was unable to produce any of her records for January to August 2007 to show her hours of work and monies earned. While the collateral witnesses testified that the plaintiff worked full-time before the accident, their estimates of her earnings based on full-time hours do not match the plaintiff's actual earnings in those years. In this regard, the work colleagues testified that if the plaintiff had worked full-time after the accident she could have earned, realistically, \$350 to \$400 per day or \$8,000 per month. Indeed, for the month of September 2007, the plaintiff earned \$7,585 working full-time. Yet, even adjusting this estimate to reflect net earnings, on an annual basis the plaintiff never earned this level of income before the accident while working as an employee or as an independent contractor under a chair rental arrangement. Again, attempting to compare the September 2007 earnings with the prior months in 2007 that the plaintiff worked as an independent contractor is impossible because none of the records were produced.
- [83] In his expert report dated May 14, 2012, Mr. Carson, who is an economist, summarized the plaintiff's past employment earnings at p. 3. In 2003, the plaintiff reported net earnings of \$28,800; in 2004, she reported net earnings of \$42,706; in 2005, her net earnings were \$44,596; in 2006, her net earnings and profits were reported as \$33,084; in 2007, her net business income and employment earnings were reported as \$43,834; and in 2008, her net business earnings were reported as \$46,588. Cash tips may have explained the difference between the estimates provided by the work colleague witnesses and the reported income; however, the plaintiff testified that she always included her tips in her income tax returns. While she testified that 2006 income was reported incorrectly, the plaintiff was unable to provide a correct figure and Ms. White was not examined on the possibility of an error in a T4 given to the plaintiff for that year. When one converts these annual income figures to 2012 dollars, as Mr. Carson did in his May 14, 2012 report at p. 3, it is apparent that 2008 was the plaintiff's best income year since 2005. The difference between 2005 and 2008 income (\$53,583 - \$51,254 = \$2,329) is essentially nominal and does not suggest any significant reduction of work hours between those years.
- [84] The plaintiff testified that she left work in February 2009 because she was not able to handle the physically challenging work as a stylist. However, her income for 2007 and 2008 was significantly greater than her 2006 income when she worked full-time hours. Moreover, the

fact that the plaintiff was able to maintain her level of earnings for over a year after the accident while attending multiple therapy sessions and doctors' appointments is inconsistent with a decline in her functional capacity. Accordingly, it is difficult to accept that the plaintiff was any more functionally impaired vis-à-vis her work after the accident than she was before the accident.

- [85] It is significant, in my view, that the plaintiff's physicians did not recommend that she leave work. I note parenthetically that the plaintiff falsely advised Dr. McPherson that her family doctor had recommended that she leave work. While Dr. Swope agreed with her decision after the fact, her opinion was based on the plaintiff's subjective assessment that she could no longer handle the duties of the job. This assessment was not supported by the income the plaintiff earned in 2008 or the continuing loyalty of her clients. In this regard, the plaintiff advised her therapists on more than one occasion that she was very busy and was working long hours during 2008 and early 2009. Dr. Travlos was also concerned that the plaintiff had left work; he felt she should be doing more rather than less and that she should go back to her normal social and recreational activities. Even Mr. Shew's work capacity assessments did not support the plaintiff's decision to leave work entirely. He was of the opinion that the plaintiff could continue to work part-time as a stylist.
- [86] For these reasons, I am unable to conclude there is an evidentiary foundation for Dr. Travlos' opinion that despite having the same pre and post-accident injuries, the plaintiff is experiencing ongoing and enhanced pain and more functional limitations as a result of an aggravation of these injuries caused by the accident.
- [87] Turning to the superimposed illnesses of depression and alcoholism, I find there is insufficient, cogent evidence to establish a causal connection between these illnesses and the accident. While there is evidence that people who suffer from chronic pain can develop depression and alcohol dependence in response to the pain experience, there is a lack of evidence to establish a causal connection on the facts of this case. The plaintiff did not raise any concerns about her mood or her alcohol dependence with her physicians until December 2009 during an unrelated consultation with Dr. Zentner when asked about alcohol consumption and in December 2010, when she reported symptoms of depression to Dr. Swope. Thus there is a significant time gap.
- [88] Further, the only evidence of when and how the plaintiff began drinking to mask the pain subsequent to the accident is the plaintiff's testimony, which is significantly inconsistent. The plaintiff's disclosure to Dr. Zentner in December 2009 that recently her consumption of alcohol had increased to two or three glasses per day is not consistent with her testimony that since the accident she was consuming the same amount or more each night. The plaintiff's testimony regarding the motivation for drinking is also inconsistent with her description of her past history with alcohol and her pre-accident injuries. The plaintiff testified that growing up with an alcoholic stepfather taught her to fear alcoholism and steeled her against becoming alcohol dependent as an adult. Prior to the accident she rarely drank and often abstained entirely. This positive attitude toward a healthy lifestyle and

aversion to alcohol generally is quite inconsistent with a decision to immediately resort to drinking to lessen pain and improve sleep after the accident. Surely it would have taken some considerable time to break down a resolve to abstain from alcohol consumption that had sustained the plaintiff until she was 42 years old. The plaintiff's description of how the drinking began is also inconsistent with a failure to develop alcohol dependence when faced with a similar history of chronic pain in her neck, shoulders and back prior to the accident. Lastly, the plaintiff's evidence that she immediately began drinking alcohol for pain reduction after the accident is inconsistent with the fact that her neck pain was actually improving in early October 2007, just a few days after the accident.

