

CANADA / JUDGMENT

Guram v. Chanthavimone

2024 BCSC 1362

COURT

Supreme Court of British Columbia

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2024 BCSC 1362 Guram v. Chanthavimone

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Guram v. Chanthavimone,

2024 BCSC 1362

Date: 20240729

Docket: M237883

Registry: New Westminster

Between:

Namnit Kaur Guram

Plaintiff

And

Denny Chanthavimone

Defendant

Before: The Honourable Justice Douglas

Reasons for Judgment

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Place and Date of Trial:

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Abbotsford, BC

July 29, 2024

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I. INTRODUCTION

- [1] The plaintiff, Namnit Kaur Guram, brings this personal injury claim for damages arising from a motor vehicle accident that occurred on April 28, 2019. The defendant admits liability for the accident and the trial proceeded on damages issues only.
- [2] The parties' central dispute is two-fold: 1) whether Ms. Guram suffered a mild traumatic brain injury or concussion in the accident; and 2) to what extent her accident-related injuries have impaired her capacity to earn an income.
- [3] The defendant admits Ms. Guram sustained soft tissue injuries in the accident but disputes their severity and functional impact. He denies that the accident caused a mild traumatic brain injury and argues that Ms. Guram is able to return to work. The parties' positions produced divergent estimates of damages.

II. BEFORE THE ACCIDENT

A. Family History

- [4] Ms. Guram was 41 years old at the time of the accident; she was 46 by the date of trial. Her parents were born in India and Ms. Guram grew up in a traditional Indian family in New Westminster, BC. She described a difficult childhood and adolescence.
- [5] Ms. Guram admitted she was bullied in school. She said that her younger brother, Jarbis Singh Guram, was her best friend. After her sister, Amrita Kaur Guram, was born, Ms. Guram became actively involved in her life, effectively assuming the role of a second mother, evidence her mother and sister both corroborated. Ms. A. Guram described her sister as bubbly, sociable, and active before the accident, recalling that they hiked and worked out together. Ms. A. Guram is now married, living in Vancouver, and has recently given birth to her first child; she and Ms. Guram no longer see each other as often as they did before the accident.
- [6] Sarbjit Kaur Guram, Ms. Guram's 64-year-old mother, testified at trial with the assistance of a Punjabi interpreter. She immigrated to Canada in 1976 and was widowed in 2001. She described Ms. Guram as an active, sociable, easygoing, and responsible child who was a motherly figure to her two younger siblings.

- [7] In 1998, at the age of 21, Ms. Guram entered into an arranged marriage, saying she then thought that marriage was the only way out of her family life. She described her former spouse as physically and mentally abusive. They divorced in 2000, after having one child, Rhea Ravneet Kaur Biring, together early that year. Ms. Guram's ex-husband left her when she was eight months pregnant. They have no ongoing contact and he has not been involved in raising their daughter.
- [8] Ms. Guram described her daughter as her "pride and joy" and the best thing in her world. After Ms. Biring was born, she and Ms. Guram moved in with Ms. Guram's parents; her parents were both supportive and Ms. Guram's mother helped with childcare.
- [9] Ms. Guram's father died unexpectedly from heart failure at the age of 49 in 2001, followed by the death of her brother in a motorcycle accident in 2004. Ms. Guram agreed that she experienced a lot of trauma while growing up and that this probably had a negative impact on her mental health. However, she denied feeling sad or seeing any counsellors as a child. She remembers wanting a better life for herself than the one her parents had.
- [10] Ms. Guram wanted Ms. Biring to have a happy childhood; both said that they spent a lot of time together hiking, walking, shopping, going to restaurants, and working out at the gym several times a week. Ms. Guram coached her daughter's basketball team from grades five to seven, evidence Ms. Biring corroborated. Ms. Biring described her mother before the accident as caring, friendly, and fun; she recalled her throwing parties and events for family and co-workers. Ms. Biring agreed that she and her mother remain best friends.
- [11] Ms. Guram met her fiancé, Kamaljit Sidhu, online in 2012. They currently live with Ms. Biring (who is now 24) in a condo in Surrey, BC. Mr. Sidhu is a 45-year-old self-employed construction property manager. On his evidence, he and Ms. Guram spent time together in the early days of their relationship watching movies, going to restaurants, hiking, working out, and playing basketball. He described Ms. Guram before the accident as an outgoing and generous people-pleaser who was family-oriented, confident, organised, and happy most of the time. He and Ms. Guram took a few trips together to Las Vegas and Mexico before the accident. Like Ms. Biring, he recalled Ms. Guram socializing with her colleagues outside work.

B. Educational History

- [12] Ms. Guram graduated from high school in 1995. In 1996, she attended Douglas College and started but did not complete a criminology program. She enrolled in a tourism program at Nationwide Travel College in 1997, followed by a Licensed Practical Nurse ("LPN") program at Sprott Shaw College in 2006. In 2008, Ms. Guram completed a hair and make-up course at Blanche Macdonald. In 2016, she obtained her real estate license.

C. Work History

- [13] Ms. Guram had a variety of diverse jobs after high school. She worked as a PNE ride operator, restaurant hostess, customer service representative for a clothing wholesaler, and part-time federal corrections officer at a prison from 2001-2004. Ms. Guram left her corrections officer job at the age of 26, after her brother's death. She found the prison environment to be very negative and conceded that it was making her a little paranoid and having an adverse impact on her mindset.
- [14] In 2005, Ms. Guram accepted a six-month contract to work as a cruise ship security officer. From 2006-2007, she worked as a receptionist for a property management company. After completing her hair and make-up course in 2008, Ms. Guram worked periodically (once or twice a month on the weekends) as a freelance stylist, earning some additional income. She stopped doing this work in about 2013, after deciding that there was too much competition in the industry.
- [15] In 2007, Ms. Guram secured her first LPN job with the BC Cancer Agency ("BCCA"). She worked there full-time (Monday to Friday) until 2016. She said that she enjoyed the work, formed positive relationships with patients and staff, planned various fundraising events and parties, and socialised with her co-workers.
- [16] After obtaining her real estate license in 2016, Ms. Guram had a few "practice run" listings. She denied selling any properties or earning any income from the sale of real estate before the accident.
- [17] After leaving the BCCA in 2016, Ms. Guram worked for about one year at a Dr. Bernstein weight loss clinic in Langley. She left this job in 2018 to do contract work for Solutions Staffing as a travel LPN. She accepted a three-week contract, working four days on and four days off (including two days and two nights) with elderly patients at Jackson House, a long-term care facility in Ashcroft, BC. This contract was extended twice and Ms. Guram ultimately spent about four months doing this work. Jackson House had care aides but no registered nurses on staff.
- [18] Ms. Guram worked 12-hour shifts at Jackson House and was paid \$39/hour, plus travel and accommodation expenses. On her evidence, she worked overtime (thereby extending her shift from 12 to 16 hours) about every one or two shifts. Her job duties included administering medication, doing wound care, and helping care aides with patient transfers. Jackson House was connected to a hospital but it was not open on the weekends; accordingly, Ms. Guram was instructed to call 911 in the event of weekend emergencies. She described her work at Jackson House as physically and mentally demanding.
- [19] Ms. Guram began working as an LPN instructor at Vancouver Career College ("VCC") in September 2018. Her job duties included lecturing, demonstrating techniques (including patient transfers, injections, and changing IVs) on life-size mannequins, supervising and grading LPN students, and creating course materials. She was paid \$30/hour for this work.

- [20] At the time of the accident, Ms. Guram was periodically working as both a travel LPN and LPN instructor at VCC. She had the freedom to accept the travel LPN contracts she wanted and to teach when she preferred not to travel.
- [21] Ms. Guram described her mental health immediately before the accident as amazing. She denied having any difficulties with anxiety or depression. She said that she had two great jobs which allowed her to work the hours she wanted and offered her many opportunities for advancement.

III. THE ACCIDENT

- [22] The accident occurred on King George Boulevard, close to the Art Knapp nursery, in Surrey, BC. Ms. Guram and Ms. Biring had been on their way to the United States to go shopping. Ms. Guram was driving a 2009 BMW (the "BMW"). Defendant, Denny Chanthavimone, was driving a 2010 Honda Accord (the "Honda"). Ms. Guram was wearing her seatbelt; the BMW was equipped with a driver's side headrest.
- [23] Ms. Guram was stopped behind another vehicle which was exiting King George Boulevard when the Honda struck the BMW from behind. She described the impact as really hard. Air bags in the BMW did not deploy. According to Ms. Guram, her head moved forward on impact and hit the driver's side window once and the headrest twice. She denied having any advance notice of the accident.
- [24] Ms. Biring was a front-seat passenger in the BMW at the time of the accident. Like Ms. Guram, she did not see the vehicle which hit the BMW from behind before impact, saying they were both very confused about what had just occurred. Ms. Biring described the impact as bad; on her evidence, her mother's body moved aggressively and the BMW moved a bit when struck. When pressed in cross-examination about the movement of Ms. Guram's body on impact, Ms. Biring said that she vaguely recalled her mother kind of moving forward and backward and her head hitting the window.
- [25] Mr. Chanthavimone is a 28-year-old industrial mechanic. Immediately before the accident, he and his former girlfriend, Brianna Ahluwalia, a front-seat passenger in the Honda, had been driving to Crescent Beach. Both were familiar with the area. As they approached the Art Knapp nursery on King George Boulevard, Mr. Chanthavimone recalls doing a shoulder check and then seeing brake lights immediately in front of him. He applied his brakes, felt his anti-lock braking system kick in, and swerved in an attempt to avoid hitting the BMW. He estimated the Honda's speed on impact to be less than 30 km/h. He described the impact as a little jolt, saying the BMW moved about one foot when struck. He accepted the accuracy of the damage estimates in evidence and agreed that the force of the impact was sufficient to damage the Honda's hood, bumper, and frame.

[26] Ms. Ahluwalia recalled that the accident occurred at about mid-day on a clear day. On her evidence, she and Mr. Chanthavimone had been driving on King George Boulevard when the vehicle in front of them braked suddenly. She testified that Mr. Chanthavimone veered to the right but was unable to avoid clipping the back of the BMW. She likened the impact to going over a speed bump a bit too fast; she denied it was associated with any forward jerking motion. No air bags in the Honda deployed.

[27] Both involved vehicles were subsequently written off.

IV. AFTER THE ACCIDENT

A. Immediate Aftermath

[28] Ms. Guram admitted she did not lose consciousness in the accident. She said that she remembers shaking, being "in shock", and having sharp neck pain after the accident. She denied exiting the BMW immediately, speaking to Mr. Chanthavimone and saying "oh, my car!" (or words to that effect), or walking to the back of the BMW and picking up pieces of its broken back bumper at the accident scene, evidence her daughter corroborated.

[29] Ms. Guram recalled that her hair became disheveled and untied after the accident, evidence her daughter corroborated. Both denied that Ms. Guram got out of the BMW to speak to Mr. Chanthavimone, saying instead that Ms. Biring did so. On Ms. Biring's evidence, she collected pieces of the BMW's broken back bumper at the accident scene and put them in the back seat of the BMW. Ms. Guram said that she remained in the BMW until after she had pulled ahead some distance, into the driveway of another nursery, and (with her daughter's assistance) exited the BMW, evidence Ms. Biring corroborated. Both said that Ms. Guram's mother arrived shortly thereafter and took them to the Peace Arch Hospital ("PAH").

[30] There is no dispute that Mr. Chanthavimone and Ms. Biring both got out of their respective vehicles at the accident scene, spoke to each other, exchanged insurance information, and took photographs. Mr. Chanthavimone admitted he apologised and accepted responsibility for the accident. After exchanging insurance information with Ms. Biring, he said that he walked to the driver's side of the BMW and spoke with the driver; on his evidence, he asked her if she was okay and she replied that, apart from being shaken up, she was fine. He recalled that the driver got out of the BMW shortly thereafter and stood next to her younger passenger (whom he understood was her daughter). He recalled repeatedly apologizing to them both.

[31] According to Mr. Chanthavimone, he saw the driver of the BMW walk around her car, pick up a piece of its broken rear bumper, and put it in her trunk. Thereafter, he said that he and the driver of the BMW both got into their respective vehicles and pulled into the nursery parking lot. He checked the Honda for leaks and to ensure it was drivable before leaving the accident scene (before the two women in the BMW).

- [32] On Ms. Ahluwalia's uncontroverted evidence, she remained in the Honda at the accident scene. She recalled that the Honda had stopped directly behind the BMW and that she had a clear and unobstructed view of it. She remembers seeing two women exit the BMW at the accident scene and that one was older than the other; she was certain that both women got out of the BMW, spoke to Mr. Chanthavimone, and exchanged information at the accident scene. While Ms. Ahluwalia could not hear their conversation clearly, she recalled seeing both women talking and one of them saying "oh gosh the car" (or words to that effect). She also remembers seeing one of the women pick up part of the BMW's broken rear bumper at the accident scene; neither of the women appeared to her to be injured.
- [33] No emergency vehicles attended the accident scene. Mr. Chanthavimone did not call 911 because, on his evidence, he and Ms. Ahluwalia were both uninjured and, based on his conversation with them, he understood that the two women in the BMW were also fine.

B. Injuries and Treatment

- [34] The PAH triage nursing notes were put to Ms. Guram in cross-examination. They are in evidence pursuant to the parties' document agreement. Ms. Guram agreed that either she, her daughter, or both of them spoke to a triage nurse at PAH the day of the accident. Ms. Guram denied (contrary to the PAH triage nursing note) that she ever reported being uncertain about whether or not she hit her head on the driver's side window on impact. On her evidence, she would have said that her head hit the side window and the headrest on impact; she denied any uncertainty about whether or not this had occurred at trial. This history is not documented in the PAH records.
- [35] A CT scan of Ms. Guram's head and cervical spine was completed at PAH the day of the accident. The reviewing radiologist reported the presence of multiple degenerative changes but no acute pathology. Ms. Guram was discharged home the same day; Ms. Biring was uninjured.
- [36] Ms. Guram testified that she attended Surrey Memorial Hospital ("SMH") a few days after the accident. On her evidence, she had experienced difficulties at work due to neck pain, headaches, and numbness and swelling in her hands.
- [37] The SMH records are in evidence pursuant to the parties' document agreement. They indicate that Ms. Guram presented to the SMH emergency room on April 30, 2019, complaining of neck pain, hand numbness/weakness, and being dizzy. The triage assessment history recorded her reported history as follows:

Driver in MVA on Sunday

Hit head on window then back rest x 2

Denies LOC [loss of consciousness]

Taken to PAH

Had CT head/neck - showed chronic C5-6 bulge - told take Tyl[enol]/Advil and d/c [discharged] home

Progressively increased pain to neck laterally and rad[iating] down to arms and across mid back

Shakey, Anxious

Took Tyl[enol] and Advil today at 0800 No relief

Headache

Blurry Vision

[38] The SMH triage assessment notes that Ms. Guram looked well. The SMH ER physician's notes record a diagnosis of "MVA (neck pain)" and indicate that Ms. Guram was given Toradol and Valium and discharged home the same day.

[39] On May 8, 2019, Ms. Guram was assessed by a Dr. Liaquat Khan; Ms. Guram thinks this might have been a walk-in clinic visit. Dr. Khan's brief notes record Ms. Guram's subjective report of "headache, neck, shoulders, rt arm, whole back and rt hip" complaints. He noted tenderness on examination and the absence of any neurological deficits, diagnosed multiple soft tissue injuries, and prescribed Diclofenac and Flexeril. For reasons that are unclear, he also diagnosed concussion. Dr. Khan did not author an expert report, was not qualified as an expert, and did not testify at trial. His notes recording his diagnoses are not in evidence for their truth.

[40] Ms. Guram attended the SMH ER again on November 10, 2019. Based on the ER ambulatory care clinical record, her stated reason for this visit was "migraine". Ms. Guram's chief recorded complaint was moderate headache pain. The triage assessment noted "headache x few days" and that Ms. Guram reported "right eye pressure and dizzy onset last night", "both eyes feel a bit blurry", and nausea but no vomiting. Ms. Guram was given medications and the ER physician's recorded diagnosis was migraine. Ms. Guram was noted to be alert, to have no slurred speech or unilateral weakness, and to ambulate and look well. She was discharged the same day.

[41] On November 12, 2019, Ms. Guram attended the SMH ER again with a chief recorded complaint of periorbital swelling; she was diagnosed with sinusitis and discharged the same day.

[42] Ms. Guram returned to the SMH ER on September 10, 2020 with a recorded chief complaint of moderate headache pain. A CT scan of the head was completed that day and confirmed the absence of any acute intracranial abnormality. The ER physician's notes record a diagnosis of migraine. Ms. Guram was given medications for migraine and noted to be well on discharge the same day.

