

CANADA / JUDGMENT

Javan Parast v. Curry

2020 BCSC 877

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2020 BCSC 877 Javan Parast v. Curry

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Javan Parast v. Curry,

2020 BCSC 877

Date: 20200612

Docket: M166978

Registry: Vancouver

Between:

Maliheh Javan Parast

Plaintiff

And

Hilary Ann Curry

Defendant

Corrected Judgment: The cover page of the judgment was corrected on June 19, 2020.

Before: The Honourable Mr. Justice Blok

Reasons for Judgment

Counsel for the Plaintiff:

K.C. Stewart

Counsel for the Defendant:

K.S. Byram

S. Li

Place and Dates of Trial:

Vancouver, B.C.

November 25-29 and

December 2, 4-6, 2019

Place and Date of Judgment:

Vancouver, B.C.

June 12, 2020

I. Introduction

- [1] The plaintiff was injured in a car accident that occurred in North Vancouver on September 11, 2014. Both liability and damages are in issue.
- [2] Before proceeding further, I will clarify a matter relating to the plaintiff's surname. As her counsel explained, the plaintiff's surname is Javanparast, but during the course of the immigration process when she came to Canada, her official documents were issued as "Javan Parast". So, despite the name format used in the style of cause, I will follow her counsel's lead and refer to her as Ms. Javanparast when referring to her by name.
- [3] The accident occurred while Ms. Javanparast was travelling south on St. Georges Avenue on her way to work as a nurse at Lions Gate Hospital (LGH). The defendant was stopped at a stop sign on 18th Street, a cross-street, waiting to enter the intersection in order to proceed north on St. Georges Avenue. The defendant proceeded forward and struck the plaintiff's vehicle on its right side.
- [4] The issue on liability arises from the defendant's contention that: (1) the plaintiff was speeding; and (2) the plaintiff was travelling unusually far to the right side of her lane of travel. The plaintiff denies both allegations and says that the accident occurred because defendant failed to yield the right of way.
- [5] On damages, the principal issues in dispute relate to the plaintiff's post-accident hip and psychological issues. The plaintiff submits these were caused by the accident, while the defendant says the plaintiff has not established she has psychological disorders and she has not shown her hip problems were caused by the accident.

II. Liability - Evidence

A. The Plaintiff

- [6] As noted earlier, Ms. Javanparast was on her way to work at LGH. She knows the route well, as it is her regular route to work. It was about 7:10 am, and her shift started at 7:30 am. She was only a few blocks from the hospital.
- [7] Ms. Javanparast said she was proceeding in her Mazda 3 vehicle at a speed of about 30 to 40 km/h, noting that St. Georges Avenue itself has several stop signs along its length, as well as crosswalks. She had stopped at the stop sign at 19th Street and she was aware there was another stop sign for her at 17th Street.
- [8] As she proceeded through the intersection at 18th Street, she "felt someone hit my car and throw me to the other lane". She pulled over to the right. She was shaken up, but after composing herself she opened her door. The other driver came over and said "I'm sorry". They exchanged information and Ms. Javanparast proceeded on to work.
- [9] The impact knocked the front bumper off the other car. Her vehicle suffered damage to the rear passenger side. Photographs show a relatively minor indentation between the rear wheel well and the rear passenger door, as well as scraping marks along the rear door itself.
- [10] In cross-examination, Ms. Javanparast said she was in the middle of her lane at the time of the collision. She said she did not see the other vehicle prior to the impact. She denied she was late for work or otherwise in a rush.

B. The Defendant

- [11] Ms. Curry's testimony was entered by way of video deposition as Ms. Curry now lives and works overseas. At the time, she lived about a block away from the subject intersection.
- [12] On the morning in question, Ms. Curry was on her way to work in her 2011 Volkswagen Golf, a vehicle that had a manual transmission. She was headed to Coquitlam. The accident happened between 7:00 am and 8:00 am.
- [13] St. Georges is a through street. Ms. Curry was eastbound on 18th Street, intending to turn left onto St. Georges in order to proceed north. There is an upward slope on 18th as it meets St. Georges, and there were cars parked on St. Georges itself. These features made it difficult for her to check for traffic on St. Georges and so she pulled her car forward so that her car was in line with the parked cars on St. Georges and she could see around them. She looked to her right and saw a van about a half-block away, then she looked to the left and determined there was no one in the immediate roadway, only a car that was over a block away. She judged it was clear enough from that direction to make a left-hand turn. She waited for the van to pass her from the right. Once that had happened she took her foot off the brake and a car came from the left and "took the licence plate off the front of my vehicle".