- [89] I am also satisfied that there were many other stressors in the plaintiff's life, apart from the injuries related to the accident, that are far more likely to be connected with her depression and alcoholism. The plaintiff had difficulties in her workplace; she left the Bee Hive because of disputes with clients that threatened the salon's business. Had she not left voluntarily, Ms. White would have terminated her arrangement with the plaintiff. The plaintiff had significant financial problems. Her condominium leaked and she needed to raise \$65,000 to pay for her share of the repairs. There was also an ongoing dispute with Visa over a \$6,000 debt that led to a protracted lawsuit. She was behind on her mortgage, strata fees and income tax. It is significant that during the counselling sessions the plaintiff attended in 2011 and 2012, the subject of the accident never came up and pain was mentioned only once in the context of the plaintiff's decision to go back to yoga for pain management. It was alcohol, relationships and financial problems that arose before the accident or were unrelated to the accident that formed the basis of her discussions with the counsellor. In addition, the plaintiff had a prior bout of depression in 2004 and 2005 that stemmed from financial worries and the troubling Visa lawsuit. She also had a significant family history of depression that created a risk for developing this illness.
- [90] While I find the evidence of Dr. Lu establishes that the plaintiff currently suffers from depression and alcoholism, I am unable to conclude on a balance of probabilities that these illnesses have a causal connection to the accident or to the injuries caused by the accident. Dr. Lu's opinions about the causal connection to the accident are highly dependent upon the veracity of the plaintiff's description of her chronic pain and its origins. As described above, the plaintiff has been dishonest with her physicians and has provided inconsistent evidence at trial. I found she was not a credible witness. Her explanations for these inconsistencies were neither candid nor reasonable. Dr. Lu agreed that alcoholics do not tell the truth about their drinking and try to appear functional when they are not. He testified that an alcoholic's ability to work is the last to go. Thus the failure to call any corroborating witnesses outside of the workplace to describe the plaintiff's drinking habits before the accident is a significant omission. I accept that the plaintiff may have lost contact with friends since the accident; however, this fact does not explain why she could not approach one of them to testify on her behalf about her pre-accident health and lifestyle. In all of the circumstances, it would be unsafe to accept the plaintiff's description of her alcohol consumption as accurate either before or after the accident without some corroborating evidence. None of

the collateral witnesses had any real knowledge of the plaintiff's drinking habits because they did not socialize with her outside of the workplace. They could only say that she did not appear to come to work hung over. Ms. Hicks had no direct contact with her daughter until four years after the accident.

- [91] Accordingly, for these reasons I find that the plaintiff has failed to prove on a balance of probabilities that her current alcoholism and depression is causally related to the accident. The evidence, at best, establishes that the plaintiff suffered an aggravation of her pre-existing neck, shoulder and back complaints. The aggravation of these injuries did not result in a significant change to her functional capacity over time. There is no evidence to support a reduction of income or work in the first 16 months after the accident. The medical records indicate an aggravation of neck pain that led the plaintiff to seek various rehabilitative therapies. However, given the mild nature of the initial aggravation, the paucity of objective signs of injury, and the lack of veracity in the plaintiff's description of her pain and suffering, I find there is no evidence to support any continuing impact caused by the accident after the first 12 months or the end of 2008 at the latest. Dr. Travlos' physical examination in October 2008 supports this conclusion; at that time he found the plaintiff had full strength in her upper extremities and normal range of motion in her neck.
- [92] What occurred after this period is not causally connected to the accident and is likely due to the pre-existing injuries the plaintiff suffered from after years of working as a hair stylist. Ms. Pino, Ms. White and Ms. Evans agreed that the job is very physically demanding, particularly on the upper body. Working with one's arms above the shoulders for long hours over many years causes significant and ongoing pain in the neck, shoulders and back. All of the workplace collateral witnesses required regular maintenance therapies to remain functional in the job. They are all younger than the plaintiff and had not worked as stylists for as many years as she had. The medical evidence is also consistent with a finding that the work of a stylist creates a risk of upper body injury. Lastly, it is significant that the plaintiff now suffers from upper body and knee injuries that are clearly unrelated to the accident. These difficulties, particularly her right shoulder tendonitis, would seriously undermine her ability to work as a stylist on a full-time basis.
- [93] I have reviewed the authorities cited by the parties regarding the range of damages for pain and suffering. The amount of damages argued by the defendant is close to the appropriate range given the duration of the pain causally related to the accident, the nature of the injuries as an aggravation of existing injuries, the age and circumstances of the plaintiff and the minimal proven restrictions on her functional capacity. Bearing the circumstances in mind, I award \$40,000 for pain and suffering.