- [43] Ms. Guram returned to the SMH ER on May 7, 2021 with a chief complaint of moderate headache pain. The ER physician recorded a diagnosis of migraine and ordered medication.
- [44] On Ms. Guram's evidence, she periodically saw her former general practitioner ("GP"), Dr. Sandeep Sawhney, for her accident-related injuries. Dr. Sawhney did not author an expert report, was not qualified as an expert, and did not testify at trial. His clinical notes and records are not in evidence.
- [45] Various imaging studies are in evidence pursuant to the parties' document agreement. They were reported as demonstrating the presence of multiple degenerative changes and included:
- a) A May 11, 2019 MRI scan of the cervical spine showing spondylosis, anterolisthesis of C3 on C4, disc bulges at C6-7, and foraminal narrowing at C6-7;
 - b) A September 11, 2019 MRI scan of the cervical spine showing multilevel degenerative disc disease, primarily at the C5-C6 and C6-C7 level, with possible borderline mild central spinal stenosis, no associated hemorrhage to suggest acute pathology, and multilevel neural foraminal stenosis, worst bilaterally at the C6-C7 level; and
 - c) A September 10, 2020 CT scan of the head showing no acute intracranial abnormality.
- [46] Ms. Guram has undergone extensive treatment since the accident. According to her lawyer, she has attended over 500 appointments. The parties agree that this treatment includes:
- a) 43 physiotherapy sessions (from May 17, 2019 to November 20, 2019);
 - b) Treatment at iScope Concussion and Pain Clinic ("iScope") (from December 20, 2019 to January 11, 2023);
 - c) Ten neurology consultations with Dr. Elliott Bogusz and Dr. James Kung (from December 30, 2019 to March 25, 2022);
 - d) 103 treatments with two occupational therapists, Nisha Sandhu and Carole King (from February 18, 2020 to December 14, 2022);
 - e) 71 active rehabilitation sessions (from May 30, 2022 to June 1, 2023);
 - f) A rheumatology consultation with Dr. James Yeung on September 13, 2021;
 - g) 193 chiropractic sessions (from May 7, 2019 to November 26, 2021);
 - h) 32 sessions with psychotherapist, Dr. Trevor Olson (from February 11, 2020 to May 30, 2023);
 - i) 39 visits with GP, Dr. Sawhney (from May 16, 2019 to September 25, 2023);
 - j) Six consultations with ear, nose and throat ("ENT") physician, Dr. Imran Samad (from October 29, 2019 to February 11, 2020); and
 - k) 31 treatments at Change Pain Clinic (from June 19, 2020 to February 17, 2023).

- [47] None of these treating health care professionals testified at trial. With the exception of the PAH records, the SMH records, Dr. Khan's notes, and some imaging studies (in evidence pursuant to the parties' document agreement), none of the treating health care professionals' records are in evidence.

C. Current Condition

- [48] Ms. Guram complains of wide-ranging ongoing problems, including headaches, light and noise sensitivity, neck and upper back pain, right shoulder pain which radiates down her right forearm and occasionally into her hands, tingling in her right thumb and forefinger, low back, right hip, and right leg pain (including occasional right leg weakness when walking), watering of her right eye, occasional dizziness, some altered depth perception, sleep disturbance, depressed mood, anxiety, and perceived cognitive changes.
- [49] Ms. Guram described her post-accident cognitive changes as a "brain fog"; she complains that she is now more irritable, interrupts more often, and finds it more difficult to concentrate and to engage in conversation. She said that she has stopped socializing with family and friends and no longer throws parties, something she once loved to do, evidence her sister and daughter corroborated. Ms. Guram described herself as moodier, less confident, and no longer feeling like herself. She said that she has been anxious and depressed recently and that she started self-isolating in the summer of 2023. She now takes an antidepressant; the dose was doubled in October 2023 and Ms. Guram admitted she now cries less often.
- [50] Ms. Guram acknowledged only modest improvement in her overall condition since the accident, limited to a better range of motion in her neck and improved right shoulder and right arm pain. On her evidence, some of her problems are worsening; she described the onset of hand tremors in the summer of 2023. She admitted she has been referred to neurologist, Dr. Singh, for this problem; he did not testify at trial and his clinical notes and records are not in evidence.

V. CREDIBILITY AND RELIABILITY OF EVIDENCE

- [51] Credibility and reliability are not the same thing. The former is concerned with a witness' veracity (i.e., speaking the truth); the latter is concerned with a witness' ability to observe, recall, and recount the events in issue accurately: *Ford v. Lin*, 2022 BCCA 179 at para. 104.
- [52] The principles to be applied when assessing the credibility of interested witnesses are discussed in the frequently cited passages of Justice O'Halloran in *Faryna v. Chorny*, [1952] 2 D.L.R. 354 at 357, 1951 CanLII 252 (B.C.C.A.) and Justice Dillon in *Bradshaw v. Stenner*, 2010 BCSC 1398 at para. 186, *aff'd* 2012 BCCA 296. Relevant factors include the ability and opportunity to observe events, the firmness of the witness' memory, the ability to resist the influence of interest to modify recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes their testimony

during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally: Bradshaw at para. 186. I have applied those principles here.

- [53] If a plaintiff's account to experts of their accident-related physical, mental, or emotional condition is different from their trial evidence, the hypothesis on which the expert opinions rest may be undermined: *Samuel v. Chrysler Credit Canada Ltd.*, 2007 BCCA 431 at para. 49. In cases where there is little or no objective evidence of continuing injury and complaints of persistent pain beyond the usual recovery period, there must be evidence of a convincing nature; the plaintiff's own evidence, if consistent with the surrounding circumstances, may suffice: *Maslen v. Rubenstein* (1993), 83 B.C.L.R. (2d) 131 at para. 15, 1993 CanLII 2465 (C.A.).
- [54] Ms. Guram's ongoing complaints are subjective. My assessment of her credibility and the reliability of her evidence has informed my analysis of all issues.
- [55] Ms. Guram was an inconsistent historian. She provided the involved experts with variable accounts of the mechanism of her accident-related injuries:
- a) On June 9, 2023, she told her physiatrist expert, Dr. Steven Helper, that she sustained only one impact to her head (when the left side of her head hit the side window);
 - b) On June 12, 2023, she told her neurologist expert, Dr. Manu Mehdiratta, that she sustained three impacts to her head (when it hit the window and then the headrest twice);
 - c) On June 24, 2023, she told defence physiatrist expert, Dr. Paul Winston, that she recalls her head flinging forward on impact and hitting the "windscreen" and then the headrest and back again;
 - d) On June 30, 2023, she spoke to her psychiatrist expert, Dr. Zohar Waisman, and reported feeling stunned and not recalling what had occurred in the accident but denied hitting her head; and
 - e) On July 12, 2023, she told defence neurologist expert, Dr. Vance Makin, that she hit her head on the side window, then the headrest, and then flexed forward and hit the headrest again.
- [56] At trial, Ms. Guram testified that she hit her head on the side window and the headrest twice. She denied any uncertainty about this history; it is inconsistent with Dr. Waisman's recorded history and his trial evidence that Ms. Guram told him she did not recall exactly what had happened at the time of the accident.
- [57] The history of Ms. Guram's chief complaint recorded in the PAH triage assessment the day of the accident is different from the information she provided to the involved experts. It indicates that she was unsure if she hit her head on the windshield in the accident.
- [58] There are other inconsistencies between Ms. Guram's reports to the experts who assessed her in connection with this litigation and her trial evidence:

- a) Dr. Helper noted that Ms. Guram reported exiting her vehicle independently at the accident scene;
 - b) Dr. Mehdiratta noted that Ms. Guram was unable to exit her vehicle independently after the accident; and
 - c) Ms. Guram testified at trial that she did not get out of her vehicle at the accident scene.
- [59] Some of Ms. Guram's complaints are poorly explained; others have evolved. Ms. Guram testified that, despite extensive treatment, her condition is worsening. Apart from Ms. Guram's own evidence about her deteriorating mental health since the summer of 2023, there is no expert evidence or objective pathology to explain why she would be experiencing new and worsening symptoms more than six years after the accident. I accept that Ms. Guram's mental health condition influences and reinforces her perception of her own disability.
- [60] Ms. Guram testified at trial over two full days. She occasionally interrupted counsel and responded with lengthy, somewhat rambling answers, sometimes forgetting the question she had been asked in the process. However, it was clear that Ms. Guram had no difficulty understanding or answering questions. While she complained of a headache on one day, she consistently looked well and appeared to be in no acute distress.
- [61] Ultimately, I have some concerns about the reliability of Ms. Guram's evidence and have approached it with caution. Two medical experts opined that some of her multiple complaints are likely non-organic; I am unable to rule out this possibility. I have looked for independent sources of corroboration and for evidence that conforms with the preponderance of probabilities.
- [62] Ms. Guram and Ms. Biring gave very similar evidence; they clearly share a close bond. Ultimately, whether or not this occurred consciously, I am unable to rule out the possibility that some of their evidence might have been tailored to suit convenience. For example, both said it was necessary to make multiple stops in order to accommodate Ms. Guram's discomfort on a road trip to Kelowna in the summer of 2023 with Ms. A. Guram and Mr. Sidhu: Ms. Guram said they made lots of stops for this reason; Ms. Biring said they probably did so three or four times. By contrast, Mr. Sidhu, the driver and a comparatively straightforward witness, clearly recalled that they stopped only twice on the highway (once in Merritt and once in Hope) to stretch, eat, and charge their electric vehicle before reaching Kelowna.
- [63] I conclude that Ms. Biring has an imperfect recollection of immediate post-accident events. Much of her evidence, including her recollection of the movement of her mother's body on impact, was vague. She said that Ms. Guram complained of numbness and tingling in her arms at the accident scene; on Ms. Guram's evidence, her only complaint at that time was sharp neck pain. There is no reference to any reported complaints of arm numbness or tingling in the April 28, 2019 PAH records.

- [64] Ms. Guram's mother testified with the assistance of a Punjabi interpreter; her evidence was occasionally somewhat dramatic and not consistently responsive. It is clear that Ms. Guram's mother, daughter, sister, and fiancé all want what is best for her and that she has a small close-knit family. While I accept that Ms. Guram's family members all testified to the best of their ability, it is clear that none was an independent or disinterested witness.
- [65] Mr. Chanthavimone and Ms. Ahluwalia were both forthright witnesses. They made reasonable concessions including, for example, that Mr. Chanthavimone might have exceeded the speed limit the day of the accident. Both acknowledged minor lapses in their memories regarding unremarkable events before and after the accident, none of which I found to be material or surprising given the passage of time. I do not accept that these minor gaps in memory regarding inconsequential events which occurred more than five years ago mean that they do not recall the accident.
- [66] There are conflicts in the evidence about what occurred immediately after the accident, including, in particular, whether Ms. Guram exited the BMW at the accident scene, whether she and Mr. Chanthavimone spoke, and whether Ms. Guram (or Ms. Biring) collected broken pieces of the BMW's bumper. In my view, none is material to the issues before me. Ultimately, I conclude that no one has a perfect recollection of immediate post-accident events. Ms. Guram and Ms. Biring bear some physical resemblance, a fact that might have led to some confusion the day of the accident.
- [67] Ms. Ahluwalia is no longer involved with Mr. Chanthavimone; she impressed me as a straightforward witness. I accept her uncontroverted evidence that she had an unobstructed view of what occurred immediately after the accident from her vantage point in the Honda. Ms. Ahluwalia has no interest in the outcome of this litigation. I place more weight on her evidence than that of either party or Ms. Biring.
- [68] There was limited objective independent evidence about Ms. Guram's pre-accident function. Only one non-family lay witness testified about this matter. There was a notable lack of evidence from the multiple professionals involved in Ms. Guram's extensive post-accident care, including treatment from specialists with expertise in areas that overlapped with her alleged accident-related injuries.
- [69] I found the experts to be generally credible. For the reasons outlined below, I prefer the evidence of defence neurologist, Dr. Vance Makin, to that of the plaintiff's neurologist expert, Dr. Mehdiratta, where there are conflicts. There were multiple errors in the report of defence kinesiologist, Matt Cole, and he did not assess Ms. Guram. For those reasons, his report was of limited assistance.

[70] The plaintiff's psychiatrist expert, Dr. Helper, was a clear, candid, and credible witness. I place considerable weight on his opinions. Defence psychiatrist, Dr. Winston, authored a heavily redacted report; in the circumstances, it was of limited assistance. While the plaintiff's occupational therapist expert, Russell McNeil, conducted a comprehensive assessment of Ms. Guram, his opinions are premised on the assumption that she sustained a mild traumatic brain injury in the accident.

VI. EXPERT EVIDENCE

A. Qualifications

[71] Ten experts testified at trial. Plaintiff's counsel called:

- a) Psychiatrist, Dr. Steven Helper;
- b) Neurologist, Dr. Manu Mehdiratta;
- c) Psychiatrist, Dr. Zohar Waisman;
- d) Occupational therapist, Russell McNeil; and
- e) Economist, Kevin Turnbull.

[72] Dr. Helper completed his residency in psychiatry at the University of British Columbia ("UBC") in 2006, followed by a fellowship in spine intervention in the United States in 2007. He obtained a history from Ms. Guram, examined her on June 9, 2023, reviewed various documents, and authored a report dated June 17, 2023. Dr. Helper was qualified as an expert in the area of physical medicine and rehabilitation.

[73] Dr. Mehdiratta has been a neurologist since 2008. He completed his neurology residency at UBC in 2006, followed by fellowship training in stroke and cerebrovascular disease in 2007. He currently works as an on-call neurologist with Trillium Health Partners, a hospital in Ontario, and at its stroke prevention clinic. Dr. Mehdiratta is also the co-founder and Medical Director of iScope, an Ontario-based concussion and pain clinic.

[74] Dr. Mehdiratta obtained a history from Ms. Guram, assessed her once in person on June 12, 2023, reviewed various documents, and authored two reports: the first one dated June 30, 2023, and the second response report dated September 29, 2023. He was qualified as an expert in neurology.

[75] Dr. Waisman has been a psychiatrist for 23 years. He assessed Ms. Guram virtually for about one hour on June 30, 2023, and authored a report dated July 28, 2023, based on the results of his assessment and his review of documents. He was qualified as an expert in forensic and general psychiatry, able to offer opinions about psychiatric diagnoses.

[76] Mr. McNeil has been an occupational therapist for 34 years and specialises in vocational rehabilitation. He conceded that most of his time is currently spent assessing individuals rather than treating them. Mr. McNeil assessed Ms. Guram on August 13 and 17, 2023,

obtained a history from her, conducted various tests, reviewed documents received from counsel, and authored one report dated August 18, 2023, regarding both his functional capacity evaluation ("FCE") and future care recommendations. He was qualified as an expert in occupational therapy, able to opine regarding FCEs and the future cost of care.

[77] Mr. Turnbull was qualified as an expert in economics, able to offer opinions regarding estimated lost past and future earnings. He authored two reports dated August 18, 2023, and November 19, 2023.

[78] Defence counsel called:

- a) Psychiatrist, Dr. Paul Winston;
- b) Neurologist, Dr. Vance Makin;
- c) Kinesiologist, Matt Cole; and
- d) Economist, Thomas Steigervald.

[79] Dr. Winston completed his post-graduate training in physical medicine and rehabilitation at the University of Toronto in 2007. He has worked as a psychiatrist with the Vancouver Island Health Authority in Victoria, BC since 2008. He assessed Ms. Guram on June 24, 2023, and authored a report dated July 10, 2023. He was qualified as an expert in physical medicine and rehabilitation, able to opine regarding musculoskeletal injuries.

[80] Dr. Makin retired from active clinical practice in 2016, after working for 31 years as a neurologist; he continues to assess patients. In addition to his neurology training, Dr. Makin did some training in internal medicine and completed a fellowship in electrodiagnosis. He assessed Ms. Guram in person on July 12, 2023, and authored two reports: the first one dated August 25, 2023, and the second response report dated September 17, 2023. Dr. Makin was qualified as an expert in neurology.

[81] Mr. Cole has been a kinesiologist since 2000. He completed the Matheson FCE certification program in 2013, and the Matheson Advanced FCE course in 2016. His practice focuses primarily on occupational rehabilitation. Mr. Cole reviewed various documents, critiqued Mr. McNeil's report, and authored a report dated October 8, 2023. He was qualified as an expert in kinesiology, able to opine regarding FCEs.

[82] Mr. Steigervald was qualified as an expert in economics, able to opine regarding economic loss. He authored three reports dated October 5, November 28, and November 29, 2023.