- [14] When asked if she had proceeded forward when she took her foot off the brake, Ms. Curry said "not that I can remember. If it shifted, it would have been very, very small". Later she repeated essentially the same point, saying "it would have been less than an inch".
- [15] Ms. Curry did not know how fast the other vehicle was going, but reasoned that it must have been going faster than a normal speed because when she had seen the car at a distance she had concluded she had enough time to enter the intersection and complete her turn.
- [16] Both drivers pulled to the side of the road and both made sure the other driver was okay. The other woman was very upset. Ms. Curry said the other driver "insisted she was late for work". In cross-examination, she agreed she did not recall the details of the conversation but said it could only have been through conversation that she learned the plaintiff was in a hurry to get to work.
- [17] Ms. Curry said it was not a traumatic accident. Both drivers were fine. The other car had some scrapes down the side and her own car had the licence plate taken off, which also ripped off part of her vehicle's grille. Ms. Curry was not injured in the accident.
- [18] In cross-examination, Ms. Curry said the other vehicle was travelling straight and was in its lane of travel. When it was suggested to her that her vehicle actually moved forward into the plaintiff's vehicle at the time of impact, she said:

I wouldn't necessarily agree with that. My vehicle may have moved slightly, but it - but it wouldn't - it - it didn't move in the sense of I felt my vehicle move - shift forward, say, four feet or something like that.

III. Positions of the Parties - Liability

A. Plaintiff

- [19] The plaintiff emphasizes that the plaintiff had the right of way and the defendant had a stop sign. The defendant had a duty to refrain from moving into the intersection or starting her left turn until it was safe to do so. The plaintiff says the defendant has failed to point to any negligence on the plaintiff's part and so the defendant must be held fully liable for the collision.

B. Defendant

- [20] The defendant submits the accident occurred because the plaintiff failed to give the defendant's vehicle sufficient room as it edged out into the intersection enough for the defendant to look past cars that were parked on St. Georges Avenue.
- [21] While conceding that the plaintiff was the dominant driver, the defendant says this is not the end of the analysis because even dominant drivers must exercise caution to avoid accidents.

IV. Discussion - Liability

- [22] I am satisfied that the defendant bears full responsibility for the accident. There is no evidence that the plaintiff was speeding; instead the defendant relies on her supposition that the plaintiff must have been speeding because the plaintiff's vehicle arrived in front of her earlier than she expected. The defendant's vague recollection about the plaintiff saying something about being late for work was, in my view, equivocal, as it seems equally likely that the plaintiff was concerned about being late for work due to the accident itself.
- [23] The defendant agreed the plaintiff was travelling in her (the plaintiff's) lane of travel on St. Georges. Accordingly, the very fact of the collision means the defendant must have encroached into the plaintiff's lane of travel.
- [24] Defence counsel relied heavily on the plaintiff's testimony that if she moved forward at all, it was "less than an inch". Her evidence on that point was not very convincing and seemed to be more of a reconstruction of events than an actual recollection. Her essential point was that she did not recall moving forward. She then reasoned that, even if she had moved forward it could not have been very far because she did not remember moving forward. So, as she later said, it was not "four feet or something like that", which is considerably farther than an inch.
- [25] On a balance of probabilities I conclude the defendant, anticipating that the lane nearest to her would be clear of traffic coming from the left side, edged forward into the plaintiff's travel lane. It did not have to be very far as she had already nosed ahead into the intersection by the width of the parked cars, and the collision was a swipe or side-swipe type of collision (as the photographs clearly depict) rather than the direct or 90 degree side impact (or "T-bone" impact) described by the plaintiff.
- [26] Section 175 of the Motor Vehicle Act, R.S.B.C. 1996, c. 318, reads as follows:
- 175 (1) If a vehicle that is about to enter a through highway has stopped in compliance with section 186,
- (a) the driver of the vehicle must yield the right of way to traffic that has entered the intersection on the through highway or is approaching so closely on it that it constitutes an immediate hazard, and
 - (b) having yielded, the driver may proceed with caution.
- (2) If a vehicle is entering a through highway in compliance with subsection (1), traffic approaching the intersection on the highway must yield the right of way to the entering vehicle while it is proceeding into or across the highway.
- [27] Section 175 was analysed as follows by Barrow J. in *Burgess v. Fisher*, 2009 BCSC 1766:

[18] In *Rae v. Thorpe*, [1963] 43 W.W.R. 405 (B.C.C.A.), Tysoe J.A. considered the meaning of "immediate hazard" in the context of s. 164 (the predecessor of the current s. 174). Although he did not attempt to exhaustively define the phrase, he wrote at para. 18 that:

if an approaching car is so close to the intersection when a driver attempts to make a left turn that a collision threatens unless there be some violent or sudden avoiding action on the part of the driver of the approaching car, the approaching car is an "immediate hazard" within the meaning of sec. 164.

