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CANADA / JUDGMENT

## Fancy v. Gareau

2014 BCSC 584

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COURT

Supreme Court of British Columbia

DECIDED

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2014 BCSC 584 Fancy v. Gareau

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Fancy v. Gareau,

2014 BCSC 584

Date: 20140404

Docket: 1037867

Registry: Prince George

Between:

Grace Fancy

Plaintiff

And

Anne M. Gareau and Marie B. Gareau

Defendants

Before: The Honourable Mr. Justice Parrett

Reasons for Judgment

Counsel for the plaintiff:

K. Fisher and K. Vicei

Counsel for the defendants:

D. A. McLauchlan

Place and Date of Trial:

Prince George, B.C.

March 19, 20, 21 and 22, 2012

Place and Date of Judgment:

Prince George, B.C.

April 4, 2014

## INTRODUCTION

- [1] This action is brought by the plaintiff to recover damages from injuries she says she suffered as a result of a motor vehicle collision.
- [2] The defendants, while admitting the details of the collision itself and their liability arising from the negligence of the driver, Anne M. Gareau, deny that the plaintiff suffered any injury in the collision or any damages as a result.

## BACKGROUND

- [3] On September 30, 2008 the plaintiff, Grace Fancy, was driving her husband's 2003 Chevrolet Suburban west on North Nechako Road and was about to make a right hand turn to head north on Foothills Blvd. when she stopped suddenly for oncoming traffic. At this point her vehicle was struck from behind by a 2000 Buick Century owned by the defendant Marie B. Gareau and driven by the defendant Anne M. Gareau.
- [4] The collision was a low impact collision which resulted in only minor, primarily cosmetic damage, to the two vehicles. Neither of the plaintiff's passengers, her 71 year old father-in-law nor her 16 year old son, were injured.
- [5] At the time of the motor vehicle collision which is the subject of this proceeding, the plaintiff was 46 years of age, at trial she was 50 years old.
- [6] The plaintiff was born on February 19, 1962 and has been married to Christopher Fancy since 1988. They have three children, who at the date of trial were aged 21, 19 and 15 years.
- [7] In this action the plaintiff seeks to recover non-pecuniary damages, past wage loss and special damages. Claims for loss of housekeeping capacity and loss of earning capacity were abandoned.
- [8] The central issue at this trial arises from the fact that the plaintiff, who at all material times was employed as an Administrative Assistant with the Northern Health Authority, was injured in a workplace incident on July 8, 2008.

- [9] At the time of the present motor vehicle collision the plaintiff was participating in a graduated return to work program and was receiving WorkSafeBC wage loss and health benefits.
- [10] On September 30, 2008 at the time of the collision the plaintiff was, in fact, returning to her home from a physiotherapy appointment.
- [11] The plaintiff suffered no wage loss while she was receiving WorkSafeBC benefits and under the collective agreement she received wage loss benefits of 75% of her regular wage following the motor vehicle accident. In addition, the plaintiff received health benefits through her extended health plan which is administered by Pacific Blue Cross. These latter two coverages give rise to subrogation claims.
- [12] The major issue raised by the defence is, as previously indicated, their denial that the plaintiff was injured or suffered damages as a result of this collision.
- [13] This defence arises in the main from the existence of the previous injury arising from the workplace incident, and what the defence submits is a failure of the plaintiff to establish that any injury in fact occurred as a result of the September 30, 2008 collision.

## THE EVIDENCE

- [14] During the course of this trial four witnesses were called, all on behalf of the plaintiff. Three of these witnesses consisted of the plaintiff, her husband and their 21 year old daughter who resides with them.
- [15] The only other witness called was a physiotherapist, David Ronald Fleming, who began seeing the plaintiff in July 2008. He was neither tendered nor qualified as an expert witness.
- [16] In addition to these witnesses, the plaintiff tendered the medical report of Dr. G.M. McKenzie.
- [17] The balance of the evidence received in this case consists primarily of documents received and admitted pursuant to the terms of a Document Agreement reached by the parties. This was filed as Exhibit #5.
- [18] I will set forth in these reasons the body of that Document Agreement:

It is agreed between the parties to the Supreme Court of British Columbia Action No. 1037867, Prince George Registry, that the use of clinical medical documents, Northern Health employment records and WorkSafeBC case management records (collectively the "Documents") contained in the Plaintiff's and Defendant's Document Briefs shall be as follows:

1. A photocopy of any Document will be presumed to be [a] true copy of the original and is admissible without proof of the original document.