B. Opinions

1. Soft Tissue Injuries

- [83] Ms. Guram complains of ongoing pain in her back and neck, and throbbing pain in her right hip, sometimes associated with spasms and radiation down her right leg. She described back stiffness with pain but admitted her physical condition has deteriorated since she decreased her activity level and that her core is no longer as strong as a result. Drs. Helper and Winston assessed her musculoskeletal injuries.
- [84] Dr. Helper reviewed Ms. Guram's Medical Services Plan printout (from September 2017 forward), her pre-accident Pharmanet records, and the post-accident records of her former GP, Dr. Sawhney. He received no other records about her pre-accident health and did not review the PAH records from the day of the accident. He conceded that patient history is important and that inaccurate reporting could change his opinions.
- [85] Ms. Guram reported multiple complaints to Dr. Helper. He diagnosed soft tissue-mediated (i.e., myofascial or musculotendinous) neck, right shoulder, mid-back, low back, and hip pain. He noted that Ms. Guram described diffuse, non-specific neck pain, aggravated by sustained postures. He concluded that the mild degenerative changes demonstrated (at C3-4, C5-6, and C6-7) on radiology studies (including a May 11, 2019 MRI scan) are non-specific; they do not alter his diagnosis of Ms. Guram's neck pain. He concluded that her description of diffuse back pain was not anatomically specific and it did not lead him to a structural diagnosis.
- [86] Given the chronicity of her complaints, the absence of a trend towards improvement, and the severity of related functional restrictions, Dr. Helper opined that Ms. Guram's prognosis for complete resolution of her complaints is poor. In his view, her musculoskeletal symptoms would be less severe and less functionally limiting if her headaches resolved and her cognitive/emotional difficulties either resolved or were well-controlled.
- [87] Dr. Winston testified that Ms. Guram was very difficult to engage and to examine. He concluded that many of her symptoms (including her hand shaking, finger trembling, blinking, facial expressions, and the reduced range of motion that he observed on examination) were not consistent with any pathology. He noted that it is extremely unusual for someone to be unable to walk across a room, turn their head, lift their arms fully, or walk on their heels and toes (as Ms. Guram reported) in the absence of any significant documented pathology. Dr. Winston diagnosed soft tissue injuries and post-accident neck pain. He explained that a diagnosis of soft tissue injury means there is no significant structural damage to the bones, joints, or nerves. In his opinion, Ms. Guram's soft tissue injuries will likely improve with time.
- [88] Ms. Guram told Dr. Winston that, despite extensive treatment, her condition was worsening. He noted it is very unusual for a patient to attend as much treatment as Ms. Guram has, with no improvement in their condition. In his view, this is a red flag. Dr. Winston referenced the September 11, 2019 MRI scan showing the presence of multilevel degenerative disc disease, primarily at C5-6 and C6-7, and borderline mild spinal stenosis, and medical imaging from May 2019 showing underlying osteoarthritis in Ms. Guram's neck, with related generalised

disc bulging.

[89] The defendant admits, and I accept, that Ms. Guram sustained soft tissues injuries in the accident.

2. Mild Traumatic Brain Injury or Concussion

[89] Two neurologists testified at trial: Drs. Mehdiratta and Makin. They offered conflicting opinions about whether or not Ms. Guram sustained a mild traumatic brain injury (or concussion) in the accident. This debate is the crux of the parties' dispute.

[90] Drs. Medhiratta and Makin agree that mild traumatic brain injury is synonymous with concussion. Both accept that direct trauma to the head is unnecessary in order to sustain a mild traumatic brain injury. Ms. Guram's post-accident imaging of the head was normal. Accordingly, there is no objective evidence that she sustained any structural brain damage in the accident. On Dr. Makin's unchallenged evidence, concussion is a clinical diagnosis; accordingly, the only "test" for it is a physician assessment.

[91] In Dr. Mehdiratta's opinion, Ms. Guram sustained a mild traumatic brain injury in the accident. In his view, her symptoms are likely permanent and her prognosis is guarded. Based on the history she reported to him, Dr. Makin concluded that Ms. Guram did not sustain a traumatic brain injury or concussion in the accident. On his evidence, concussion is a transient physiological condition which causes no permanent structural brain injury.

[92] Dr. Makin conceded that it is possible Ms. Guram was concussed for a few seconds after the accident; in his opinion, any such concussion would have resolved quickly. On his evidence, if a person is concussed for less than 30 minutes, they are not at risk for any structural brain damage and there is no material difference between having no concussion or one lasting only a few seconds. He testified that concussion is transient and self-limited by almost all definitions.

(a) PAH Records

[93] Neither Dr. Mehdiratta nor Dr. Makin received the PAH records before they were asked to write their reports. Dr. Makin specifically requested and ultimately reviewed them. Dr. Mehdiratta makes no reference to the PAH records in his reports; the earliest post-accident records he discusses in his June 30, 2023 report are the SMH records (from Ms. Guram's April 30, 2019 visit). Dr. Mehdiratta conceded at trial that he has no recollection of seeing the patient history recorded in the PAH chart as part of his assessment. He apparently made no attempt to fill this evidentiary gap in the foundation for his opinions.

[94] I share Dr. Makin's view that the PAH records are important in this case. Ms. Guram's immediate post-accident complaints and reported history are central to the clinical diagnosis of concussion. The PAH chart records the following information:

a) Ms. Guram arrived at the PAH on April 28, 2018 at 15:28;

- b) Her stated complaint on arrival was chest, right shoulder, and arm pain;
- c) She was triaged at 15:43;
- d) She was prescribed Tylenol, Advil, and Toradol in the ER; and
- e) She was discharged ambulatory at 22:40 the same day.

[95] None of this factual information was challenged at trial and I accept it.

[96] The PAH triage assessment notes that Ms. Guram was oriented, obeyed commands, and looked well. Her breathing was noted to be spontaneous and her Glasgow Coma Scale ("GSC") score was normal. The history of her chief complaint was recorded in the triage assessment as follows:

Restrained driver in MVA. Car in front of pt's car was turning so pt slowed down - pt states was almost stopped when car behind rear ended pt at high speed. Unsure if hit head on windshield. No LOC. Self-extricated + damage to rear of car.

[97] Ms. Guram denied ever telling anyone at PAH that she was unsure if her head hit the windshield of the BMW. The PAH chart records Ms. Guram's complaints when triaged in the ER as follows:

At triage pt c/o headache. Bilat shoulder blade pain. Central chest pain. Worse with deep inspiration. Right side back/shoulder and c/o R side entire back pain. C/o C spine and pain/tenderness on palpation and pain to R lateral neck and R jaw.

[98] The PAH ER assessment record completed at 16:25 indicates, in part, that Ms. Guram suffered no "LOC" (loss of consciousness) and that she "self-extricated". This record also notes that Ms. Guram's pulse was regular and her breathing non-laboured. The box for "alert" was checked (and not the one for "confused"). At 17:30, it was noted that Ms. Guram was awake, alert, and in no apparent distress. At 19:11, it was noted that she was alert and oriented and, at 20:13, that she was speaking and laughing with her daughter.

[99] The PAH ER physician notes completed at 16:35 state, in part, that Ms. Guram's head "struck window". The PAH chart contains no recorded reference to any reports of nausea, dizziness, confusion, or memory loss. The PAH ER physician notes reference neither a diagnosis nor a query about mild traumatic brain injury. Under "diagnosis", this physician wrote "R/O [rule out] acute disc C5/6".

[100] A CT scan of the head and cervical spine completed at PAH the same day was reported as showing no acute or significant traumatic intracranial abnormality and no acute fracture to the cervical spine. Degenerative changes were noted.

(b) Patient History

[101] Both neurology experts relied on Ms. Guram's subjective history in reaching their opinions. Dr. Mehdiratta conceded that patient history is a critical part of his assessment and the most important part of making a diagnosis. As noted, Ms. Guram provided a variable history regarding the mechanism of injury in the accident.

(c) ONF Guidelines

[102] Dr. Mehdiratta relied on the 2018 Ontario Neurotrauma Foundation Guidelines for Concussion/Mild TBI and Persistent Symptoms: Third Edition (the "ONF Guidelines") in diagnosing Ms. Guram with a mild traumatic brain injury and concussion. Despite conceding that these diagnostic labels are synonymous, he listed them as separate diagnoses in his first report.

[103] Dr. Mehdiratta testified that the ONF Guidelines were assembled by a group of experts to assist in the diagnosis and treatment of mild traumatic brain injury. On his evidence, they are extrapolated from various other guidelines, including those from the American Academy of Neurology and other acute concussion evaluation techniques used in practice, including the Acute Concussion Evaluation ("ACE") questionnaire authored by Gerald Gioia, Ph.D., and Micky Collins, Ph.D., from the University of Pittsburgh. Dr. Mehdiratta admitted the ONF Guidelines do not originate from an independent committee of experts; rather, he conceded that they have essentially been cut and pasted from various other sources. It is unclear why Dr. Mehdiratta chose to rely on the ONF Guidelines, rather than the peer-reviewed source documents from which they were partially extrapolated.

[104] Dr. Mehdiratta summarized the ONF Guidelines as follows:

- a) Any period of a loss or decreased level of consciousness of less than 30 minutes;
- b) Any lack of memory for events immediately before or after the injury (post-traumatic amnesia) at less than 24 hours;
- c) Any alteration in mental state at the time of the injury (e.g., confusion, disorientation, slowed thinking, alteration of consciousness/mental state);
- d) Physical symptoms (e.g., vestibular symptoms, headaches, weakness, loss of balance, changing vision, auditory sensitivity, dizziness); and
- e) No evidence of intracranial lesion on standard imaging (which, if present, is suggestive of more severe brain injury).

[105] On Dr. Mehdiratta's evidence, only one of the above-noted criteria is required in order to diagnose mild traumatic brain injury. Dr. Makin testified that the three cardinal symptoms of concussion (which must occur at the time of injury for diagnostic purposes) include: 1) loss of consciousness; 2) post-traumatic amnesia; and 3) confusion.

[106] Dr. Makin described the ONF as a defunct organization; he does not endorse the non-peer-reviewed ONF Guidelines. Dr. Mehdiratta conceded that the ONF encountered funding difficulties which, in turn, affected its ongoing ability to review research and to publish. He was unable to confirm whether or not the ONF still exists; it is unclear on the evidence whether the ONF Guidelines reflect current research. Dr. Mehdiratta was unconcerned that the ONF Guidelines were created without the involvement of a neurologist. By contrast, Dr. Makin expressed concern that a committee with no neurologist members purported to define a neurological condition.

[107] The parties agree that Ms. Guram did not lose consciousness in the accident. There is no evidence that she experienced a decreased level of consciousness after the accident. Accordingly, there is no dispute that the first ONF Guidelines criterion for diagnosing concussion is not met here. In Dr. Mehdiratta's opinion, Ms. Guram met the second, third, and fourth ONF Guidelines criteria. I consider each in turn.

(1) Post-Accident Amnesia

[108] There was substantial trial evidence about whether or not Ms. Guram suffered any neurologically significant memory loss regarding events immediately before or after the accident. Retrograde amnesia refers to an absence of memory before injury or impact. Anterograde amnesia refers to an absence of memory after injury or impact.

[109] Dr. Mehdiratta offered his views about possible gaps in Ms. Guram's memory regarding pre-accident events; Dr. Makin denies she suffered any clinically significant amnesia regarding pre-accident or post-accident events.

[110] Based on the ONF Guidelines, Dr. Mehdiratta stated that any gap in memory, before or after a traumatic event, is relevant to an assessment of possible mild traumatic brain injury. Dr. Makin accepts the second ONF Guidelines criterion as a valid symptom of concussion but cautions that it must be carefully assessed. In his view, Dr. Mehdiratta interprets it so broadly that it overlaps with the first ONF Guidelines criterion.

[111] It was suggested to Dr. Mehdiratta in cross-examination that Ms. Guram has a fairly vivid recollection of what occurred immediately before the accident. He replied that this is a matter of what she actually remembers versus what she has since been told, saying the brain is very good at filling in small gaps in memory. He interprets her statement to Dr. Makin that she believed the driver behind her tried to swerve before impact, as meaning that she does not remember this event. He interprets her statement to Dr. Makin that she did not see the vehicle that hit her, or hear brakes, to mean that she has no memory of those events and her pre-accident memory is therefore "patchy". In his opinion, the biomechanical forces applied to Ms. Guram's brain in the accident were sufficient to cause possible amnesia.

- [112] Dr. Makin has a different view. He denied that Ms. Guram reported having any difficulty remembering things immediately before the accident. Rather, she told him that she was rear-ended by a vehicle she did not see coming. Dr. Makin testified that retrograde amnesia is difficult to assess and that caution is required when doing so because no one remembers everything that happens. He noted that a person might not see a car that hits them from behind simply because they were not then looking in their rearview mirror; in his view, this history does not necessarily indicate retrograde amnesia. On his evidence, most patients with mild concussion have no retrograde amnesia. He admitted the extent of memory loss (which would typically be post-traumatic, and not retrograde, amnesia) would be predictive of outcome.
- [113] Ms. Guram told Dr. Makin that she thought the driver of the Honda had tried to swerve because he struck the corner of her car. While Dr. Makin conceded that this history could indicate a lack of memory of events immediately preceding the accident, he views this as unlikely, saying many people do not see a vehicle that hits them from behind. He denied this is an example of Ms. Guram "filling in memory" based on what others have told her, describing this instead as a deduction on her part, based on her review of the post-accident damage to her vehicle. Ms. Guram told him that she concluded (after looking at the BMW following the accident) that the driver who struck her must have tried to swerve.
- [114] Dr. Makin's opinion is consistent with Ms. Guram's own trial evidence. She testified that she "didn't see [the Honda] coming"; notably, she did not say that she does not remember seeing it. Ms. Biring gave the same evidence; she too denied seeing the Honda before it struck the BMW and said that she was really shocked, very confused, and had no idea what had just occurred.
- [115] In my view, the evidence does not support the conclusion that Ms. Guram had any clinically significant retrograde amnesia after the accident. It is at least equally plausible that she (like Ms. Biring) simply did not see the Honda before impact.
- [116] Dr. Mehdiratta conceded that Ms. Guram reported no anterograde amnesia or major gaps in her memory following the accident. In my view, there are none. On Dr. Makin's evidence, it is against all published experience with amnesia for patients to report retrograde, but no anterograde, amnesia. He noted that everyone's memory is patchy for events that occurred four years (or even one day) ago. He stated that pre-traumatic amnesia in the absence of post-traumatic amnesia is usually considered to be non-organic; Dr. Mehdiratta neither identified nor addressed this possibility in his report.
- [117] Dr. Makin explained that anterograde amnesia is a functional, and not a structural, problem: the area of the brain that lays down memories can temporarily stop doing so due to trauma. On his evidence, memories that were never recorded cannot be recovered. They are not "filled in" unless someone tells the person what occurred; he described this as new learning. Ms. Guram provided Dr. Makin with a detailed description of multiple immediate post-accident events. Based on this history, he concluded that she had quite a seamless

immediate post-accident memory. He noted that, if she had post-traumatic amnesia, she would not remember her head hitting the headrest.

[118] I share Dr. Makin's view that it is unreasonable to conclude that someone has amnesia just because they do not recall every single detail from a specific day (now several years ago) when a person with no head injury would not either. Notably, when asked about the accident impact, Ms. Biring testified that events were really blurry for her; she gave evidence about what she vaguely remembered. Ms. Biring admitted her recollection of the events of that night (after she and her mother returned home from PAH) was also "pretty blurry".

[119] Similarly, neither Mr. Chanthavimone nor Ms. Ahluwalia recalled everything that transpired on April 28, 2019, either before or after the accident. However, like Ms. Guram, both were quite clear about what Ms. Ahluwalia described as the highlight of the day: namely, the accident.

[120] In my view, Dr. Mehdiratta's suggestion that Ms. Guram might have filled gaps in her memory after the accident (based on what others may since have told her) is speculative and argumentative. I accept Dr. Makin's view that, if this actually occurred, it comprises new learning and is not evidence of post-traumatic amnesia consistent with a mild traumatic brain injury. Ms. Guram provided details about many immediate post-accident events at multiple pre-trial expert assessments and at trial.

[121] In my view, the evidence does not support a finding that Ms. Guram had any clinically significant retrograde or anterograde amnesia after the accident.

(2) Altered Mental State

[122] Dr. Mehdiratta cites the third ONF Guidelines criterion (i.e., any alteration in mental state at the time of injury) as support for his diagnosis of mild traumatic brain injury. He admitted Ms. Guram did not advise him that she was anxious after the accident. He asked her if she was confused and she responded to this question in the affirmative.