The point at which the determination of whether the through travelling motor vehicle is an immediate hazard is the moment before the servient vehicle begins to encroach on the through vehicle's lane of travel (*Rae* at para. 25).

[19] Ballance J. adopted both of the foregoing propositions in *Hynna* [*Hynna v. Peck*, 2009 BCSC 1051] in the context of s. 175 of the Motor Vehicle Act. In addition, she distilled two further principles applicable to the analysis required by s. 175 from *Keen v. Stene*, [1964] 44 D.L.R. (2d) 350 (B.C.C.A.). In that case, Davey J.A. wrote at para. 46 that:

A driver waiting at a stop sign ought not to enter a through street unless it is clear that oncoming traffic does not constitute an immediate hazard. Excessive refinement of what traffic is an immediate hazard will defeat the purpose of the right-of-way regulations contained in s. 165 [now s. 175], and make them an inadequate and confusing method of regulating traffic at intersections on through streets.

Sheppard J.A., in a separate concurring judgment, made the point that the hazard to which the section is directed extends to the threat of collision as opposed to simply a collision itself.

[20] One final general principle applicable to the analysis comes from the frequently quoted observation of Cartwright J. in *Walker v. Brownlee*, [1952] 2 D.L.R. 450 (S.C.C.). There, at p. 461, he wrote:

when A, the driver in the servient position, proceeds through an intersection in complete disregard of his statutory duty to yield the right-of-way and a collision results, if he seeks to cast any portion of the blame upon B, the driver having the right-of-way, A must establish that after B became aware, or by the exercise of reasonable care should have become aware, of A's disregard of the law B had in fact a sufficient opportunity to avoid the accident of which a reasonably careful and skilful driver would have availed himself; and I do not think that in such circumstances any doubts should be resolved in favour of A, whose unlawful conduct was *fons et origo mali*.

- [21] Whether a through travelling vehicle constitutes an immediate hazard to a crossing or left turning vehicle is a function of at least two things: how far away the through travelling vehicle is from the intersection and how fast it is travelling. Both of these are matters that the servient driver must estimate before entering the intersection. In making those estimates, the servient driver is entitled to assume, in the absence of evidence suggesting otherwise, that crossing or approaching vehicles will observe and obey the rules of the road.
- [28] Here, it is clear that the defendant, the servient driver, entered the intersection by encroaching into the plaintiff's lane of travel at a point when the plaintiff's vehicle was an immediate hazard. For these reasons, I am satisfied the defendant bears full responsibility for the accident.

V. Plaintiff's Evidence - Damages

A. Plaintiff

Background

- [29] Ms. Javanparast was 60 years old at the time of the accident and she was 65 at the time of trial. She was born, raised and educated in Iran, where she trained as a midwife. She married Alireza Sabet, a family physician, in 1976, and thereafter worked in his medical clinic. They have two children who are both in their 30s.
- [30] The family immigrated to Canada in 1996. Ms. Javanparast did not work for some time due to her limited English skills, but she did some volunteer work, then part-time work in retail shops, and then took a course to train as a care aide. Thereafter she worked as a care aide in a hospital. Through further hard work and study, and having been given some credit for her past education, Ms. Javanparast passed the necessary exams for qualification as a registered nurse. She became qualified in June 2002.
- [31] Ms. Javanparast thereafter worked as a nurse at two hospitals, on a casual status basis, with hours that were equivalent to, and sometimes exceeded, full-time hours. Her work was in the post-partum wards of the hospitals. Ultimately, she accepted a permanent part-time posting at LGH, which became a full-time permanent position in or around 2005.
- [32] Ms. Javanparast was diagnosed with breast cancer in November 2003. She opted to have a double mastectomy and she had reconstructive surgery about two months afterward. She was off work between four and six weeks. These events put financial stress on Ms. Javanparast and her husband as she was still a casual employee at that point, she had no benefits, and her husband was still struggling to find suitable full-time work. She said she was the "breadwinner" in the family.
- [33] Ms. Javanparast said she had a problem in her left groin in or around 2005. She was referred to a sports medicine physician "who fixed it for me".