2. The Documents are admitted into evidence on the basis that the Documents are documents made and kept in the usual or ordinary course of business from which they were originally obtained. The Documents are admitted as prima facie proof that any fact personally observed and recorded occurred, or that the statements personally observed and recorded were made. Statements recorded in the Documents are not admitted for their truth.
3. The parties reserve the right to challenge the accuracy of any fact or statement recorded in the Documents.
4. The parties reserve the right to submit to the Court that individual statements recorded in the Documents are admissible for their truth as an exception to the hearsay rule.
5. The Documents are not admitted for the purpose of proving any opinion stated therein.
6. Any opinion to be relied upon must be provided in the ordinary way pursuant to Rule 121 of the Rules of Court.

- [19] The terms of the Document Agreement are important to a consideration of this case for the contents of the three binders, filed as Exhibits 1, 2 and 3, are almost exclusively clinical notes and records of the University Hospital of Northern British Columbia, the Nechako Medical Clinic, those of various doctors and other medical professionals as well as some employment records of Northern Health Authority and the WorkSafeBC records related to their claim #081\*\*\*\*5.
- [20] What is perhaps most notable from this short summary is the complete absence of any evidence, viva voce or by report, from the plaintiff's family doctor, Dr. Burns, who was treating the plaintiff both prior to and after both the workplace injury and the motor vehicle collision.
- [21] The absence of the evidence of Dr. Burns either testifying or providing a report leaves the court without the evidence of the doctor who both assessed and treated the plaintiff immediately after both events and was most familiar with the plaintiff's medical condition before both events.
- [22] It should also be noted that after the motor vehicle collision on September 30, 2008 the plaintiff attended a walk-in clinic before seeing her family doctor.
- [23] The sequence of these events is of some interest. Shortly after reaching her home on September 30, 2008 the plaintiff reported the accident to ICBC and as well apparently reported the fact she was injured. She testified that she ". . . felt sore, that her low back and upper back were sore . . ."
- [24] At the time of the motor vehicle accident the plaintiff was returning home from a 2:00 p.m. physiotherapy treatment. The following day, Wednesday October 1, 2008, she went to work for the five hour shift she was working under her graduated return to work program. The next day she testified she was sorer but according to her calendar she again worked her five hour shift after attending a scheduled 8:00 a.m. appointment at the hospital for a CAT scan

procedure. Later that day, October 2, 2008, she attended at the Nechako Medical Clinic where she was seen on a walk-in basis by Dr. Murray.

- [25] The attendance report of this visit is found in Exhibit 1, Tab A (2). The report consists of approximately 30 largely illegible handwritten words. Under the heading History and Physical there is written "Neck/lower back stiffness" followed by a series of cryptic notations. Below that, under the heading Diagnosis, it appears that the words "muscle spasm" are written.
- [26] Dr. Murray was, of course, not called to testify and no report from him was introduced.
- [27] The evidence is unclear about the events of Friday October 3, 2008. The plaintiff's calendar (Exhibit 6) notes that she apparently worked 5 hours but then notes beside it that she was apparently "off work" and then attended physiotherapy.
- [28] On Monday October 6, 2008 the plaintiff met with an ICBC adjuster, apparently at 10:00 a.m. while apparently working her 5 hour shift. She apparently attended physiotherapy later that day and again on October 8, 2008.
- [29] It seems clear from the clinical records that she saw her family doctor, Dr. Burns, on October 6, 2008, one week after the motor vehicle collision. As I have previously observed, no evidence was presented from him or Dr. Murray.

## SUBMISSIONS

### The Plaintiff

- [30] In their submissions on behalf of the plaintiff counsel conceded that in this case the court must assess the plaintiff's credibility. She went on to submit that the plaintiff ". . . is not someone who enjoys confrontation".
- [31] They went on to submit that the plaintiff's symptoms are ongoing and that in pursuing her Workers Compensation claim ". . . they were not seeking compensation for a neck injury . . ." and that by attempting to parcel her injuries into two separate claims made it appear that this was the case.
- [32] The plaintiff submits that her evidence was that she not only suffered increased or aggravated symptoms as a result of the motor vehicle collision but also suffered new injuries.
- [33] In support of this submission, plaintiff's counsel referred to p. 9, para. 4, of the opinion of Dr. G. M. McKenzie which reads:
4. She developed an increase in her pre-existing symptoms and also developed new complaint of pain in the left side of her neck.

- [34] Counsel went on to submit that the evidence of the plaintiff's daughter "should be believed" and supported the conclusion that the plaintiff was injured.
- [35] The plaintiff submits that her neck injury was entirely from the motor vehicle collision and that in the collision her upper and lower back injuries were aggravated.
- [36] During argument, counsel for the plaintiff advised that the plaintiff had abandoned (a) her claim for loss of capacity; and (b) her claim for loss of housekeeping services.
- [37] The plaintiff seeks an award for general damages of between \$45,000 and \$50,000.
- [38] She also seeks compensation for past wage loss of \$19,320.84. In advancing this claim she acknowledges that there is no claim for the periods July 8, 2008 to October 13, 2008 and from March 23, 2009 to April 8, 2009.
- [39] In addition, the plaintiff seeks full compensation for chiropractic and massage treatments and an additional \$3,464.84 in special damages.