[123] In Dr. Makin's opinion, it is more likely that Ms. Guram was emotionally distressed than neurologically impaired at the accident scene. In his view, of the three cardinal symptoms of concussion, this is the only one that was possibly but not probably positive; he cautions that it would be risky to base a diagnosis of concussion on this factor alone.

[124] Dr. Makin opines that it would be more important to look at a patient's GSC score in the PAH ER; in this case, it was normal. He noted that the PAH records make no mention of Ms. Guram being dazed or confused and reference none of the three cardinal diagnostic features of concussion. He testified that most patients experience some degree of surprise, anxiety, and emotional shock after a motor vehicle accident and that this needs to be distinguished from concussion-based confusion. This statement is consistent with the evidence of Ms. Biring, Mr. Chanthavimone, and Ms. Ahluwalia, all of whom testified that they experienced some degree of surprise and emotional shock after the accident.

- [125] On Dr. Makin's evidence, a primary source of information about whether or not a patient sustained a concussion comes from paramedics, independent witnesses, and the notes of ER staff. No emergency personnel attended the accident scene. The PAH records reference no post-accident complaints about Ms. Guram being dazed or confused; by contrast, she was consistently noted to be alert and oriented. While I do not rely on this information for its truth, I conclude that the evidence, taken as a whole, does not support a finding that Ms. Guram reported or had a neurologically significant altered mental state immediately after the accident.
- [126] When asked, Dr. Makin admitted concussion would be a possible diagnosis if Ms. Biring reported that Ms. Guram had hit her head, did not lose consciousness, but was confused and dizzy after the Accident. In my view, this hypothetical question is not one that is rooted in the evidence. Ms. Biring testified that her mother complained of being in pain after the accident and that they were both then "in shock". She agreed that her mother was confused after the accident and said that seeing the damage to the BMW "kind of freaked [Ms. Guram] out". Ms. Biring did not testify that Ms. Guram was then dizzy. Ms. S. Guram said that, when she arrived at the accident scene, Ms. Guram was in pain and holding her head; she did not testify that Ms. Guram was then dizzy or confused.
- [127] Ultimately, I am not persuaded on the evidence, taken as a whole, that Ms. Guram had any clinically significant post-accident confusion.

(3) Physical Symptoms

- [128] The fourth and final ONF Guidelines criterion on which Dr. Mehdiratta relies for his diagnosis of mild traumatic brain injury is the presence of physical symptoms (including vestibular symptoms, headaches, weakness, loss of balance, changing vision, auditory sensitivity, and dizziness). Many of these symptoms appear to overlap.
- [129] Dr. Mehdiratta attributes Ms. Guram's post-accident complaints of headache, dizziness, and perceived cognitive changes to post-concussion syndrome, a disease entity which Dr. Makin does not accept as valid. In Dr. Makin's experience, patients who are diagnosed with post-concussion syndrome typically have a variety of non-specific complaints which raise the possibility of other more conventional diagnoses. He denies that non-specific symptoms are appropriately described only as concussion symptoms or as post-concussion syndrome. I agree.
- [130] Dr. Makin interprets the physical symptoms referenced in the ONF Guidelines to mean non-neurological symptoms, something he views as peculiar in the context of a neurological diagnosis. He stated that none of the physical symptoms on which Dr. Mehdiratta relies would generally be regarded by neurologists as valid signs of concussion (although he concedes that some could be due to neurological diseases). While, in his view, none is a cardinal feature of concussion, he agreed that, if present, they would merit investigation for other possible causes. Dr. Makin considers complaints of weakness and dizziness as too vague to be meaningful. He admitted he would be looking for possible neurological

problems to explain post-accident headache (including, for example, a subdural hematoma) but he would not attribute this complaint to possible concussion. Dr. Makin does not agree that headache is a sign of concussion.

[131] Apart from headache, the physical symptoms identified in the ONF Guidelines are not referenced in the PAH records; Ms. Guram, Ms. Biring, and Ms. S. Guram did not include them in their description of Ms. Guram's immediate post-accident complaints, either at the accident scene or at PAH.

[132] Ultimately, I am not persuaded that the ONF Guidelines, assuming they comprise a valid diagnostic framework, support the diagnosis of mild traumatic brain injury.

(d) ACE Questionnaire

[133] Dr. Mehdiratta also relies on the ACE questionnaire to support his diagnosis of mild traumatic brain injury. Dr. Makin disputes its validity and clinical utility; he denies it is widely used by physicians in Canada. He does not agree that, just because it is posted on the Centers for Disease Control and Prevention website, the CDC endorses it.

[134] The ACE questionnaire references four areas of functioning: physical, cognitive, emotional, and sleep. Dr. Makin commented on them, in the context of an acute patient assessment for concussion, as follows:

a) Of the physical symptoms referenced:

i. Headache is not a feature of concussion and headache following concussion has been removed from the International Classification of Headache Disorders;

ii. Nausea may be a sign of increased intracranial pressure but it is not specific to concussion;

iii. Balance would be low on a physician's list of priorities in this setting;

iv. Dizziness typically means different things to different people and has many different causes (including, for example, hypotension or an inner ear problem) and he would not ask about it in this context;

v. While the other listed physical symptoms could present after trauma, none is specific to concussion; and

vi. Neck pain is a red flag for possible spinal cord injury but not for brain injury;

b) The cognitive symptoms listed (i.e., feeling mentally foggy, slowed down, or having difficulty concentrating or remembering) are essentially all the same and an acute head injury patient would not actually be asked any of these questions;

c) One of the last things Dr. Makin would ask a patient who is being assessed acutely for a possible head injury is whether they feel sad or emotional and, in his view, this question is neither relevant nor appropriate in this context; and

d) Fatigue and sleep quality are not relevant when assessing a patient for an acute head injury.

[135] I am not persuaded that the non-peer-reviewed ACE questionnaire, prepared by non-medical American Ph.D. authors, who are neither clinicians nor neurologists, provides compelling support for diagnosing a mild traumatic brain injury in this case.

(e) Possible Axonal Disruption

[136] Dr. Mehdiratta opines that the accident was associated with sufficient force to cause mild traumatic brain injury through axonal disruption, saying this can occur without direct trauma to the head. He notes that Ms. Guram began to experience a constellation of classic post-concussion syndrome symptoms after the accident.

[137] On Dr. Makin's evidence, axonal disruption is statistically unlikely in a patient whose head trauma was not severe enough to cause concussion; in his opinion, it is very unlikely here. He notes that the post-accident MRI of Ms. Guram's head was normal and inconsistent with abnormalities diagnostic of axonal injury. Ms. Guram has undergone no neuropsychological testing to date. In Dr. Makin's view, permanent structural brain damage is an improbable diagnosis.

[138] Plaintiff's counsel referenced photographs of damage to the parties' vehicles and trial evidence about the perceived force of the impact in her submissions. It is well-settled that findings of fact regarding injuries cannot be based on assumptions regarding the force on impact or the extent of vehicular damage: *Greenway-Brown v. MacKenzie*, 2019 BCCA 137 at paras. 27-30, leave to appeal to SCC ref'd, 38696 (12 December 2019). I make no such assumptions here.

(f) Treating Physicians' Diagnosis of Concussion

[139] Plaintiff's counsel underscored the discrepancy between Dr. Makin's opinion (that Ms. Guram did not sustain a concussion in the accident) and the diagnoses of three physicians involved in her care: GP, Dr. Khan; GP, Dr. Sawhney; and iScope neurologist, Dr. Bogusz.

[140] None of these treating physicians authored an expert report, was qualified as an expert, or testified at trial; their diagnoses are not in evidence for their truth. The fact that other physicians involved in Ms. Guram's care may have diagnosed concussion (or adopted a diagnosis of concussion made by others) is not probative of any matter in issue.

[141] Plaintiff's counsel criticizes Dr. Makin for undertaking a critical analysis of the records of Ms. Guram's treating health care professionals, describing his review as advocacy and likening it to an aide-memoire for cross-examination. I disagree. Defence counsel sent Dr. Makin a substantial volume of records; in my view, he reasonably assumed that he was being asked to review and comment on them. In my view, an unquestioning acceptance of other physicians' diagnosis of concussion is unhelpful, particularly when the basis for doing so is unclear and the accuracy of this diagnosis is the central issue in contested litigation.

[142] On Dr. Makin's uncontroverted evidence, Drs. Khan, Sawhney, and Bogusz provided no clear basis in their clinical records for diagnosing Ms. Guram with concussion and identified none of the cardinal features of concussion (i.e., a loss of consciousness, immediate post-accident confusion, and post-traumatic amnesia). Dr. Makin also noted that Dr. Sawhney diagnosed Ms. Guram with cervicogenic headache and multilevel cervical and lumbar nerve root compressions, in the absence of any supporting neurological examination or clinical basis for doing so.

[143] Unlike Dr. Makin, Dr. Mehdiratta apparently undertook no critical assessment of the diagnoses of Drs. Khan, Sawhney, and Bogusz. Significantly, by the time he assessed Ms. Guram, she had already been treated extensively for concussion (for more than three years) at iScope, the private clinic with which he is affiliated.

(g) Differential Diagnoses

[144] Conspicuously absent in Dr. Mehdiratta's reports is any reference to a differential diagnosis, including, in particular, mental health conditions, which could explain Ms. Guram's ongoing symptoms. Despite conceding at trial that he had read somewhere that Ms. Guram reported deriving no benefit from the extensive treatment she received at iScope, there is no indication that this information prompted Dr. Mehdiratta to consider any alternate diagnoses.

[145] Dr. Mehdiratta admitted the brain controls behavior and emotions and that psychiatric and neurological conditions overlap. He agreed that serotonin levels are "off" in patients with depression, anxiety, and brain injury, and that this disruption can result in emotional changes. He recommended that Ms. Guram undergo a neuropsychiatry evaluation, conceding that this area is outside his expertise. Dr. Makin denied that neuropsychological testing comprises part of a standard follow-up plan for mild traumatic brain injury patients in Canada outside the litigation context; he described it as expensive, time-consuming, and difficult to interpret.

[146] In my view, Dr. Mehdiratta's failure to reference any differential diagnoses which could explain Ms. Guram's ongoing complaints suggests a predisposition in favour of concussion. Dr. Mehdiratta's iScope colleague apparently either diagnosed or accepted the diagnosis of concussion in this case. It is unclear whether Dr. Mehdiratta would have been comfortable offering a contradictory diagnosis, particularly after Ms. Guram received extensive treatment over about three years at iScope (without benefit, on her evidence). In my view, Dr. Mehdiratta's close affiliation with iScope undermines his objectivity as an expert in this case.

[147] While Dr. Makin does not accept post-concussion syndrome as a valid diagnosis, he testified that the symptoms said to be associated with it overlap with those of depression. Although Ms. Guram completed a depression questionnaire in October 2021 (at the request of treating occupational therapist, Ann Sandhu) and her responses were consistent with moderate to severe symptoms of depression, Dr. Makin noted that no involved health care

professional diagnosed depression. Based on his review, despite referencing symptoms of depression in his earlier records, Dr. Sawhney first recorded a diagnosis of depression on October 31, 2019. Dr. Makin questions this approach. On his uncontroverted evidence, depression is a common disorder and one that usually responds to treatment; in his view, it is therefore important not to overlook this diagnosis.

[148] In Dr. Winston's opinion, many of Ms. Guram's reported symptoms are suspicious for non-organic findings. Dr. Makin agrees that the possibility of non-organic disease should not be overlooked, especially in forensic cases (like this one). There is no indication that Dr. Mehdiratta considered this possibility as part of a differential diagnosis.

(h) Allegations of Advocacy

[149] Counsel for both parties assert that the opposing neurology expert was an advocate. Plaintiff's counsel described Dr. Mehdiratta as a superior expert on the subject of traumatic brain injury and someone who is widely respected by this Court. Drs. Makin and Mehdiratta are both general neurologists. Both have been accepted by this Court as experts on previous occasions. I reject the suggestion of plaintiff's counsel that, because Dr. Mehdiratta's opinions (apparently based on the ONF Guidelines) were recently accepted by this Court in another case, the same result should follow here. I have decided the issues in this case on the trial evidence.

[150] Dr. Mehdiratta gave many lengthy answers to questions in cross-examination; they were not consistently responsive. He seemed reluctant to make unqualified admissions. Despite acknowledging having read that Ms. Guram reported deriving no benefit from the treatment she received at iScope, he declined to admit this was of concern, suggesting instead that some patients simply reach a plateau. In my view, reaching a plateau (after a period of improvement) is distinct from deriving no benefit from three years of extensive treatment, or perceiving (as Ms. Guram testified) that it was making her condition worse.

[151] Dr. Mehdiratta speculated about some matters outside his knowledge and expertise. For example, he stated that, in his experience, ER physicians do not order CT scans absent a concern about possible brain injury. Dr. Mehdiratta is not an ER physician and has no information about why the PAH ER physician ordered a CT scan of the head and cervical spine on April 28, 2019 in this case. Dr. Makin appropriately declined to speculate about why that occurred but noted there could be many potentially compelling reasons for ordering a CT scan of the head (apart from a suspected brain injury) including, for example, an insistent family.

[152] Ultimately, for all the foregoing reasons, I am not persuaded that the trial evidence, taken as a whole, supports the conclusion on a balance of probabilities that Ms. Guram sustained a mild traumatic brain injury in the accident. In my view, Dr. Makin undertook a more robust and critical review, offered more nuanced opinions, and was a more independent expert.

[153] The evidence of Dr. Winston and Mr. McNeil supports this conclusion. Based on Ms. Guram's history, Dr. Winston determined that she had a good recollection of what occurred during and immediately after the accident. He found that she suffered no loss of consciousness and no periods of retrograde or post-traumatic amnesia. Following his comprehensive two-day assessment, Mr. McNeil concluded that Ms. Guram is cognitively intact.

3. Headaches

[154] Ms. Guram complains of post-accident headaches, describing regular headaches with an intensity of 3-6/10 (on a scale of one to 10) and migraines with an intensity of 10/10. She agreed that she currently has fewer migraines than she did shortly after the accident and said that they now occur about once or twice a month and can be associated with light and noise sensitivity.

[155] Dr. Mehdiratta attributes Ms. Guram's headaches to the accident and diagnoses chronic migraines and post-traumatic headaches. In Dr. Makin's opinion, Ms. Guram likely has migraine headaches, possibly exacerbated by analgesic overuse. He testified that 15% of the general population has migraine headaches and that this is usually a lifelong condition, with periods of waxing and waning. In his view, Ms. Guram's headache symptoms fit with those of migraine. He opines that the childhood headaches she described were likely also migraine headaches. While he noted that exacerbations can sometimes be attributed to stress and/or depression, he denied there is any biological reason for a minor blow to the head to cause a permanent worsening of migraine headache.

[156] Dr. Makin denies there is any basis for concluding that Ms. Guram has a second type of headache, in addition to migraines; he noted while the diagnosis of "post-traumatic headache" was in the now obsolete International Classification of Headache Disorders Version 2, it has been removed from Version 3 of the same.

[157] Dr. Makin opines that the diagnostic criteria for cervicogenic headaches are not met in Ms. Guram's case. He denies it is acceptable to make this diagnosis based on a patient's reports of migraine headache and non-specific neck pain. Dr. Helper agrees that Ms. Guram's headaches are inconsistent with cervicogenic headache and more consistent with symptoms of migraine headache. Based on her reported history of about one migraine headache per week, Dr. Winston concludes that Ms. Guram does not meet the criteria for chronic migraine.

[158] The defendant admits, and I accept, that Ms. Guram had worse and more frequent migraine headaches after the Accident. I find that she does not have cervicogenic headaches or post-traumatic headaches due to a head injury.

4. Vision Issues

[159] Ms. Guram complains of ongoing eye strain with reading, occasional watering in her right eye, perceived altered depth perception, and sensitivity to the sun and to fluorescent lighting.

[160] Based on Ms. Guram's reported history, Dr. Mehdiratta concluded that she has reduced convergence as part of a post-traumatic vision syndrome. He explained that convergence is a normal physiological response which occurs when the eyes move inwards (including, for example, when a person is reading or following an object). Dr. Mehdiratta looks for reduced convergence as a surrogate marker for mild traumatic brain injury and to corroborate possible symptoms of vision difficulties. Dr. Makin notes that reduced convergence is a fairly prevalent finding in the general population and is frequently abnormal due to age alone.

[161] Ms. Guram remains a fully licensed driver, with no restrictions on her license. She testified that she has a very minimal prescription for corrective lenses which she does not require for driving. Although Ms. Guram admitted she has seen an ophthalmologist, this specialist gave no evidence at trial. I accept that there is an association between Ms. Guram's sensitivity to light and her migraine headaches.