- [34] Ms. Javanparast said she upgraded her skills by completing further studies in perinatal nursing, which includes antenatal, labour and post-partum care. After that, she worked in a labour and delivery ward, but she found the atmosphere there to be "very rushing, urgent and stressful". At one point, her nurse manager asked Ms. Javanparast which field she preferred, and she opted for post-partum. She found that area less stressful, and she enjoyed the teaching aspect of the job in that much of her role was to teach skills (principally breastfeeding) to new mothers.
- [35] Ms. Javanparast said overtime work was available in the post-partum unit and she worked overtime "quite a bit" because she was the breadwinner in the family and they needed the money.
- [36] Ms. Javanparast and her husband separated in 2010. Ms. Javanparast suffered from depression as a result, which lasted 12 to 18 months. Mr. Sabet moved back in with her in 2013 after she had some health issues, discussed below.
- [37] She was involved in a car accident in May 2010 and suffered pain in her neck and back, as well as numbness and tingling in her feet, as a result. She had no symptoms from that accident in the months leading up to the subject accident.
- [38] In December 2013 she had an incident of atrial fibrillation (AFib), which involved an irregular heartbeat that was racing to 150 to 170 beats per minute. She was put on medications to thin her blood and to regulate her heartbeat. She was off work for a month and a half as a result. She was also told to reduce her stress and exercise to lose weight. She was given referrals for a nutritionist and for an ablation procedure, but she has never had the ablation done. Since that time she has had "a couple of small episodes" of AFib which resolved on their own, but in October 2019 she had another major incident. She missed two work shifts as a result.
- [39] In the time leading up to the subject accident Ms. Javanparast had no pain or limitations. Her activities included walking and exercise and outings with friends. She still resided in the family home (it was sold in 2015) and she kept up the yard and garden. She now lives in a condominium.

Accident and Aftermath

- [40] Ms. Javanparast said she felt her body had "twisted" in the accident. She was thrown to the left and then she pulled herself back to the right.
- [41] Ms. Javanparast said when she arrived at work she felt "weird", which was a very confusing feeling, but she thought it was nothing major and she felt she could work. Towards the end of her shift she felt tightness in her upper and lower back, right elbow and neck, but again these were not "major". She went to the emergency room (ER) at the end of her shift as her pain was getting worse, but it was very crowded there. She then went to the ER at Royal Columbian Hospital (RCH), but it was crowded there too and so she went home.

- [42] She woke up in "so much pain" the next morning. The pain was in her lower back, right elbow, shoulder, neck and between her shoulder blades. She said she also felt a "tightening" in her left hip or groin area. She went to the ER to get checked out, and x-rays were done. She was given a prescription for Tylenol 3 medication and told to see her family doctor. Ms. Javanparast said she cannot take Tylenol 3 medication because it makes her nauseated. She called in sick that day and, altogether, was off work for seven or eight days.
- [43] Subsequently, she saw her family doctor, Dr. Wasswa-Kintu, who gave her painkillers and recommended massage therapy. Dr. Wasswa-Kintu referred her to a physiatrist, Dr. Underwood. Dr. Underwood referred her to a physiotherapist for her groin symptoms.

Current Status

- [44] Ms. Javanparast is not undergoing physiotherapy at present. She found it relieved symptoms for just 24 hours, so her doctor said she should discontinue it.
- [45] Ms. Javanparast continues with massage therapy and she also has a personal trainer, who does exercises and stretching with her. The locations she focuses on are her upper and lower back, neck and groin.
- [46] Ms. Javanparast said she also developed a right-side bursitis starting in about March 2018, which originates in the outside of her upper thigh and radiates to her groin. She has had an MRI for this issue, and she was told it is bursitis. The recommended treatment was steroid injections, but she has not carried these out due to her concerns about having injections while being on blood thinners. She said she is "scared to do that".
- [47] She also has some knee problems that bother her at work. These arise when she squats or kneels, but the symptoms go away after a time. She was not sure when these symptoms first started, but thought it was perhaps in 2018.
- [48] When asked what work duties can cause pain, Ms. Javanparast said patient transfers, bending, fetching things, teaching breastfeeding, and charting. Typing causes her upper and lower back pain. Sitting for lengthy periods also aggravates her pain. One patient transfer in August 2016 resulted in symptoms that caused her to be off work for two shifts (although she told Dr. Underwood it was approximately two weeks). She still does patient transfers, however.
- [49] The areas that bother her most currently are her upper and lower back and both her left and right groins. She tends to get pain when she is tired.
- [50] When asked what symptoms have resolved, Ms. Javanparast said her right elbow pain is now "totally gone", and her neck pain is now much less and only arises occasionally. She finds her symptoms increase when she lies down and that makes it hard for her to find comfortable positions.