## The Defendants

- [40] The defendants submit that the evidence does not establish that the plaintiff suffered any injury in the motor vehicle collision, either by way of aggravating existing injuries or by means of new injury.
- [41] In the alternative they submit that, at best, the evidence establishes a minor injury of no lasting significance.
- [42] The defence points to the plaintiff's evidence, in both direct and in cross-examination, that she was sore from physiotherapy and that she suffered significant severe flare-ups of her symptoms as a result of the physiotherapy.
- [43] The defence submits that either these complaints are genuine and constituted real pain and problems caused by the physiotherapy or it was contrived as a pretext for a higher level of symptoms.
- [44] This, the defence suggests, touches on the central issue of credibility which arises both from the evidence of the plaintiff and that of her husband. The plaintiff, he submits, was malleable at the hands of her husband in an attempt to seek financial compensation and that her evidence is replete with contradictions and evidence that is demonstrably untrue.
- [45] Mr. Fancy, the defence submits, is a witness who is entirely unreliable and whose primary interest is in material gain.
- [46] The defence submits that the plaintiff has failed to prove to the civil standard that the defendant either caused or contributed to her injuries.
- [47] The defence submits that -
  - 1. Neither the plaintiff nor her husband was candid or truthful in their evidence;

2. There is no report from her family doctor, Dr. Burns, which could presumably directly address the causation issue. He submits that it is possible to draw an adverse inference from Dr. Burns' absence; and
  3. If there was any injury, it was minor and of limited duration.
- [48] The defence submits that if there is any injury at all it would be compensated for by an award of \$3,000 to \$5,000.
- [49] He further submits that chiropractic and massage therapy treatments are not compensable in the current circumstances and should draw no award.

## DISCUSSION

- [50] Counsel are in agreement that credibility in this case is an important issue. This is particularly important in the circumstances of this case because of the absence from the evidence of the family doctor, Dr. Burns, and the doctor who first saw the plaintiff at the walk-in clinic two days after the accident on October 2, 2008. The plaintiff then saw her family doctor four days after that on October 6, 2008.
- [51] The absence of evidence from these two treating medical professionals leaves the court, with one exception, without any medical opinion on causation. The exception is the opinion letter of Dr. McKenzie produced on behalf of the plaintiff.
- [52] I will deal with this letter from Dr. McKenzie later in these reasons.

## CREDIBILITY OF THE PLAINTIFF, GRACE FANCY

- [53] The plaintiff was employed as an Administrative Assistant for the Northern Health Authority. On July 8, 2008, while at work, she was helping to move a shelving unit weighing 50 to 60 pounds when "she felt a tightness in her back . . ." She finished her day at work but at home that night she began having what she described as low back spasms with tingling in her left arm and left leg.
- [54] The plaintiff returned to work the next day but testified that she was only able to work for an hour and a half. She reported the injury to her supervisor and left. She saw Dr. Burns that same day. His clinical note for the visit on July 9, 2008 says, in part:

. . . moderate muscle spasm upper back and bilateral L-spine paraspinal muscles.

RADICULOPATHY

c spine / l. spine . . .

c spine film ordered

It is notable that from this first clinical record the assessment involves the cervical spine.

- [55] Ms. Fancy was directed to begin physiotherapy and attended her first session the next day on July 10, 2008. The Physiotherapy Initial Notification form provided to WorkSafeBC by Accelerated Sport and Spine Physiotherapy reports the plaintiff's personal particulars, her date of injury as July 8, 2008, and the date of treatment as July 10, 2008.
- [56] The form from the physiotherapist (Exhibit 10) records under the heading Injury Recorded on Claim (Area of Injury and Diagnosis) only a single word and this is: "Neck".
- [57] Throughout her direct examination the plaintiff testified in various ways that her workplace injury was to her back, saying at various times:
- twisted my back
  - felt a twinge in back
  - had lower and upper back pain
  - pain in lower and upper back prevented me from working full time
  - could not sit for long, upper back very painful and had to stretch lower back
  - he was treating my shoulder and using traction on my lower back
- [58] Throughout this portion of the plaintiff's evidence the only mention of her neck came in the context of a statement that 'he [the physiotherapist] was stretching my neck as well because it tightened up with the pain'.
- [59] When the plaintiff began describing her injuries and symptoms following the motor vehicle collision there were essentially three components -
1. she described her symptoms from the workplace accident as being "exacerbated" with pain in her lower and upper back and tingling in her legs;
  2. her neck was tight; and
  3. the onset of headaches.
- [60] The plaintiff in initially describing her symptoms did not mention her neck, except in passing. Towards the end of her direct evidence, this changed quite dramatically from the initial description of the neck as being tight a day or two after the collision, to describing it in these terms -
1. in the past 6 months I still have lower back pain, upper back pain and constant neck pain;
  2. neck is chronic, always tight.
- [61] At approximately 2:30 p.m. on the first day of this trial the plaintiff began her cross-examination.
- [62] During the initial series of questions the plaintiff was asked about the cervical spine and her neck. In her responses she gave what, in my view, became a significant answer:

. . . by upper back I mean thoracic and when I say upper back I do not mean my neck . . .

[Emphasis added.]

[63] The plaintiff went on during this series of responses to describe in more detail what she meant, saying that at the time of her workplace accident she had pain in her lower back on the left side with tingling and numbness in her left leg. She went on to say that the pain in her upper back was 'between my shoulder blades' and there was 'no pain in my neck at the time of the workplace accident'.

[64] As the cross-examination continued a different story began to emerge -

1. the plaintiff first acknowledged that between July 8, 2008, the date of the workplace accident, and the date of the motor vehicle collision she had ' . . pain and stiffness in her neck but went on to say that she didn't recall seeking treatment for neck pain;
2. the plaintiff acknowledged that in mid-August 2008, more than a month before the motor vehicle collision, she was unable to work because of neck pain.

[65] In response to this cross-examination the plaintiff retreated to the proposition that:

I say the motor vehicle accident injured these same areas.

[66] The plaintiff discussed the status of her symptoms with a WorkSafeBC case manager on August 5, 2008. The WorkSafeBC log notes of that discussion reads as follows:

Her back was fine prior to the date of injury. She hadn't had to see her GP due to back problems prior to this incident. She wasn't aware of pre-existing DDD, the doctor told her during her visit on July 16, 2008, when he reviewed the x-ray report. She went back to the doctor on July 30, 2008. He recommended a graduated return to work over a three week period. She has been in contact with Northern Health. She started work August 1, 2008. She only lasted two hours on August 1st 2008. She went back for two hours again today. Her pain keeps increasing since her return to work. She went to physiotherapy after the two hours today and is very sore. She's meeting again with Stephanie next Monday, August 11, 2008 the original plan was for four hour shifts, five days per week, she feels the graduated return to work plan needs to be adjusted. She's being paid for her hours worked Current condition: She's still sore between her shoulder blade area, her neck and her left arm. She does not know whether this is from physiotherapy treatments or her symptoms have flared up

[Emphasis added.]

[67] In a series of questions the defence raised the fact that the plaintiff had complained at various times that her physiotherapy had caused flare-ups of her symptoms and had on one occasion left her bed ridden for two weeks or more.

- [68] During this portion of her evidence the plaintiff acknowledged that the symptoms she described on October 2 and 3, 2008 could have been either from her physiotherapy treatment or the motor vehicle collision.
- [69] Perhaps the most startling reversal in her evidence was the cross-examination of the plaintiff about a portion of Exhibit 8.
- [70] This document was a spreadsheet prepared by the plaintiff and her husband as a part of their submission to the Workers Compensation Board to help establish that she had suffered "an upper back injury". In item 11 on page 2 of the spreadsheet the plaintiff specifically refers to the August 5, 2008 Physiotherapy Initial Notification (Exhibit 10) referred to above. The excerpt contained in item 11 specifically notes that the "Injury Recorded on Claim: Neck" and then records the following submission regarding the document:

Corroborating Documentation of stiff neck from workplace injury (July 8, 2008) - this injury is NOT from the MVA as suggested by CD in Item 32.

- [71] The last column of this spreadsheet is entitled "Proof of:" and is divided into two columns, the first of which is "Upper back/left arm injury".
- [72] The plaintiff entered "Yes" in this column with respect to Item 11.
- [73] When confronted with this document the plaintiff conceded that when the Workers Compensation Board case manager said that the neck injury was not as a result of the workplace injury but from the motor vehicle accident she disagreed and said 'no, I injured my neck in the workplace accident'.
- [74] When pressed on this point she advised the court that:
- The upper back, to me, includes the neck.
- [75] This evidence was given without the faintest embarrassment or apparent realization that the previous day she had testified that:
- When I say upper back I do not mean my neck.
- [76] One of the final points raised by the defence in their cross-examination of the plaintiff was the fact that neither she nor her husband had filed tax returns since 2005.
- [77] The plaintiff's explanation was the remarkable statement that:
- She did not provide or file tax returns for 7 years because of a home based business.
- [78] Although the full documents and decisions of the Workers Compensation Board are not before the court, it is clear from the evidence and the limited documents before the court that the plaintiff pursued a claim as a result of the workplace injury on July 8, 2008.