5. Psychiatric Conditions

[162] Dr. Waisman is the only psychiatrist who testified at trial. The defendant does not dispute his psychiatric diagnoses and I accept them. Dr. Waisman interpreted the self-report inventories he asked Ms. Guram to complete as follows:

- a) Her answers on the PHQ-9 questionnaire indicate severe symptoms of depression; and
- b) Her answers on the GAD-7 questionnaire indicate severe symptoms of anxiety.

[163] Dr. Waisman opined as follows:

- a) The accident caused Ms. Guram to develop an adjustment disorder with mixed anxiety and depressed mood; and
- b) Her chronic pain leads to frustration and depression which, in turn, leads to low motivation, inactivity, and deconditioning (which further promotes feelings of sadness).

[164] In Dr. Waisman's view, Ms. Guram's prognosis is guarded and largely dependent on the prognosis for treatment of her physical condition, a matter on which he appropriately defers to others.

[165] As noted, while Dr. Mehdiratta conceded that the brain controls emotions (and that emotional changes can occur as a result of both mild traumatic brain injury and psychiatric diagnoses), he addressed no differential diagnoses in his reports. He stated in his second report dated September 29, 2023, that he offered his opinions from a purely neurological perspective. I accept that Dr. Mehdiratta is a neurologist and not a psychiatrist but, on his own evidence, psychiatric disorders present commonly in neurology patients. It appears

that he did not consider them here.

[166] Dr. Makin agrees that depression is common in all areas of clinical medicine, including neurology. He opines that depression likely forms part of Ms. Guram's current condition; in his view, this is difficult to disentangle from personality factors and compensation issues. He opines that the cognitive and emotional symptoms she reported are all consistent with depression and possible personality issues. In his view, she would benefit from a mental health referral.

[167] Dr. Helper defers to his colleagues in psychiatry regarding the diagnosis of Ms. Guram's cognitive and emotional complaints. It is his impression that her lack of progress and related functional limitations are influenced by her cognitive/emotional response to pain. He agreed that improvement in the latter will improve the former.

[168] In my view, Ms. Guram's mental health condition significantly influences her perceived disability. She testified that her anxiety started shortly after the accident. On her evidence, her depression has impacted her a lot; she said that she was "down all along" after the accident, and that her mood has been "slowly declining". At some point, Ms. Guram stopped all her post-accident treatments because she was depressed. She has not yet restarted active rehabilitation because, on her own evidence, she is hoping for her mood to improve so that she will be more motivated.

[169] Dr. Makin notes that Ms. Guram reported (for no specific reason which she could identify) that all of her symptoms worsened in June 2023. Ms. Guram testified that she was then depressed. In Dr. Makin's opinion, a diagnosis of depression is highly consistent with Ms. Guram's reported symptoms. I conclude that this is likely the best explanation for why she perceives her condition to be worsening, in the absence of any objective pathology to explain such a decline. It is also consistent with her perception that she has accident-related cognitive changes, despite Mr. McNeil's opinion that she is cognitively intact.

6. Miscellaneous Symptoms and Other Diagnoses

[170] Ms. Guram reports a wide variety of other vague complaints. In my view, many of them are poorly explained. She testified that her hands now tend to shake a lot but admitted this could be due to anxiety. She thinks she has decreased right hand grip strength. Mr. McNeil tested her right grip strength to be average and within a functional range for repetitive grasping in daily activities, including work. Ms. Guram admitted her post-accident dizziness has improved but said it is still present "here and there".

[171] In Dr. Makin's opinion:

- a) Ms. Guram's reported hand tremor is likely a non-organic problem as there is no category of brain injury that would produce an organically-caused tremor for the first time several years after a minor blow to the head;

- b) Ms. Guram's right arm sensory symptoms cannot be attributed to the accident (which did not injure her arms) and are most suggestive of a carpal tunnel syndrome; and
 - c) Ms. Guram's non-specific references to dizziness have no identifiable neurological cause.
- [172] Ms. Guram admitted she was referred to a neurologist for her hand symptoms; this physician gave no evidence at trial.
- [173] Dr. Makin concludes that Dr. Mehdiratta apparently bases his diagnosis of post-traumatic vestibulopathy on Ms. Guram's vague reports of dizziness and poor balance, which were not clearly confirmed on Dr. Mehdiratta's examination and definitely not confirmed on Dr. Makin's examination. I accept Dr. Makin's evidence that balance issues fall squarely within the expertise of ENT physicians. Notably, Ms. Guram saw ENT physician, Dr. Samad, at least six times in 2019 and 2020 for unknown reasons. It is unclear whether or not she raised any concerns about dizziness, poor balance, or post-traumatic vestibulopathy with Dr. Samad. Dr. Samad gave no evidence at trial.
- [174] Ms. Guram reported an inability to walk on her heels and toes at Dr. Mehdiratta's assessment. On Dr. Makin's evidence, this is typically considered to be a test of muscle strength and not balance. He noted that an inability to do either would be a puzzling finding here as Ms. Guram's neurological examination identified no abnormalities affecting muscle power, sensation, reflexes, gait, or coordination. Dr. Mehdiratta's own strength test results were 5/5 (i.e., normal); coordination, gait, muscle tone, and bulk were also all normal. Dr. Mehdiratta did not comment on the apparent discrepancy between these objective findings and Ms. Guram's reported inability to walk on her heels or toes.
- [175] Dr. Makin distinguished organic disease (which is caused by an identifiable structural, physiological or biochemical abnormality with the brain) from non-organic causes (which he defined as everything else). In his view, Ms. Guram's stated inability to walk on her toes or heels on examination (as reported by Dr. Mehdiratta) is suspicious for a non-organic finding. Ms. Guram had no difficulty walking on her heels or toes at Dr. Makin's assessment. Dr. Helper noted that Ms. Guram had a normal gait pattern. Mr. McNeil observed no restrictions with her gait pattern (with or without a load) at his assessment.
- [176] Dr. Mehdiratta diagnosed Ms. Guram with thoracic outlet syndrome ("TOS"). He neither explained this diagnosis nor provided his rationale for diagnosing Ms. Guram with this condition. Notably, the tests Dr. Helper administered were negative for TOS.
- [177] Dr. Makin describes TOS as an ambiguous diagnosis; in his view, it is untenable here. He notes that diagnosing arterial TOS (in the absence of symptoms relating to arterial insufficiency) normally falls within the purview of a vascular surgeon and not a neurologist.

- [178] Dr. Mehdiratta includes in his list of diagnoses for Ms. Guram a "Report of Decreased Sense of Taste and Smell". Ms. Guram did not complain of this problem at trial. I accept Dr. Makin's view that it is a reported symptom and neither an examination finding nor a diagnosis. The basis for Dr. Mehdiratta's statement that this "neurological diagnosis" is related to the accident is unclear.

VII. CAUSATION

A. Legal Framework

- [179] The basic test for determining causation is the "but for" test. The plaintiff bears the burden of establishing that "but for" the defendant's negligent act or omission, the injury would not have occurred: *Resurface Corp. v. Hanke*, 2007 SCC 7 at para. 21; *Athey v. Leonati*, [1996] 3 S.C.R. 458 at paras. 13-14, 1996 CanLII 183 [Athey]. The "but for" test must be proven on a balance of probabilities: *Athey* at para. 13. The accident need not be the only cause of the plaintiff's injuries but it must be a causal factor beyond the *de minimis* range: *Athey* at para. 15. If a defendant's negligence exacerbates or aggravates an existing condition, the defendant is liable for causing the resulting injury: *Athey* at para. 47.
- [180] The most basic principle of tort law is that the plaintiff must be placed in the same position they would have been but for the defendant's negligence. Tortfeasors must take their victims as they find them, even if the plaintiff's injuries are more severe than they would be for another person. However, a defendant need not compensate a plaintiff for any debilitating effects of a pre-existing condition that the plaintiff would have experienced anyway: *Dornan v. Silva*, 2021 BCCA 228 at paras. 44-45.
- [181] Whether manifest or not, a weakness inherent in a plaintiff that might realistically cause or contribute to the loss claimed, regardless of the tort, is relevant to an assessment of damages; such a contingency does not have to be proven to a certainty but should be given weight according to its relative likelihood: *T.W.N.A. v. Canada (Ministry of Indian Affairs)*, 2003 BCCA 670 at para. 48 [T.W.N.A.]. Both latent and active pre-existing conditions must be considered in assessing the plaintiff's original position: *T.W.N.A.* at para. 30.
- [182] Plaintiff's counsel submits that because Ms. Guram was in good health before the accident and now has multiple complaints, the accident caused all of her alleged injuries. However, a temporal connection alone may be insufficient to establish causation: *White v. Stonestreet*, 2006 BCSC 801 at paras. 74-75.

B. Expert Evidence

1. Soft Tissue Injuries

- [183] Dr. Helper attributes his diagnosis of myofascial injury to the accident. He opines that Ms. Guram's non-specific complaints of diffuse neck pain are probably due to soft tissue injury rather than facet joint pain. Dr. Winston diagnosed Ms. Guram with probable soft tissue injuries to her neck as a result of the accident.
- [184] Dr. Helper notes that Ms. Guram was involved in another motor vehicle accident in the spring of 2022 and that he did not fully understand its implications. Dr. Mehdiratta states in his first report that this second accident caused a further aggravation of Ms. Guram's neck pain and headache. There was no trial evidence about this 2022 accident. The parties agree that it is irrelevant to the assessment of Ms. Guram's 2019 accident-related injuries.
- [185] Dr. Helper found that Ms. Guram had full motor power in her upper and lower extremities. He noted that she presented with delayed bilateral anterior knee aching and crepitus (a crackling or crunching sound) after the accident. He testified that this can indicate the presence of underlying arthritis or a joint that is not sliding smoothly. He admitted this is an abnormality but denied it is an "earth-shattering" one. In his opinion, while Ms. Guram is likely experiencing mild symptoms of patellofemoral joint pain, she probably sustained no direct trauma to her knees at the time of the accident. He admitted there is no clear causal link between Ms. Guram's knee symptoms and the accident and confirmed that crepitus is a common condition in the general population. Ms. Guram demonstrated full range of motion in flexion and extension and minimal findings on his examination of her knees.
- [186] I find that the accident caused soft tissue injuries of variable intensity to Ms. Guram's neck, right shoulder, mid-back, low back, and right hip. I find that her knee complaints are not causally related to the accident.

2. Mild Traumatic Brain Injury or Concussion

- [187] For the above-noted reasons, I prefer Dr. Makin's opinions to those of Dr. Mehdiratta regarding whether or not Ms. Guram sustained a mild traumatic brain injury in the accident. I find that Ms. Guram has not met her burden of proving on a balance of probabilities that the accident caused a mild traumatic brain injury.

3. Headaches

- [188] In Dr. Helper's view, there is a weak association between Ms. Guram's neck pain and her headaches. He and Dr. Makin agree that Ms. Guram's headache complaints are not consistent with cervicogenic headache. Dr. Helper notes the absence of any association between Ms. Guram's neck pain and her headaches, in addition to her description of migraine phenomena (including sensitivity to noise and light). Drs. Makin and Helper both conclude that Ms. Guram's complaints are more consistent with symptoms of migraine; this conclusion is consistent with her own recorded description of her post-accident headaches in the SMH records.

[189] I find that Ms. Guram has post-accident migraine (and not cervicogenic) headaches. The defendant admits and I accept that she now experiences more frequent and more severe migraine headaches as a result of the accident.

4. Psychiatric Conditions

[190] I accept Dr. Waisman's unchallenged opinion that the accident caused Ms. Guram to develop an adjustment disorder with symptoms of anxiety and depression. In my view, her mental health condition is a prominent feature of her ongoing disability.

5. Other Complaints

[191] I am not persuaded on a balance of probabilities that Ms. Guram's complaints of occasional dizziness and visual symptoms are due to an accident-related head injury. Dr. Makin recommended that she be referred to an otolaryngologist (for her vague reports of occasional dizziness and poor balance) and to a neuro-ophthalmologist (for the visual symptoms which he described as fairly prevalent in the general population and frequently due to aging). Ms. Guram admitted her dizziness has improved and that she has learned to manage it.

[192] I accept Dr. Makin's opinion that Ms. Guram's hand tremor complaints are not due to a neurological cause. I am unable to find on a balance of probabilities that the accident caused her subjective complaints of arm weakness, tingling, and/or numbness. I am not persuaded that Ms. Guram developed TOS due to the accident.

C. Summary of Findings

[193] In summary, I make the following findings:

- a) Ms. Guram sustained soft tissues injuries to her neck, right shoulder, mid-back, low back, and right hip in the accident;
- b) Ms. Guram's knee complaints are not causally related to the accident;
- c) Ms. Guram did not develop cervicogenic headaches as a result of the accident;
- d) Ms. Guram now has worse and more frequent migraine headaches, which can be associated with light and noise sensitivity, due to the accident;
- e) Ms. Guram did not sustain a concussion or mild traumatic brain injury in the accident;
- f) Ms. Guram's complaints of hand tremors and right arm sensory symptoms are not related to the accident;
- g) Ms. Guram's complaints of occasional dizziness are poorly explained and not due to a head injury from the accident;
- h) Ms. Guram has developed an adjustment disorder with symptoms of anxiety and depression as a result of the accident;

- i) Ms. Guram's mental health difficulties enhance her experience of pain and negatively impact her mood and function; and
- j) Ms. Guram has not proven on a balance of probabilities that the accident caused her to develop TOS, reduced convergence, or other vision issues.

[194] I agree with Dr. Makin that complaints of a reduced sense of taste and smell are symptoms and not a diagnosis. I find that the evidence does not support a causal connection between the accident and those complaints.

VIII. MITIGATION

[195] The defendant does not assert that Ms. Guram has failed to mitigate her damages. Accordingly, I do not address this issue.

IX. GENERAL DAMAGES

[196] Non-pecuniary damages are awarded to compensate a plaintiff for pain, suffering, loss of enjoyment of life, and loss of amenities. The compensation awarded should be fair to all parties; fairness is measured against awards made in comparable cases. Such cases, while helpful, serve only as a rough guide. Each case depends on its own unique facts: *Trites v. Penner*, 2010 BCSC 882 at para. 189.

[197] The Court of Appeal outlined the non-exhaustive factors to be considered when assessing non-pecuniary damages in *Stapley v. Hejslet*, 2006 BCCA 34 at para. 46 [Stapley]. They include the plaintiff's age, nature of the injury, severity and duration of pain, disability, emotional suffering, loss or impairment of life, impairment of family, marital and social relationships, impairment of physical and mental abilities, loss of lifestyle, and plaintiff's stoicism, a factor which generally ought not to penalize a plaintiff.

[198] In Ms. Guram's view, everything in her life was perfectly aligned before the accident: she enjoyed good physical and mental health, was actively engaged in her life, and was well-positioned in her career. She now describes her future as scary and unknown. She seeks non-pecuniary damages in the range of \$220,000-\$230,000 and relies on the following authorities:

- a) *Young v. Anderson*, 2008 BCSC 1306 [Young] (\$200,000);
- b) *Pololos v. Cinnamon-Lopez*, 2016 BCSC 81 (\$180,000);
- c) *MacKinnon v. Swanson*, 2022 BCSC 1821 (\$180,000); and
- d) *Ballantyne v. Kruger*, 2023 BCSC 1324 [Ballantyne] (\$200,000, including past loss of housekeeping capacity).

[199] The defendant assesses non-pecuniary damages in the range of \$100,000-\$125,000 and cites the following authorities:

- a) Rajan v. Hudon, 2014 BCSC 1678 [Rajan] (\$90,000);
- b) Sidhu v. Baturin, 2022 BCSC 102 (\$150,000); and
- c) Taylor v. Porter, 2023 BCSC 777 (\$120,000).