B. Past Wage Loss

- [94] The plaintiff argues that past wage loss should be awarded based on a projection of what she could have earned as a stylist while working full-time up to the date of trial. The plaintiff calculates the wage loss for these years on alternative bases: (1) the income she earned at

Divas in September 2007; (2) the income she could have earned at the Bee Hive according to the evidence of Ms. White and Ms. Pino, which was \$8,000 per month; or (3) the average of her income over the years prior to the accident with the exception of 2003 and 2006, which is inexplicably low. The loss of wages claimed varies from a low of \$158,479 to a high of \$282,706, depending on which method of calculation is used. The plaintiff argues the loss is not proven on a balance of probabilities but on a reasonable possibility test: *Piper v. Hassan*, 2012 BCSC 189.

- [95] The defendant argues that past wage loss is in the range of \$4,000 based on an average of her past income levels adjusted to 2012 dollars.
- [96] In my view, there is a lack of evidence to support a claim for past wage loss beyond the figures argued by the defence. It is speculation to project an income of \$7,500 to \$8,000 per month based on a single month's earnings in September 2007. The income Ms. White testified that the plaintiff could have been earning when she left in the fall of 2006 is clearly an overstatement. In 2006, the plaintiff earned \$38,623 in 2012 dollars working full-time hours. While she worked only part of the year as an independent contractor, the plaintiff's income in 2007 was only \$49,481 in 2012 dollars. Ms. White's estimate was not based on any records she kept of the plaintiff's earnings. Instead, it was based on what she was earning at the time. The plaintiff's income for 2008 was \$51,254 (based on 2012 dollars). This is significantly higher than her 2006 and 2007 income. It is only if one ignores 2003 and 2006 that an average of the plaintiff's income during 2004 and 2005, based on 2012 dollars, results in an actual loss of wages before December 30, 2008. The total amount according to Mr. Carson's Table 2 in his May 14, 2012 report is \$2,380 for 2007 and \$1,342 for 2008.
- [97] I have concluded that the plaintiff was no longer suffering from an aggravation of her pre-existing injuries 12 months post-accident or at the latest at the end of 2008. Up to this date there is no evidence of a substantial wage loss due to her injuries. The plaintiff left Divas salon in February 2009 and thereafter her income was quite nominal throughout 2009 and 2010. However, there is no evidence to support a conclusion that the plaintiff left work as a result of the aggravation of her injuries caused by the accident. Moreover, the decision to leave work entirely was not supported by Dr. Travlos or by Mr. Shew's assessment of the plaintiff's work capacity. In their view, the plaintiff could work part-time as a stylist despite her injuries. Her income in the months of January and February 2009 was no less than her monthly earnings in 2008. Thus there is little evidence that her condition was worsening in terms of functional capacity.
- [98] I have some reservations concerning Mr. Carson's opinion that the plaintiff's earnings in 2004 and 2005 reflect her earning capacity absent the accident due to the lack of any cogent explanation for the low income for 2003 and 2006; however, the defendant does not appear to take issue with Mr. Carson's expert evidence. Accordingly, I award past wage loss on the basis of an average net income of \$53,383 in 2012 dollars. In the year 2007, the loss is \$2,380 and for 2008 it is \$1,342.

[99] I thus award \$3,722 for past wage loss.

C. Future Loss of Earning Capacity and Cost of Future Care

[100] In light of my findings that the plaintiff recovered from the aggravation of her pre-existing injuries within 12 months of the accident, I am unable to conclude there is a future loss of earning capacity or a basis for awarding future care costs. I thus make no award under these headings.

D. Special Damages

[101] The plaintiff's special damages must be limited to those incurred within the first 12 months of the accident or, out of an abundance of caution, until the end of 2008. Further, there should be no recovery for items that are not supported by a receipt due to my assessment of the plaintiff's credibility. The book of special damages marked as an exhibit in this proceeding is representative of the costs expended by the plaintiff to date. I award the cost of medications up to the entry for October 28, 2008; the cost of therapies up to the entry for December 22, 2008; the veterinarian bill for \$174.69 and parking of \$6. I cannot award the cost of the pillow as there is no date on the receipt and the mileage claim is not recoverable because there is no breakdown by date. I will leave the total to the parties to calculate and retain jurisdiction to resolve any dispute regarding this matter.

MITIGATION

[102] There is no evidence that within the first year after the accident the plaintiff failed to mitigate her loss. The plaintiff regularly saw her family doctor, submitted to specialist investigations, exercised, and attended for physiotherapy, chiropractic and massage therapies to the point where her physicians felt they were no longer necessary or helpful.

COSTS

[103] The plaintiff is entitled to her costs and disbursements at Scale B. If there is any dispute as to costs, I retain jurisdiction to resolve the matter.

"Bruce J."

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