[79] A decision was reached on June 14, 2011. This was followed by a Review Board decision on November 7, 2011. This in turn resulted in a decision of a case manager on March 6, 2012. The case manager, Mr. Paul Loog, notes in his decision that there has been a further appeal Review Board Decision on February 6, 2012 that dealt with a claim for chronic pain in her low back.

[80] Mr. Loog's decision (Exhibit 7) sets out on the first page the issues returned to him by the Review Board for further investigation and a new decision. The issues were:

1. The Board's decision to accept the worker's claim for an aggravation of pre-existing DDD at C5-6 resulting in radiculopathy.
2. The Board's decision that the worker does not have compensable chronic pain as a result of the aggravation of pre-existing DDD at C5-6.
3. The Board's decision that the worker is not entitled to any further temporary disability benefits as a result of the acceptance of an aggravation of pre-existing DDD at C5-6.
4. The Board's decision that the worker is not entitled to a referral to Disability Awards for the aggravation of pre-existing DDD at C5-6.
5. The Board's decision that the worker is not entitled to coverage for certain health care items for her aggravation of pre-existing DDD at C5-6.

[Emphasis added.]

[81] I note that each of the five issues referred back for decision relate to the existence of an injury to C5-C6 in the workplace accident.

[82] Mr. Loog's decision as to each issue is set out on page 2 of his decision:

The following are answers to the questions as set out by the review board decision dated November 7, 2011.

1. The Board's decision to accept the worker's claim for an aggravation of pre-existing DDD at C5-6 resulting in radiculopathy.

There is no change in the prior decision regarding this matter. The worker's claim has been accepted for a mild exacerbation of pre-existing condition (degenerative disk disease at C5-6) and resulting radiculopathy.

2. The Board's decision that the worker does not have compensable chronic pain as a result of the aggravation of pre-existing DDD at C5-6.

I will be accepting that the worker has chronic pain associated to her pre-existing DDD at C5-6. I do not accept any restrictions or limitations associated to this.

3. The Board's decision that the worker is not entitled to any further temporary disability benefits as a result of the acceptance of an aggravation of pre-existing DDD at C5-6.

There is no change in the prior decision in that the worker is not entitled to further wage loss benefits as the expected recovery timelines for such an injury is at most 7 months post date of injury. The worker was paid till she was involved in an MVA at which point benefits were stopped till such time she could participate in the gradual return to work. Benefits were then started again till the end of the gradual return to work. Which was far past 7 months from date of injury.

4. The Board's decision that the worker is not entitled to a referral to Disability Awards for the aggravation of pre-existing DDD at C5-6.

The worker's claim will be referred to Disability Awards for a permanent functional impairment assessment associated to chronic pain in her neck only as there is no indication that she has sustained a permanent injury to her neck as a result of this injury.

5. The Board's decision that the worker is not entitled to coverage for certain health care items for her aggravation of pre-existing DDD at C5-6.

I will be accepting health care benefits only up to 7 months from the date of injury associated to the worker's neck and low back.

In summary with regards to changed decisions:

1. I have accepted the worker's claim for chronic neck pain.
2. I have referred the claim to Disability Awards for a permanent functional impairment associated to this chronic neck pain.
3. There are no restrictions or limitations associated to the worker's chronic neck pain.
4. I will be accepting health care benefits for 7 months post date of injury associated to the worker's low back and neck as it relates to her compensable injury.

[Emphasis in original; underlining added.]

[83] I am unable to accept that the plaintiff's version of events and, in particular, that her description of her symptoms and their cause are accurate and candid.

[84] At the very least her evidence as to her symptoms and when they arose are unreliable but, in my view, they are calculated to advance the financial interests of herself and her husband.

[85] The most revealing summary of her evidence is found in her own words:

I just feel I hurt a lot more after the car accident.

I don't know which it was.

[86] The last of these refers to the flare-ups following her physiotherapy treatments but her pursuit of this claim remained unencumbered by either truth or accuracy.

**REPORT OF DR. G. M. MCKENZIE**

[87] At this point it is necessary to turn to the expert report on which the plaintiff relies for it touches directly on the issue of the plaintiff's credibility.

[88] Dr. G. M. McKenzie is an orthopaedic surgeon who works with the Vancouver Bone and Joint Clinic. He has specialities in the areas of sports medicine, and arthroscopic surgery of the shoulder and knee.