- [200] I accept that Ms. Guram's life has changed since the accident. On her own evidence, as corroborated by members of her immediate family, she is now a different person. On the uncontroverted trial evidence, Ms. Guram was active and physically fit before the accident; she enjoyed fitness classes and going to the gym. She read to unwind. Apart from breaking her ankle a few times and having headaches in 2014 (which she understood were associated with a pituitary adenoma), she said that she was otherwise healthy.
- [201] On Ms. Guram's evidence, as corroborated by her family, she no longer wants to be around people, is anxious if she goes out, and prefers to stay home. According to Ms. Guram, as corroborated by her daughter, she previously enjoyed cooking, hosting events, and inviting people over for dinner. On their evidence, Ms. Guram has become depressed and despondent, is no longer active, no longer socialises with friends or family, and spends her days at home (mostly sitting on the couch or on the deck). Ms. Guram's family members now describe her as moody, impatient, and irritable. While I accept that Ms. Guram's relationships with her family have changed since the accident, they clearly remain strong and supportive.
- [202] There was substantial trial evidence about various photographs posted on social media accounts depicting several post-accident Guram family events. In my view, they have limited probative value. According to Ms. Guram, as corroborated by her daughter, sister, and fiancé, she was consistently a reluctant participant, was always uncomfortable, and often retired for breaks with her heating pad.
- [203] I have found that Ms. Guram has not met her burden of establishing on a balance of probabilities that she sustained a concussion or mild traumatic brain injury in the accident. That finding distinguishes this case from many of the authorities on which she relies.
- [204] I conclude that there is potential for significant improvement in Ms. Guram's condition. There are treatment options that she has not yet pursued, including, in particular, SNRI anti-depressants like Duloxetine (which, on Dr. Waisman's uncontroverted evidence, target both depression and chronic pain) and the intensive psychotherapy that Dr. Waisman recommends. The experts agree that there is a correlation between mental and physical health. I conclude on the expert evidence (of Drs. Waisman and Helper, in particular) that improved mental health would help motivate Ms. Guram to become more active, social, and engaged, thereby resulting in better strength, stamina, confidence, and overall well-being. I accept Dr. Makin's unchallenged view that analgesic overuse might be exacerbating her headaches.

- [205] The plaintiff's authorities generally involve plaintiffs with worse injuries, more significant limitations, and less potential for further improvement. The defendant's authorities include plaintiffs with more significant pre-accident health issues, better recoveries, and less overall negative impact on their function and ability to work.
- [206] The plaintiff relies on *Young*, a decision that was decided more than a decade ago; the defendant relies on *Rajan*, a decision that is now about ten years old. The Court of Appeal has cautioned against relying on non-pecuniary awards in cases older than ten years because simply adjusting for inflation ignores the fact that non-pecuniary awards have continued to increase (in addition to adjustments for inflation): *Valdez v. Neron*, 2022 BCCA 301 at para. 58, leave to appeal to SCC ref'd, 40442 (30 March 2022); *Callow v. Van Hoek-Patterson*, 2023 BCCA 92 at paras. 16-18.
- [207] The authorities that counsel cite all have unique facts. Having regard to the Stapley factors, Ms. Guram's injuries and their impact on her life, my findings of fact, and my assessment of the trial evidence as a whole, I award non-pecuniary damages of \$135,000. In doing so, I have considered the impact of Ms. Guram's accident-related injuries on her past and future loss of housekeeping capacity.

X. LOSS OF HOUSEKEEPING CAPACITY

- [208] Ms. Guram seeks a separate award in the amount of \$78,660, for the past and future loss of housekeeping capacity. The defendant submits that any loss of housekeeping capacity is appropriately considered as part of a non-pecuniary award.
- [209] The principles that govern when a plaintiff may recover damages for loss of housekeeping capacity are canvassed in *Riley v. Ritsco*, 2018 BCCA 366 at para. 101 and *Kim v. Lin*, 2018 BCCA 77 at paras. 27-37 [Kim]. The Court of Appeal recently affirmed these principles in *Haug v. Funk*, 2023 BCCA 110 at paras. 98-107, and *McKee v. Hicks*, 2023 BCCA 109 at para. 112, where the Court held:

To sum up, pecuniary awards are typically made where a reasonable person in the plaintiff's circumstances would be unable to perform usual and necessary household work. In such cases, the trial judge retains the discretion to address the plaintiff's loss in the award of non-pecuniary damages. On the other hand, pecuniary awards are not appropriate where a plaintiff can perform usual and necessary household work, but with some difficulty or frustration in doing so. In such cases, non-pecuniary awards are typically augmented to properly and fully reflect the plaintiff's pain, suffering and loss of amenities.

- [210] Depending on the facts, a loss of housekeeping capacity may be compensated by pecuniary or non-pecuniary damages: *Campbell v. Banman*, 2009 BCCA 484 at para. 13, citing *McTavish v. MacGillivray*, 2000 BCCA 164.

- [211] Before the accident, Ms. Guram was living with her mother and daughter in her mother's single detached house in Surrey. On Ms. Guram's evidence, she cleaned the part of the house where she and Ms. Biring resided, made breakfast and dinner for them, and shared kitchen cleaning with her mother; her mother did all the outside work.
- [212] According to Ms. Guram, she was not doing much housework immediately after the accident. On her evidence, she spent most of her time in her room and told Ms. Biring to eat whatever Ms. Guram's mother cooked. At some point, Ms. Guram's mother became upset because Ms. Guram was spending so much time in her room after the accident and she called the "mental health unit" to assess Ms. Guram. Sometime thereafter, Ms. Guram moved into the 1,000 square foot, two-bedroom, two-bathroom, condo that she now shares with her daughter and fiancé. According to Ms. Guram, Ms. Biring and Mr. Sidhu share the housework and she helps as much as she can.
- [213] After Mr. Sidhu moved into Ms. Guram's condo in June 2021, he began helping with housework, including vacuuming, mopping, loading and unloading the dishwasher, doing laundry, folding clothes, taking out garbage, and buying groceries. Ms. Biring has developed an interest in cooking and has started making dinner. When asked, Ms. Guram said that while it would be helpful to have housekeeping assistance, she does not want to become dependent on it. She agreed that, apart from some area rugs, there are no carpets in her condo and that it takes only "a minute" to vacuum.
- [214] Ms. Guram was cross-examined about information that she provided to Drs. Helper and Winston about her housekeeping capacity; she said that she understood their questions about this matter related only to the previous 24-48 hours.
- [215] Ms. Guram informed Dr. Helper that she is able to complete all housework activities, with some difficulty, and that she tends to defer some push and pull tasks. She described being poorly tolerant of heavy or prolonged grocery shopping, and breaking down cooking duties into smaller tasks. Dr. Helper would expect Ms. Guram to be independent with the activities of daily living, with pacing and an acceptance of some degree of pain. He opines that she will likely require assistance with above shoulder height tasks until she achieves the tangible improvements in shoulder movement, strength, and increased tolerance he expects with kinesiology training.
- [216] In Dr. Helper's opinion, brief periods of vacuuming or other heavy push or pull activities over a small surface area (such as a condo) might cause a small escalation in Ms. Guram's pain but not so much as to require hired help. He agreed that she reported being able to vacuum, with some increase in her symptoms. Based on her responses on Dr. Winston's intake form, Ms. Guram reported needing help with most listed activities, including all home maintenance tasks.

- [217] Dr. Waisman notes that Ms. Guram lacks motivation to perform household tasks and needs to pace herself due to symptoms of chronic pain, depression, and anxiety. He does not say that she is unable to do these tasks.
- [218] Mr. McNeil agreed that, if Ms. Guram is not working, she should be doing her own routine housekeeping as a form of therapeutic exercise. When she is working, he recommends two hours per week of homemaking assistance (52 weeks/year) at the rate of \$34.50/hour for an annual cost of \$3,588. Mr. McNeil contemplates that Ms. Guram would perform lighter household chores. He relied on a 2015 Statistics Canada General Social Survey indicating that women aged 45-54+ spend an average of 3.7 hours per day doing unpaid work (including 2.7 hours on household chores). Ms. Guram claims \$68,172 (before discounting to present value), based on 19 years of weekly homemaking assistance in this amount, to her age 65.
- [219] Mr. McNeil also described heavy seasonal indoor housecleaning (i.e., moving fixtures, cleaning fans, blinds, and drapes) and recommends that Ms. Guram receive 16 hours per year of help with these tasks. Ms. Guram claims \$10,488 to cover future seasonal housekeeping costs, before discounting to present value, based on this recommendation at a cost of \$34.50/hour or \$552/year. Mr. Cole opines that the weekly housecleaning and heavy seasonal cleaning assistance that Mr. McNeil recommends is excessive for someone capable of light housekeeping tasks. In his view, two to four hours per month of housekeeping services is more reasonable, given the size of Ms. Guram's residence.
- [220] Dr. Mehdiratta opines that the exertional demands for household activities are outside Ms. Guram's current capability (due to headaches, neck pain, low back pain, dizziness, and cognitive impairments) and would likely exacerbate her symptoms. He concludes that she is at least partially disabled from housekeeping and home maintenance as a result of her neurological injuries sustained in the accident. His opinions (some of which arguably fall outside his area of expertise as a neurologist) are premised on a finding that the accident caused a mild traumatic brain injury.
- [221] Ms. Guram resides in a small condo with two other adults. Her weekly housecleaning demands are modest; they are currently being met predominantly by her fiancé and daughter. I accept Mr. McNeil's opinion that, while Ms. Guram is not working, she would benefit from doing some housework. On all the expert evidence, it is important for her to transition to a more active lifestyle. On Ms. Guram's own evidence, she has become weaker and deconditioned since she stopped attending active rehabilitation.
- [222] Based on her report to Dr. Helper, I conclude that Ms. Guram is capable of light housekeeping, albeit with some increase in her symptoms. Based on Dr. Waisman's evidence, I conclude that her motivation to do housework will improve with better mental health. Ms. Guram gave no evidence about whether, or how often, she would have moved appliances, cleaned drapes and blinds, or engaged in other heavy seasonal cleaning, absent the accident. There is no evidence that she intends to relocate to a house, where the

demand for seasonal cleaning would be higher.

[223] Ms. Guram's claim for future housekeeping costs is premised on assumptions that I do not accept: namely, that she sustained a mild traumatic brain injury in the accident, that her condition will never improve, and that she will never be able to do any of this work. Ms. Guram is a tall but slight woman who had multiple pre-existing degenerative changes in her spine at the time of the accident. It is unclear to what extent she would have engaged in heavy seasonal cleaning absent the accident. I accept that she will likely have some degree of chronic pain indefinitely but, for the reasons previously stated, I do not agree that her condition will never improve.

[224] In my view, Ms. Guram's claim for past and future loss of housekeeping capacity is best assessed as a loss of amenities. I have considered this loss in my assessment of non-pecuniary damages.

XI. SPECIAL DAMAGES

[225] Claims for special damages are generally subject only to the standard of reasonableness.

[226] The parties agree on special damages of \$3,183. This figure includes costs for medications, physiotherapy, active rehabilitation, chiropractic and ocular treatment fees, and various other expenses related to an ambulance invoice, housecleaning costs, a heating pad, physician fees, and mileage to attend treatments. I award special damages in this amount.

XII. INCOME LOSS

A. Legal Framework

[227] I adopt my summary of the relevant law, as set out in Ballantyne.

[228] Compensation for past loss of earning capacity is based on what the plaintiff would have, not could have, earned but for the injury that was sustained: *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141 at para. 30 [Rowe]; *M.B. v. British Columbia*, 2003 SCC 53 at para. 49. The burden of proof regarding actual past events is a balance of probabilities. When courts are assessing past loss of income, they are really assessing lost earning capacity: *Rowe* at para. 30.

[229] An assessment of the loss of both past and future earning capacity involves a consideration of hypothetical events: *Grewal v. Naumann*, 2017 BCCA 158 at para. 48 [Grewal]. The plaintiff is not required to prove these hypothetical events on a balance of probabilities; a hypothetical possibility will be considered as long as it is a real and substantial possibility and not mere speculation: *Grewal* at para. 48.

[230] A claim for future loss of earning capacity requires the court to compare the plaintiff's likely future working life if the accident had not happened with the likely one after its occurrence, accounting for negative and positive contingencies: *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para. 32.

- [231] Depending on the facts of the case, the loss may be quantified on either an earnings approach or a capital asset approach: *Perren v. Lalari*, 2010 BCCA 140 at para. 32. The earnings approach is typically used in cases where there is an identifiable loss of income: *Kringhaug v. Men*, 2022 BCCA 186 at para. 43. The capital asset approach is typically used when this is not the case and the court makes an award for the loss of opportunity.
- [232] The Court of Appeal recently clarified the law regarding the assessment of lost future earning capacity in a trilogy of cases: *Dornan v. Silva*, 2021 BCCA 228; *Rab v. Prescott*, 2021 BCCA 345 [Rab]; *Lo v. Vos*, 2021 BCCA 421. In *Rab* at para. 47, Justice Grauer set out a three-step process for assessing future income loss:

[A] three-step process emerges for considering claims for loss of future earning capacity, particularly where the evidence indicates no loss of income at the time of trial. The first is evidentiary: whether the evidence discloses a potential future event that could lead to a loss of capacity (e.g., chronic injury, future surgery or risk of arthritis, giving rise to the sort of considerations discussed in *Brown*). The second is whether, on the evidence, there is a real and substantial possibility that the future event in question will cause a pecuniary loss. If such a real and substantial possibility exists, the third step is to assess the value of that possible future loss, which step must include assessing the relative likelihood of the possibility occurring--see the discussion in *Dornan* at paras 93-95.

- [233] The assessment of damages is a matter of judgment and not calculation: *Rosvold v. Dunlop*, 2001 BCCA 1 at para. 18. While assessing an award for future loss of income is not a purely mathematical exercise, the court should endeavour to use factual mathematical anchors as a starting foundation to quantify such loss: *Jurczak v. Mauro*, 2013 BCCA 507 at paras. 36-37; *Morgan v. Galbraith*, 2013 BCCA 305 at para. 54.

B. Lay Evidence

1. Ms. Guram

- [234] Although Ms. Guram retains a current real estate license, she has never earned any income working as a realtor. Ms. Guram abandoned her claim for the loss of past and future earning capacity to work as a realtor at trial.
- [235] In Ms. Guram's view, she is unable to return to her LPN instructor job, saying she no longer has the cognitive capacity to do this work (including speaking coherently, having the confidence and self-esteem to teach, demonstrating, supervising, and ensuring patient safety). She noted that, as an LPN instructor, she is responsible for any mistakes her students make while under her supervision. She admitted she could likely put course materials together and conceded that she had a lot of freedom regarding how to structure her teaching at VCC.
- [236] Absent the accident, Ms. Guram planned to work as an LPN travel nurse in good weather and as an LPN instructor at VCC during bad weather months. She attempted a return to work as a travel LPN in the summer of 2019. On her evidence, she was accommodated and

worked mostly 12-hour graveyard shifts at Jackson House in Ashcroft. Ms. Guram said that she experienced significant neck, shoulder, low back, and headache pain; she took her heating pad to work and used it when sitting in a reclining chair. She agreed that the care aides were very helpful.

- [237] Ms. Guram admitted LPN work is always available through Staffing Solutions. Staffing Solutions sends emails about available contracts and Ms. Guram can respond to any that are of interest. She still receives information about LPN work contracts and conceded that there is a currently a universal demand for LPNs and many LPN job opportunities. She has maintained her LPN licence and said that she would love to return to work. In her view, she cannot safely resume travel LPN work given her cognitive and functional deficits.
- [238] The parties agree that Ms. Guram collected employment insurance benefits after the accident. They also agree that she was approved by Service Canada on August 12, 2021, for Canada Pension Plan disability benefits and that she has been receiving total temporary disability benefits from ICBC since 2019.

2. Ms. Bordas

- [239] Amy Bordas has been a registered nurse since 2010; she now works as a self-employed foot care nurse and casual employee with the Interior Health Authority. In 2019, Ms. Bordas was the long-term care coordinator at Jackson House. She held this position from 2017 to 2019. Her job duties involved overseeing Jackson House staff, including LPNs, care aides, and one recreational coordinator.
- [240] Ms. Bordas described the role of an LPN at Jackson House as including vital sign checks, administering medications, communicating with the nurse manager and/or medical staff about any patient concerns that extended beyond the scope of their expertise, maintaining inventory, counting narcotics, and checking expiry dates. She said that LPNs have more duties during the day shift, including administering medications, doing wound care, and communicating with staff. During the night shift, they have fewer duties, substantially more down time, and do not complete vital sign checks, administer medication, or engage in the same level of communication with other staff. LPN shifts at Jackson House are 12 hours.
- [241] Ms. Bordas met Ms. Guram in December 2018. Ms. Guram then worked for Staffing Solutions, an agency which filled LPN contract positions at Jackson House. Her first impression of Ms. Guram was positive: she described Ms. Guram as social, fun, and a pleasant co-worker; she liked how Ms. Guram interacted with staff and residents and was happy with the quality of her work.
- [242] After the accident, Ms. Guram consistently worked the night shift; Ms. Bordas worked the day shift. Accordingly, Ms. Bordas only saw Ms. Guram in passing in the staff residence. It was her general impression that Ms. Guram seemed sore when they spoke (by the way she moved her entire torso, rather than just her neck). Ms. Bordas gave Ms. Guram permission

to switch to the night shift and to take micro-breaks during her shift to rest and ice. She advised the care aides that Ms. Guram might need some additional assistance. She had no recollection of Ms. Guram having an altered gait, balance issues, or sensitivity to light.