[89] Dr. McKenzie was asked to provide a medical legal report on the clinical status of the plaintiff on January 17, 2011 and saw her for the first time in his Vancouver office on February 1, 2011. This examination was conducted some 28 months after the motor vehicle collision and some 31 months after the work place injury.

[90] On page one of his report Dr. McKenzie notes:

I assume she is making no attempt to omit or change any of the pertinent details of the accident or her condition.

[91] On page 2 of his report Dr. McKenzie, under the heading Status Prior to the Accident, writes in part:

. . . March 1, 2004 there is an entry regarding neck pain. The diagnosis was torticollis. Grace recalls that she "woke up funny". Her neck pain resolved within a day or two and did not recur.

Just prior to this accident she had a Workers' Compensation Board claim. July 8, 2008 she was moving furniture at Northern Health. She developed pain in the lower part of the scapula. She also had some pain just below the beltline and into the left side going into the left leg. It involved the whole leg to the toes and her whole foot. She had parasthesias in the whole foot and some numbness. She had no neck pain with that event.

[Emphasis added.]

[92] At page 3 under the same heading Dr. McKenzie summarizes the history provided to him by the plaintiff:

In essence then prior to this accident this lady had some left arm tingling and numbness. She had some pain in the mid to lower interscapular area. She had lower back pain going into the left leg with tingling and numbness. She had no complaints of neck pain. She tells me she was getting better. Prior to the accident the left arm tingling was approximately once a week. There was no numbness. The tingling involved the whole arm and would last a few minutes.

[Emphasis added.]

[93] On page 4 under the heading History of the Motor Vehicle Accident two passages are of interest:

She did not go to the Emergency Room. She went home. She noted that she now had some neck pain which she did not have prior to the accident. She also noted that the remainder of her spine was more painful. Over the next day she developed neck pain and headaches. The tingling in the left arm got worse. The pain between the shoulder blades and the lower back pain as well as the left leg pain and tingling got worse as well.

...

She recalls being treated with physiotherapy. She had ongoing pain. She was referred to Dr. Janet Ames. Dr. Ames saw her on a number of occasions. The initial visit was January 8, 2009 (incorrectly dated 2008). In this record it states that "there was a flare up of all the original symptoms plus more left sided neck pain and also headaches". Grace again told me that she had no pre-existing left sided neck pain before this accident but does agree that she had a flare up of her other pains with this accident.

[Emphasis added.]

[94] Near the conclusion of this section of his report giving the History of the Motor Vehicle Accident Dr. McKenzie writes at the top of page 5:

She had treatment with massage. She does recall a major flare up in December 2009 and January 2010. That is when she started going to the chiropractor Dr. Morgan.

[Emphasis added.]

[95] What is notable about this portion of Dr. McKenzie's report is that throughout the entire history to this point, despite the frequent mention of the various medical professionals who had treated the plaintiff, there is no mention of David Fleming or of his physiotherapy treatments of the plaintiff which began in July 2008 after the workplace accident and continued until early January of 2010 covering the time from immediately after the workplace injury on July 8, 2008 until well after the motor vehicle collision.

[96] The Index appended to Dr. McKenzie's report notes that among the clinical records he was provided with, reviewed and based his report and opinion on, was:

3. Accelerated Sport and Spine Physiotherapy records from June 15, 2009

[Emphasis added.]

[97] On page 5 of his report under the general heading Current Situation and the further heading 1. Neck Pain, Dr. McKenzie writes the following:

She has pain in the whole left side of the neck going into the left trapezius muscle area. She also has pain in the left interscapular area. Her pain goes into the left arm "a bit". The left arm symptoms are mainly parasthesias, not pain. The parasthesias involve the whole left arm and all of her fingers. That however is intermittent. It occurs multiple times a day in 30 second increments over about half her day.

Her major complaint is pain in the neck. It is on the left side as noted above. It is aggravated by holding her head in one position or looking to the left. Any use of her neck aggravates it. Prolonged sitting aggravates it.

She grades per pain as a 5 to 9/10. Her typical pain is an 8/10. She gets associated headaches. Headaches are not an area of my expertise and I will not opine on that issue. She thinks it is slowly improving. She again told me that she had no pain in the neck prior to this accident.

[Emphasis added.]

[98] On page 8 of his report Dr. McKenzie sets out under the heading Facts and Assumptions the assumptions on which his opinion is based. The first five of these are material to this aspect of this decision:

1. This lady was not normal prior to her motor vehicle accident. She had no complaints of neck pain but did have some radicular symptoms in the form of tingling and numbness in the left arm. She also had some lower back pain and left leg pain with tingling and numbness. These were due to a Workers' Compensation Board claim from July 8, 2008 when she was moving furniture.
2. She did have improvement in these symptoms. She continued to have no neck pain. By the time of her motor vehicle accident she reports that her left arm tingling was intermittent and occurring about once a week. She still had some ongoing lower back pain which was constant and some tingling and numbness which was constant. She had returned to work and was working approximately five hours a day.
3. She was then involved in a motor vehicle accident September 30, 2008.
4. She developed an increase in her pre-existing symptoms and also developed new complaint of pain in the left side of her neck.
5. She has had extensive investigations since then which have shown some degenerative changes in her neck and in the lower back.

[Emphasis added.]

[99] The central factual assumption underlying Dr. McKenzie's opinions is found in points 1 and 2. The assumption based on the information provided by the plaintiff was that prior to the motor vehicle accident the plaintiff had no complaints of neck pain and that this continued to be the case after her workplace injury on July 8, 2008.

[100] The importance of the plaintiff 'not omitting or changing any of the pertinent facts' is made apparent on the first page of the medical report.

[101] The importance of the absence of prior existing neck pain at the time of the motor vehicle collision is made apparent in the four separate passages of the report quoted above.

[102] Its significance is made even clearer in the portion of the opinion found on page 10:

With regard to the neck pain, she had no pre-existing neck pain but she did have radicular symptoms. Currently her radicular symptoms are relatively mild occurring about once a week. Her major complaint is her headaches and her neck pain. In my opinion her diagnosis is an activation of pre-existing but asymptomatic degenerative changes in her neck and also myofascial pain. In my opinion the causation of her pain is the motor vehicle accident. She did not have this pain prior to the accident even though she did have the radicular symptoms [in] her left arm.

[Emphasis added.]

[103] The evidence before the court is clear that prior to the motor vehicle collision her neck was far from asymptomatic and that on at least one occasion in mid-August of 2008 she was unable to work because of neck pain.

[104] The information provided by the plaintiff to Dr. McKenzie about the absence of complaints of neck pain prior to the motor vehicle collision was completely untrue.

[105] It is impossible, in my view, to conclude that this was other than deliberate in this case. Throughout the period during 2010 leading up to the appointment she had with Dr. McKenzie, the plaintiff and her husband were heavily engaged in advancing her various appeals concerning her Workers Compensation claims. During this process spreadsheets were created along with detailed written submissions touching on most, if not all, aspects of her medical assessment and treatment.

[106] Two things result from this -

1. the factual assumptions and underpinning of Dr. McKenzie's opinion are false and untrue; and
2. this results in the opinion being of no assistance in determining a causal connection between the motor vehicle accident and the neck injury.

## CREDIBILITY OF CHRISTOPHER JOHN FANCY

[107] The defence submits that the plaintiff's husband is "an entirely unreliable witness". They submit that the relationship between these two was such that Mr. Fancy dominated the relationship and the plaintiff was "malleable and complicit" in his plans. Those plans are the pursuit of financial gain he submits.

[108] Mr. Fancy was in my view a problematic witness. He gave evidence with a level of confidence and assurance yet did not seem to grasp some difficulties that emerged in his evidence.

[109] He described his educational achievements in some detail completing a Bachelor of Science degree in Forestry and what he described as three years of the CGA program.

- [110] During cross-examination Mr. Fancy acknowledged that he had business administration training and that he understood financial documents and balance sheets.
- [111] When asked why he had not prepared and filed tax returns for either of them since 2005 he responded 'I have not filed them because I haven't completed the bookkeeping'. When pressed he explained this further by saying that he had done "a quick trial run, found that it wasn't profitable and that they were owed a \$4,000 or \$5,000 refund".
- [112] Mr. Fancy appeared to believe that those were reasonable explanations for his failure to file tax returns for 6 or 7 years.
- [113] Mr. Fancy described himself in his direct evidence as being "intimately familiar" with his wife's WCB claims and went on to advise that "at Grace's request" he attended WorkSafeBC meetings with her.
- [114] In the course of his cross-examination he acknowledged that he was designated and authorized in writing to act as his wife's representative in advancing her WCB claim and that the same occurred with respect to the claim following the motor vehicle collision.
- [115] Although he was "intimately familiar" with his wife's WCB claim and heavily involved in presenting her evidence and submissions throughout the appeal process, he seemed unable or unwilling to accurately characterize the claims. In direct examination he described there being claims for two workplace injuries - (a) her lower back/left leg which was accepted; and (b) her upper back/left arm which was missed.
- [116] He went on in a particularly confusing portion of his evidence to say that a neck claim was denied "because there was clearly no neck claim".
- [117] He then testified that he was very clear that there were two injuries including the upper back/left arm but that "in the last few months" there was an error made and it was called a neck injury.
- [118] He then testified that a June 14, 2011 letter "sort of recognized it" and that when it was appealed the review said the neck.
- [119] He concluded this review by advising the court that this wasn't the outcome that was sought and then saying that he was not aware of his wife ever making a claim for her neck arising from a workplace accident.
- [120] When the entry from the spreadsheet, Exhibit 9, Page 2, Item 11, was put to him in cross-examination he acknowledged that he had prepared the document but went on to say:
- I am not sure why I wrote this as it is contrary to the claim which is very clear.
- [121] In summary, Mr. Fancy's evidence was that although his wife never advanced a claim for a neck injury as a result of the workplace accident, he, for some unknown and unexplained reasons in Exhibit 9, Item 11, referred to the Physiotherapy Initial Notification and quoted the portion of that form that noted "Injury Recorded on Claim: Neck" and provided as his