[243] Ms. Bordas described the staffing of LPNs at Jackson House as having gone from bad to worse in recent years; I interpret this statement to mean that it is difficult to staff this facility. Ms. Bordas understands that Jackson House terminated several staff persons who declined to be vaccinated for COVID-19.

[244] Ms. Bordas admitted Ms. Guram had the flexibility to choose the contracts she wanted to work. She confirmed that Jackson House had care aides to assist LPNs: during the day shift, there was a maximum of four care aides for 22 residents; there was one care aide during the night shift. Ms. Bordas conceded that the care aides did most of the work associated with the residents' physical care.

C. Expert Evidence

1. Mr. McNeil, OT

[245] Mr. McNeil assessed Ms. Guram's capacity to work. He reached the following conclusions:

- a) Ms. Guram's reports of pain and ongoing physical restrictions were generally consistent with her measured and observed abilities;
- b) Ms. Guram consistently demonstrated her best effort and his test results are an accurate and reliable measure of her overall physical capacity;
- c) Ms. Guram demonstrated a good understanding and recollection of test instructions; and
- d) Scores of her functional cognition were consistently average and he identified no significant cognitive weaknesses on his testing.

[246] Mr. McNeil summarized Ms. Guram's overall work capacity as follows:

- a) Ms. Guram was somewhat impulsive and impatient when reading instructions;
- b) Her reports of increased pain corresponded with increased distractedness and impulsiveness and decreased tolerance and, in his view, this would impact her capacity to work in a fast-paced environment;
- c) Ms. Guram is capable of working in occupations with sedentary physical demands;
- d) Ms. Guram has the capacity to work with accommodations but she will struggle to maintain a competitive pace;
- e) Ms. Guram did not demonstrate the capacity to do light, medium, or heavy strength work;
- f) LPN work is classified as a medium strength job; and

g) Ms. Guram is capable of part-time LPN work within a limited scope of practice (primarily light duty nursing, including, for example, education or community nursing where she is performing assessments and taking vital signs) with restrictions and accommodations to manage pain but she will struggle to obtain and maintain a productive work pace.

[247] Mr. McNeil confirmed that Ms. Guram's former LPN job did not require prolonged overhead work. He conceded that she did very well and better than he expected on the cognitive tests he administered. In his view, her problem lies in her tendency to rush and this is what might impact her cognitive function at work; in his experience, this is not an uncommon approach in individuals with chronic pain.

[248] In Mr. McNeil's opinion, Ms. Guram could physically manage a sedentary part-time job, with accommodations that permit her to slow down and pace herself. He agreed that she could lecture, with accommodations (including an ergonomic set-up, variable hours, and the ability to stand and sit). In his view, an administrative office job would be very similar to a lecturing position and Ms. Guram might be able to do this kind of work part-time, with accommodations, in a quiet environment.

[249] Mr. McNeil admitted most patient transfers require either two persons or a mechanical lift and that Ms. Guram would have required help with patient transfers before the accident.

2. Mr. Cole, Kinesiologist

[250] Kinesiologist, Mr. Cole, provided a rebuttal report, critiquing Mr. McNeil's report. He offered the following comments:

- a) While Mr. McNeil concludes that Ms. Guram's cognition would impact her ability to work in a fast-paced work environment with significant distractions and increased pain and fatigue, her cognitive test results revealed average or better performance;
- b) In residential care facilities, LPNs do not normally perform patient transfers and they are instead performed by care aides with the assistance of lift devices;
- c) LPNs are responsible for dispensing medication, doing wound care, administering feeding tubes, and developing and updating patient care plans, duties that are largely sedentary; and
- d) Mr. McNeil confirms that Ms. Guram is capable of working in occupations with sedentary physical demands.

3. Dr. Helper, Psychiatrist

[251] In Dr. Helper's opinion, Ms. Guram would be competitively employable if she was not experiencing headache symptoms and the cognitive and emotional difficulties that she describes. In his view, she would likely need to work reduced hours, at least over the next one to two years, while she completes appropriate active rehabilitation. He concludes that she would have limitations for heavy push or pull tasks with her right arm, repeated or heavy above shoulder height work, repeated squatting or crouching activities, and

prolonged postures, without the ability to take a break.

[252] If assessing Ms. Guram's musculoskeletal difficulties in isolation, Dr. Helper concludes that she could likely work 80% of full-time hours (i.e., four days per week), with modifications. He admitted it is difficult to separate physical and emotional complaints. Taking her headaches and cognitive/emotional difficulties into account, he concludes that she is currently not competitively employable.

[253] Dr. Helper agreed that part of his practice involves making recommendations, within his area of expertise, to improve a person's function (including their vocational function). He conceded that, for the average person:

- a) The sooner they return to work, the better;
- b) Movement and activity can be beneficial for musculoskeletal injuries;
- c) Being sedentary can prolong recovery;
- d) Inactivity can cause someone to become deconditioned; and
- e) A person's motivation is an important factor that contributes to their return to work.

4. Dr. Winston, Physiatrist

[254] Dr. Winston noted in his report that Ms. Guram has not had a trial return to work since the accident. He clarified at trial that this refers to a formal return to work, organised by a third party. Based on his experience, he would have expected Ms. Guram to recover from her accident-related injuries within about six months, before beginning a formal graduated return to work program. He knew that she attempted a brief return to her LPN job on her own initiative and worked about nine shifts after the accident. She attempted no formal return to work in the following four years.

5. Drs. Mehdiratta and Makin, Neurologists

[255] Dr. Mehdiratta opines that Ms. Guram is not competitively employable in her pre-accident role as a result of her accident-related injuries (including headache, neck pain, dizziness, low back pain, and decreased memory, concentration and cognition). In his view, it is improbable that she will return to work given the duration of her symptoms. Dr. Makin says he is aware of no reason for Ms. Guram to be off work.

6. Dr. Waisman, Psychiatrist

[256] Dr. Waisman opines as follows:

- a) The cumulative effects of Ms. Guram's chronic pain, depression, and anxiety impair her ability to regulate her emotions and manage her stress in an unstructured workplace setting;
- b) She is unable to work on a persistent basis or to manage deadlines and multitasking; and

- c) Her past LPN work is safety-sensitive and an error in judgment could lead to serious consequences for her patients.

[257] In Dr. Waisman's opinion, it would be difficult for Ms. Guram to do the kind of practical demonstrations required of an LPN instructor given her ongoing symptoms. In his view, she is currently unable to work in jobs for which she is suited by her education and training. Dr. Waisman conceded that he is not a vocational consultant and that he cannot comment on Ms. Guram's ability to do all kinds of work.

D. Analysis and Conclusions

1. Past Loss

[258] Ms. Guram has not worked as an LPN instructor at VCC since April 30, 2019. She worked nine shifts as a travel LPN for Staffing Solutions between June 20, 2019 and August 17, 2019. She has not worked in any capacity since then. The defendant admits Ms. Guram has sustained a past loss of earning capacity; the parties disagree about how to quantify it.

[259] Plaintiff's counsel relies on Mr. Turnbull's projection of Ms. Guram's without-accident earnings in three alternative scenarios to estimate her damages for the net loss of past earning capacity. Ms. Guram claims \$258,078 for past loss of capacity, a figure her lawyer describes as conservative. This estimate assumes that, absent the accident:

- a) Ms. Guram would have worked eight months per year as an LPN instructor at VCC and four months per year as a travel LPN doing contract work (as contemplated by Mr. Turnbull's "Scenario 2"); and
- b) Ms. Guram's pre-trial income would have been commensurate with her earnings from January-April 2019 (the four months immediately before the accident).

[260] Based on these assumptions, Mr. Turnbull calculates projected, without-accident, past earnings (in 2023 dollars, net of tax) to the date of trial in the amount of \$258,078. Plaintiff's counsel says there was a real and substantial possibility that Ms. Guram would have worked 12 months per year as a full-time travel LPN and earned a substantially higher income.

[261] The defendant estimates Ms. Guram's gross past income loss in the amount of \$184,554. This estimate relies on the calculations of Mr. Steigervald, the defendant's economist expert, based on Ms. Guram's average annual historical income of \$42,806 (calculated based on her actual pre-accident earnings from 2016-2019, in 2023 dollars) instead of the four months immediately preceding the accident. Defence counsel submit that Mr. Turnbull estimates what Ms. Guram could, not would, have earned but for the accident and that Mr. Steigervald's estimate ought to be preferred.

- [262] Ms. Guram began teaching at VCC in September 2018; she was only in her second semester of teaching there at the time of the accident. She had not yet completed one full year of working as a travel LPN with Staffing Solutions and as an LPN instructor at VCC. Accordingly, she had no established history of working consistently in both jobs at the time of the accident.
- [263] Plaintiff's counsel submits that, because Ms. Guram was doing some travel LPN work on weekends before the accident, while also teaching at VCC, estimating the loss of past income-earning capacity based on her income in the four months before the accident, is a conservative approach. She submits that Ms. Guram would probably have continued to work weekends as a travel LPN during her teaching semesters at VCC, in addition to doing contract travel LPN work for four months in the summer. She argues that this assumption is consistent with Ms. Guram's evidence that she planned to do some travelling with Ms. Biring in BC, while working as a contract LPN in the summer.
- [264] In my view, the evidence does not support the conclusion that Ms. Guram would have worked consistently as both a full-time instructor at VCC (which, on Ms. Guram's evidence, required some work outside the classroom to prepare course materials, mark assignments, complete after-hours labs, and supervise practicum students at long-term care facilities) and travelled on weekends to work as an LPN.
- [265] I also do not agree that the evidence supports the conclusion that Ms. Guram would have worked as a full-time travel LPN, absent the accident, thereby earning a substantially higher income (as contemplated by Mr. Turnbull's "Scenario 3"). On her own evidence, her plan before the accident was to teach at VCC during the months when she would not want to drive, and to work as a travel LPN in the summer when the weather was better. This is consistent with her report to Dr. Winston that her hours were variable before the accident and that there was "no normal".
- [266] I acknowledge it is possible that, absent the accident, Ms. Guram might have worked as a full-time LPN. However, in my view, this possibility is effectively off-set by the possibility that she might have decided to work 12 months a year at VCC as an instructor, thereby earning less annual income (as contemplated by Mr. Turnbull's "Scenario 1"). Notably, neither of these two hypothetical scenarios matches Ms. Guram's trial evidence about her actual pre-accident work plans. Accordingly, I conclude that both are speculative and not reasonably construed as real and substantial possibilities.
- [267] Ms. Guram's income fluctuated considerably in the five years before the accident. Mr. Turnbull conceded that her historical earnings at the time of the accident were less than those of the average 40-year-old BC female. Similarly, Mr. Steigervald noted that Ms. Guram's prior earnings were significantly lower than her earnings in the short period when she worked as an LPN instructor (from the beginning of October 2018 to the end of April 2019). I appreciate that Ms. Guram was a single parent and had a young daughter. However, she moved in with her supportive parents when her daughter was young and they assumed

Ms. Biring's full-time care after Ms. Guram accepted a six-month contract position on a cruise ship in 2005. If Ms. Guram's average historical earnings are more representative of what she would have earned in the pre-trial period (rather than her earnings in the four months immediately preceding the accident), Mr. Turnbull's approach overstates her loss.

[268] Ms. Guram had never worked for one full year as a travel LPN (for four months) and an LPN instructor (for eight months), as contemplated by Mr. Turnbull's hypothetical "Scenario 2". Mr. Turnbull admitted Ms. Guram's earnings from her travel LPN work decreased when she began working as an LPN instructor.

[269] Ultimately, it is unknown whether an average historical annual income (based on Ms. Guram's actual past earnings from 2016-2019) or her higher income in the four months immediately preceding the accident more accurately reflects what she would have earned, absent the accident. Ms. Guram had a variable work history, and, on the evidence of Mr. Turnbull, historical earnings that were substantially lower than the average LPN before the accident. It is unknown whether she would have sustained an income that was commensurate with her earnings in the four months immediately before the accident to the trial date. In my view, given her work history, there is a real and substantial possibility that she would not have done so. It is unclear on the evidence how the COVID-19 pandemic might have affected Ms. Guram's income and work plans.

[270] In assessing past income loss, I have considered illustrative projections of gross past lost earnings (less actual income in the amount of \$6,018 earned in 2019) based on:

- a) Ms. Guram's historical average income of \$42,806 (in 2023 dollars) from 2016-2019 (not adjusted for labour market contingencies, on the assumption they are accounted for in Ms. Guram's historical earnings);
- b) Assumed annual earnings of \$50,000; and
- c) Ms. Guram's income in the four months immediately before the accident (adjusted for unemployment and part-time work labour market contingencies).

[271] In my view, these projections likely reflect the upper and lower limits of a reasonable range for Ms. Guram's claim for the past loss of earning capacity. Given her variable earnings history, I conclude that assessing past earning capacity on a base period of only four months risks overvaluing this loss. I have considered the fact that Mr. Steigervald's calculation of Ms. Guram's average historical income did not include her 2015 income of \$52,693 and that, if it had, her average historical earnings would be slightly higher.

[272] Having regard to the evidence as a whole and recognizing that this is an assessment and not a precise mathematical calculation, I award \$215,000 for gross past income loss, a figure that falls within the above-noted range. I have discounted this award for employment income earned in the pre-trial period but not for income tax payable or benefits received.

[273] The parties agree that it is not appropriate to deduct any disability benefits that Ms. Guram has received from the award for past income loss before judgment. Counsel therefore made no submissions on that matter. I leave it to them to discount the award for past loss to account for tax and benefits received, as appropriate.

[274] In my view, this award is reasonable and fair to both parties.

2. Future Loss

[275] Ms. Guram asserts that her accident-related injuries have effectively ended her working career. She claims damages in the amount of \$770,804 for future income loss. This estimate is based on the following assumptions:

a) Absent the accident:

i. Ms. Guram would have worked to age 70;

ii. She would have had full-time, full-year annual earnings of \$68,660 (in 2023 dollars), based on Mr. Turnbull's "Scenario 1" (which contemplates Ms. Guram teaching 12 months/year, with occasional LPN shifts); and

iii. The present value of these future earnings is appropriately adjusted for the labour market contingencies of part-time work and labour force non-participation, but unemployment rates are set at zero; and

b) With the accident, Ms. Guram has no residual earning capacity.

[276] Plaintiff's counsel submits that, absent the accident, there was a real and substantial possibility that Ms. Guram would have worked as a full-time travel LPN, thereby earning a substantially higher income. She denies that this award should be discounted by any amount to reflect Ms. Guram's possible return to the workforce; alternatively, she says that any such deduction should not exceed 10%. Notably, this submission is premised on the assumption that Ms. Guram sustained a mild traumatic brain injury in the accident, a finding I have not made.

[277] Mr. Turnbull's estimate of future income loss in the amount of \$770,804 to Ms. Guram's age 70 (i.e., 23 years) is based on without-accident annual future earnings of \$68,660; this figure assumes that Ms. Guram's earnings from January-April 2019 (i.e., over four months) will continue unchanged for the next 23 years. As noted by Mr. Steigervald, 23 years is approximately 69 times the length of the four-month base period used in this income projection. It is unclear on the trial evidence whether such a short snapshot of Ms. Guram's variable pre-accident earnings provides a reasonable basis on which to forecast her remaining lifetime earnings. As noted, historically, Ms. Guram earned substantially less than the average LPN.