written comments on that document "Corroborating Documentation of stiff neck from workplace injury (July 8, 2008) - this injury is NOT from the MVA as suggested by CD in Item 31".

- [122] A Review Board Decision then referred the matter back to the board for reconsideration of a number of issues, all of which are related to "aggravation of DDD (Degenerative disk disease) at C5-6". This referral resulted in Mr. Loog's decision of March 6, 2012. This decision accepted "the worker's claim . . . for a mild exacerbation of pre-existing condition (degenerative disk disease at C5-6) and referred the matter ". . . to Disability Awards for a permanent functional impairment assessment associated to chronic pain in her neck . . ."
- [123] All of these findings and decisions by the Board, according to Mr. Fancy, occurred in error, in the absence of any claim of neck injury by the plaintiff.
- [124] To be blunt, I do not believe Mr. Fancy's evidence which I found to be contrived and self-serving. I agree with the defence submission that he was an entirely unreliable witness seeking to advance the financial interest of him and his wife.

## CONCLUSION

- [125] This is a personal injury action in which the issue is causation. Simply put the question amounts to this - Was the plaintiff injured or did she have existing injuries or conditions aggravated by the motor vehicle collision on September 30, 2008?
- [126] The evidence presented to the court by the plaintiff is devoid of medical evidence and opinion touching on the issue of causation.
- [127] The only expert opinion placed before the court is that of Dr. McKenzie who first saw the plaintiff some 28 months after the motor vehicle collision. In providing Dr. McKenzie with the history he used as the foundation of his opinion the plaintiff misrepresented and altered the facts and withheld critical information about her physiotherapy treatments and pre-existing symptomology.
- [128] The effect of her actions destroyed any value of Dr. McKenzie's opinion.
- [129] The absence of her family doctor, Dr. Burns, was explained in the evidence by one in passing comment, he moved.
- [130] No other explanation was offered for the absence of his evidence either written or oral.
- [131] The value and use of the documents presented and admitted, in particular, the clinical medical records, Northern Health employment records and the WorkSafeBC case management records are circumscribed and restricted by the terms of the document agreement reached between the parties. Of particular importance are paras. 5 and 6 of that agreement which stipulates that none of the documents are admitted for the purpose of proving any opinion stated in them which must be proved in the ordinary way under Rule 11.

- [132] David Fleming, one of the plaintiff's physiotherapists, was called as a witness but was neither qualified nor tendered as an expert.
- [133] Mr. Fleming's treatments of the plaintiff were responsible, according to Mrs. Fancy, for severe flare-ups of the plaintiff's symptoms. He administered one session of his physiotherapy treatments immediately prior to the motor vehicle collision.
- [134] The evidence of the plaintiff's daughter Michelle was helpful but reflects the perspective of a young person living in the presence and subject to that presence and discussions of her parents. It did not assist or address the issue of causation.
- [135] After reviewing and considering the whole of the evidence, the plaintiff has failed to meet the burden of proof in this action.
- [136] I am wholly unable to conclude that the plaintiff suffered injury or aggravation of her existing condition as a result of the low velocity collision of September 30, 2008.
- [137] The uncertainty created by the flare ups described by the plaintiff in relation to her physiotherapy treatments and the regrettable state of the medical evidence compound and add to the strength of that conclusion.
- [138] The defence has submitted that the court should draw an adverse inference from the absence of Dr. Burns. In my view it is not necessary to draw an adverse inference in this case for Dr. Burns' absence leaves his apparent referral to physiotherapy as a result of neck injury as reflected in Exhibit 10 unexplained. That, together with the credibility findings with respect to the plaintiff and her husband, and the causation findings, arises in part from the absence of Dr. Burns' evidence.
- [139] The plaintiff's action is dismissed.
- [140] If costs cannot be agreed upon between the parties they may be spoken to.

"W. G. Parrett, J."

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