- [278] The defendant estimates Ms. Guram's future income loss in the amount of \$169,537.50. This figure represents a 30% loss of capacity based on Mr. Steigervald's estimate of the present value of future earnings to Ms. Guram's age 65 in the amount of \$565,125 (based, in turn, on the plaintiff's average annual historical earnings in the amount of \$42,806), not adjusted for labour market contingencies, on the assumption they are accounted for in Ms. Guram's historical earnings.
- [279] In the alternative, if the Court accepts that the plaintiff's future income loss should be based on Mr. Turnbull's assumed earnings of \$68,660 (given Ms. Guram's earnings from January-April 2019), the defendant submits that the present value of this annual loss is \$761,576 up to age 70 (using Mr. Steigervald's cumulative economic multiplier). The defendant argues that this amount should be discounted to reflect a 30% loss of capacity, resulting in an estimated future loss of earning capacity of \$228,470.
- [280] The defendant admits, and I accept, that the first and second steps in Rab are met here. The parties agree that the earnings approach is appropriate in this case. The challenge is to value the loss. It is not the actual lost income which is compensable; rather, the task is to assess lost earning capacity: *Ibbitson v. Cooper*, 2012 BCCA 249 at para. 19. As noted by the Court of Appeal in *Ploskon-Ciesla v. Brophy*, 2022 BCCA 217 at para. 11, even where the first and second steps in Rab are foregone conclusions, it remains necessary to assess the probability of future hypothetical events occurring that might affect the quantification of the loss, such as potential positive or negative contingencies.
- [281] The parties' estimates of the loss of future earning capacity reflect three essential differences: 1) whether the award is appropriately discounted for the labour market contingency of unemployment (given the trial evidence about a current high demand for LPNs); 2) whether Ms. Guram has any residual capacity to work; and 3) the appropriate baseline annual income to use in projecting future earnings.
- [282] In my view, unemployment is appropriately included as a labour market contingency in assessing the loss of future earning capacity. Ms. Guram was unemployed in 2014 and she collected employment insurance in 2016. I do not agree that she faced no future risk of unemployment absent the accident simply because there is currently a demand for LPNs.
- [283] As noted, I have found that the trial evidence does not establish on a balance of probabilities that Ms. Guram sustained a mild traumatic brain injury in the accident. In my view, Mr. McNeil's evidence is the best and only objective evidence about Ms. Guram's current cognitive function; he confirmed that she performed well on his cognitive function tests and is cognitively intact.
- [284] On the trial evidence I accept, I find that Ms. Guram will have better overall mood, decreased anxiety, greater confidence, and increased motivation to return to work with improved mental health. I conclude that she will have better strength, stamina, and endurance with improved physical conditioning. I accept the evidence of Dr. Helper that improvement in one area will have a positive and synergistic effect on the other. I find that

Ms. Guram's social isolation and sedentary lifestyle have resulted in physical deconditioning, perpetuated her anxiety and depression, and reinforced her perception of her own disability.

- [285] I do not accept that Ms. Guram is permanently disabled from work. I find there is a significant real and substantial possibility that she can improve her mental and physical health with focused treatment, including the prescription of Duloxetine (or another SNRI antidepressant) to target both chronic pain and depression, and the kind of intensive psychotherapy that Dr. Waisman recommends. Given Dr. Makin's evidence about the possible impact of Ms. Guram's analgesic use on her headaches, she might also benefit from a review of her current medications.
- [286] On Ms. Guram's own evidence, fitness provided a good release for her before the accident and left her "pumped up" for the whole day. She conceded that she has seen a decline in her strength and core fitness since she stopped attending active rehabilitation in May 2023. She agreed that she is now probably weaker and has more pain because of her sedentary lifestyle.
- [287] I acknowledge that Ms. Guram has not worked in any capacity since August 2019, almost five years ago. She has applied for no jobs since the accident. In my view, she requires a period of intensive treatment, focused on improving her physical and mental health, before she can transition back to the workforce. I accept her evidence that, despite having made no efforts to do so since 2019, she would like to return to work.
- [288] In assessing the loss of future earning capacity, I have considered the following statistical anchors and corresponding projections of future lifetime earnings based on:
- a) Ms. Guram's average annual historical income in the amount of \$42,806 (excluding contingencies for unemployment and part-time work, which are assumed to be captured by her historical average earnings);
 - b) An assumed annual income in the range of \$50,000, adjusted for labour market contingencies (including unemployment); and
 - c) An assumed annual income of \$68,660 based on Ms. Guram's earnings in the four months immediately before the Accident, adjusted for labour market contingencies (including unemployment).
- [289] Recognizing that this is an assessment and not a precise mathematical calculation, I award \$185,000 for the loss of future income-earning capacity. This figure is based on a without-accident annual income that falls within the above-noted range, discounted for labour market contingencies (including unemployment). It incorporates my finding that there is a real and substantial possibility of significant improvement in Ms. Guram's condition with different, targeted treatment, and is based on a residual loss of earning capacity of about 30%.

[290] In my view, this award is reasonable and fair to both parties.

[291] I note that Ms. Guram had multiple pre-accident degenerative changes in her spine and, on Dr. Makin's evidence, a pre-accident history of migraines, a condition which he described as typically lifelong and fluctuating. Neither counsel nor the experts addressed the possible long-term implications of this medical history on Ms. Guram's capacity to work. I have not therefore discounted the award for lost future earning capacity to account for any corresponding specific contingencies as they are unmeasurable on the evidence.

XIII. FUTURE CARE COSTS

A. Legal Framework

[292] Ms. Guram claims future care costs in the amount of \$128,813.94, based on Mr. McNeil's recommendations. The defendants assess her future care costs in the amount of \$25,000, based roughly on the cost of psychological counselling, kinesiology treatment, Botox injections, and medications for one year.

[293] Ms. Guram has undergone extensive treatment since the accident. On her own evidence, she discontinued most of it at some point on her own initiative because, in her view, it was worsening and not improving her condition. She was imprecise about when this occurred but thought it was more than one year ago. This evidence is consistent with her reports to Dr. Winston (that this treatment made her worse and that she had increasing pain, despite treatment) and to Dr. Makin (that, despite two to three years of treatment and daily appointments with various therapists and clinicians, she stopped all this treatment because it was unhelpful).

[294] Ms. Guram nonetheless testified that she would follow all of the treatment recommendations that her experts made in this litigation. In my view, reimplementing extensive treatment which did not work previously risks reinforcing Ms. Guram's already entrenched perception of her own disability. It would also be inconsistent with my finding that she did not sustain a mild traumatic brain injury in the accident.

[295] Justice Kent conveniently summarized the governing principles regarding an assessment of future care costs in *Dzumhur v. Davoody*, 2015 BCSC 2316 at para. 244. I have applied those principles here.

[296] An assessment of future care costs is not a precise accounting exercise: *Krangle (Guardian ad litem of) v. Brisco*, 2002 SCC 9 at para. 21. The court must identify the specific amount awarded for each item claimed: *Sunner v. Rana*, 2015 BCCA 406 at para. 50. The cost of each particular item is an important consideration in assessing whether it meets the test of reasonableness: *Elzinga v. Sharpe*, 2019 BCSC 314 at para. 210. The plaintiff must prove there is a real and substantial possibility that the cost will be incurred: *Owen v. Folster*, 2018 BCSC 143 at para. 314. A court may decline to award future care costs for items or services that a plaintiff is unlikely to use: *Liu v. Bipinchandra*, 2016 BCSC 283 at para. 163.

B. Pain Management

[297] Dr. Waisman suggests that Ms. Guram be referred to a multidisciplinary pain management program. On Ms. Guram's evidence, she received about three years of treatment at iScope in addition to treatment at the Change Pain clinic between June 2020 to February 2023; she testified that it worsened her condition and provided her with no substantial benefit. Attendance at a pain clinic is not included in Mr. McNeil's summary of future care costs. I make no award for this cost.

[298] Mr. McNeil recommends:

- a) A body pillow (at a cost of about \$50) to be replaced every two years;
- b) A TENS machine (at a cost of \$45 to \$90) to be replaced every five years;
- c) A heated vest (at a cost of about \$74) to be replaced every three years; and
- d) A sacroiliac support belt and lumbar support (at a cost of about \$50) to be replaced every three years.

[299] In Mr. Cole's opinion, a body pillow does not need to be replaced every two years and every five years is more reasonable.

[300] I award one-time costs of \$240 to fund a body pillow, heated vest, sacroiliac and lumbar support belt, and the mid-range cost of a TENS machine, to assist Ms. Guram while she engages in active rehabilitation and transitions to a more active lifestyle.

C. Homemaking Assistive Devices

[301] Mr. McNeil recommends:

- a) A combined electric floor scrubber/steam mop (at a cost of about \$188) to be replaced every five years; and
- b) A cordless electric bathroom scrubber (at a cost of about \$70) to be replaced every five years.

[302] I award \$260 to cover the one-time costs of these devices to assist Ms. Guram while she re-engages in a more active lifestyle.

D. Ergonomic Equipment

[303] Mr. McNeil recommends ergonomic equipment to assist Ms. Guram if she works in a sedentary setting. In Mr. Cole's opinion, apart from a sit-stand desk, Mr. McNeil's ergonomic recommendations are not justified. In his view, an ergonomic assessment would first be required.

[304] In my view, it is not reasonable to make an award for ergonomic equipment that Ms. Guram may never require. She is currently not working in any capacity. If she were to obtain sedentary work, her employer might provide an ergonomic workplace or work station. I make no award for the cost of ergonomic equipment.

E. Rehabilitation and Health Costs

1. Concussion Rehabilitation

[305] Based on the recommendation of Dr. Mehdiratta, Mr. McNeil supports 12-24 sessions of vestibular, ocular-motor, and cervicogenic treatments at a total cost of \$6,610-\$10,570 as follows:

- a) Initial multidisciplinary assessment - \$2,650
- b) Physiotherapy sessions - \$1,980-\$3,960
- c) Athletic therapist sessions - \$1,980-\$3,960

[306] As noted, Ms. Guram has already received extensive treatment at the iScope concussion clinic which, on her own evidence, provided no substantial benefit. The particulars of this treatment are outlined in detail in Dr. Helper's report. I have found that the accident did not cause a mild traumatic brain injury or concussion. It follows that there is no indication for further concussion treatment as a result of any accident-related injuries.

[307] Dr. Winston rejected the suggestion that discontinuing treatment which might have been managing Ms. Guram's pain could be detrimental. In his view, discontinuing treatment that has provided no benefit and addressing the potential harm it might cause (i.e., the nocebo effect) before rebuilding a management plan is quite common in his practice. He did not agree that stopping the treatment that Ms. Guram reported had not improved her condition would make her worse.

[308] I award no costs for additional concussion treatment.

2. Sleep Study

[309] Mr. McNeil recommends a sleep study. On his evidence, it could be funded through MSP. I make no award for this cost.

3. Fitness Pass

[310] In Mr. McNeil's view, ideally Ms. Guram would exercise in a pool (to reduce impact and strain on her neck, shoulders, and spine) and have access to a gym. He notes that the annual cost of a public fitness pass in Surrey is \$513.45.

[311] On Ms. Guram's own evidence, as corroborated by her daughter, sister, and fiancé, she attended a fitness facility regularly before the accident. She told Dr. Waisman that she did so five to six times a week before the accident. I conclude that Ms. Guram would have incurred this expense absent the accident. I therefore make no award for the annual cost of a fitness pass.

4. Kinesiologist

[312] Dr. Helper expects that Ms. Guram would be able to improve her musculoskeletal symptoms further through strength-based training. He strongly recommends that her future rehabilitation efforts focus on active rehabilitation, with the guidance of a kinesiologist (or similarly qualified therapist). He opines that, if she is able to maintain compliance with regular strength-based training, he expects further moderate improvement in her musculoskeletal symptoms. He admitted that being sedentary can cause a person to become deconditioned and prolong recovery.

[313] Dr. Helper recommends kinesiology training once per week for 12 weeks, followed by 12 weeks of training once every two weeks, and then once a month for the following 24 months. Typically, he recommends 12 months of once-monthly maintenance care. He opines that Ms. Guram will likely require an extended course of maintenance to ensure that she remains on track with her independent training. He would expect Ms. Guram to participate in strength-based training (as guided by her kinesiologist) four days a week on average and that this will be the cornerstone of her future partial recovery from her musculoskeletal complaints. He would expect moderate partial improvement within one to two years with this treatment.

[314] Based on Dr. Helper's recommendation that Ms. Guram attend 42 kinesiology sessions over two years, Dr. McNeil estimates this cost to be \$3,738 (\$89/session). The present value of this cost is \$3,665. I award this amount.

5. Passive Therapy

[315] In Mr. McNeil's view, it would be beneficial for Ms. Guram to have access to ongoing passive modalities to help her manage periods of increased pain, especially as she increases her activity level. He estimates this cost as follows:

- a) Massage therapy - \$2,640/year (\$110/session x 24 sessions/year)
- b) Physiotherapy - \$2,880/year (\$120/session x 24 sessions/year)
- c) Chiropractic treatment - \$1,680/year (\$70/session x 24 sessions/year)

[316] Mr. McNeil defers to medical specialists regarding the number and frequency of these sessions. In Mr. Cole's opinion, Mr. McNeil's recommendations for ongoing passive therapies are excessive. In his view, \$1,200/year for 10-12 sessions for the passive therapy of Ms. Guram's choice to address occasional symptom flares is more reasonable.

[317] Ms. Guram has undergone substantial passive therapy to date. I do not agree that ongoing, indefinite passive therapy is likely to assist Ms. Guram, assuming she would pursue it. Notably, she discontinued all of her treatments about a year ago because she found them to be overwhelming, unhelpful, and worsening her condition. I award a contingency fund of \$2,500 to cover passive therapy of Ms. Guram's choice, to assist her while she transitions to a more active lifestyle.

6. Psychological Counselling

[318] Dr. Waisman recommends that Ms. Guram attend psychotherapy sessions once a week for one year, followed by a reassessment. Dr. Makin recommends referral to a forensic psychiatrist for a more specific psychiatric assessment.

[319] Based on Dr. Waisman's opinion that Ms. Guram would benefit from counselling, Mr. McNeil estimates this cost to be \$11,700 for 52 sessions (\$225/hour). Mr. Cole notes that a clinical counsellor can administer cognitive behavioural therapy at a cost of \$160/session. In his view, 52 sessions would be excessive; he recommends 20 bi-weekly sessions, followed by a reassessment.

[320] Mr. Cole is not a psychiatrist. I prefer the recommendations of Dr. Waisman on this matter. I accept that Ms. Guram would benefit from the kind of psychological counselling Dr. Waisman recommends. I award \$11,700 to fund this cost.

7. Medication

[321] Dr. Waisman suggested that Ms. Guram might benefit from a trial of Duloxetine or another SNRI antidepressant. He admitted there is evidence that this medication can target depressive symptoms and reduce chronic pain symptoms including, in particular, neuropathic pain. There is no trial evidence about its cost. Apart from one antidepressant, Ms. Guram takes no medication to manage her anxiety.

[322] Dr. Mehdiratta suggests that Ms. Guram might benefit from Botox injections but makes no specific recommendation regarding the frequency or duration of this treatment. He states that this would depend on Ms. Guram's response to it. Dr. Mehdiratta also notes that Ms. Guram reported trying Botox injections and saying that they did not help much. This statement is consistent with Ms. Guram's report to Dr. Winston that she has had several treatments of Botox which did not help so she stopped them.

[323] Dr. Winston opines that Ms. Guram does not meet the criteria for treatment of her migraine headaches with agents such as botulinum toxin or any of the new CGRP biologic agents.

[324] Mr. McNeil estimates the annual cost of Botox injections to be in the range of \$1,700-\$2,200 (assuming two to four treatments per year). Despite the evidence that it has not assisted Ms. Guram in the past, the defendant admits the cost for a further one-year trial of Botox. Accordingly, I award \$2,000, representing the approximate mid-range cost of one further year of Botox treatment.

[325] Ms. Guram seeks to recover an additional \$10,000 (or \$526.32/year), representing estimated future medication costs based on past costs of \$933.62/year for medications to Ms. Guram's age 65. This figure is not discounted to present value. It is also not adjusted for any contingencies, including the real and substantial possibility that Ms. Guram's physical condition will improve with treatment targeted to address her physical deconditioning, increase her strength and stamina, better manage her pain, and improve her mental health. On Ms. Guram's evidence, she currently takes Celebrex and Tylenol 3, plus an antidepressant.

[326] The trial evidence does not support the conclusion that Ms. Guram has incurred annual pre-trial costs of about \$1,000 for medication, or that this cost will continue unchanged to her age 65. The defendant admits costs of \$7,362 for Ms. Guram's future pharmacological care; I award this amount.

[327] In summary, I award future care costs as follows:

- a) Pain management devices - \$240
- b) Homemaking assistive devices - \$260
- c) Kinesiology - \$3,665
- d) Passive therapy - \$2,500
- e) Psychological counselling - \$11,700
- f) Medications - \$9,362

TOTAL: \$27,727

XIV. DISPOSITION

[328] I award damages as follows:

- a) General Damages (including loss of housekeeping capacity) - \$135,000
- b) Special Damages - \$3,183
- c) Gross Loss of Past Income-Earning Capacity - \$215,000
- d) Loss of Future Income-Earning Capacity - \$185,000
- e) Future Care Costs - \$27,727

TOTAL - \$565,910

[329] Absent information of which I am aware that might alter this view, Ms. Guram is entitled to costs on the ordinary scale. If there are any issues arising from these reasons, the parties are at liberty to apply to speak to them by contacting Supreme Court Scheduling within 30 days.

"Douglas J."

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