- [51] She is reluctant to take sick days, but has done so on occasion where she has had no sleep due to pain.

Psychological Issues

- [52] Ms. Javanparast said she is depressed, frustrated and is unable to sleep properly. She feels a lot of helplessness and frustration; a feeling that she does not like her life any more. She is less tolerant of others, and can be short-tempered. She finds it very hard to exercise, and this makes her depressed as well. She says she gained weight after the accident, which she attributes to lack of exercise and eating more due to her mood, and she feels sad, guilty and frustrated about that.
- [53] She was not sure when these feelings started, but they became more prominent in 2016. Her physicians recommended antidepressant medication, but her pharmacist said antidepressants are not suitable for persons with AFib who are taking blood thinners. Counselling was suggested instead. Ms. Javanparast started counselling in 2017 through her employee benefits program and continued with it until shortly before trial. She found the counselling helpful.
- [54] She said her social life is limited now, although counselling has helped with that and so it is getting better.
- [55] Ms. Javanparast also said she has driving anxiety insofar as she avoids streets that involve stop signs instead of traffic lights.

Work Changes

- [56] Ms. Javanparast said she still takes overtime shifts, but not as many as before. There is plenty of overtime work available. She said her pain is the limiting factor; but for that, she would probably accept one overtime shift per week on her days off. Later, she added she would also take shifts during her vacation times.
- [57] Ms. Javanparast said she would like to reduce her work hours but she cannot afford to do so because she is not yet at her maximum pension entitlement. Also, if she reduced her hours she would have to work "both sides", that is, both labour and delivery and post-partum, and she finds labour and delivery too stressful.
- [58] Ms. Javanparast is concerned about having to retire earlier than she planned.

Household Work

- [59] Ms. Javanparast said she finds it hard to: (1) mop; (2) dust; (3) vacuum under the bed; (4) drag the vacuum from place to place; and (5) bend to place or retrieve dishes in the dishwasher. She has someone come in to clean her place once every two months or so, as that is all she can afford. In cross-examination, she modified that to once every one or two months.

- [60] Mr. Sabet comes by regularly because he does his laundry at her place, and he will help her with her laundry, including helping her change her bed. He also helps with grocery shopping, as he takes her to the store and carries the bags. In cross-examination, she said she shops frequently so she does not have heavy bags.
- [61] Prior to the accident she enjoyed cooking. She liked to cook for herself, for visitors or for family get-togethers. Now she does not enjoy cooking because it makes a mess that she finds hard to clean up.

Treatments

- [62] Ms. Javanparast said her physiotherapy sessions involved intramuscular stimulation treatments, which helped her symptoms for a while but which were very painful. She found massage to be more helpful because after a while physiotherapy gave only temporary relief. Massage therapy makes her more relaxed. Analgesic medication is the only other treatment that helps.
- [63] She hired a personal trainer in mid-2019, which brought "lots of relief". She started this in June or July 2019 and attended twice a week, although the trainer has since moved to the Fraser Valley and so these sessions have not continued. She said she paid the trainer \$70 per hour, but she does not have any receipts because the trainer insisted on being paid in cash.
- [64] Her doctor referred her to kinesiology at Karp Rehabilitation. The areas treated were her upper and lower back, neck and shoulder. Essentially, the treatment involved stretching exercises, such as hamstring stretches. At one point she felt pain in her groin. She told the kinesiologist that she felt some tightening in her groin, and the kinesiologist gave her a stretching exercise for her groin. Ms. Javanparast said she found the stretching very intense and very painful. She raised this with the kinesiologist but no changes were made to any of the exercises. She tried to do the stretches at home but she was too sore to do so.
- [65] Ms. Javanparast said the symptoms in her left groin changed at that point, going from a "tightness" to actual pain. She stopped the kinesiology sessions after six of the scheduled nine sessions. She found it too painful to continue.

Cross-Examination

- [66] In cross-examination, Ms. Javanparast said:
- a) she acknowledged she was working overtime shifts starting in late 2014, despite various notes made by her doctor, psychiatrist, a kinesiologist, and two functional capacity evaluators indicating she told them she no longer worked any overtime shifts. She said these were in error as she intended to say she was not working as much overtime as before;

- b) her concerns about travelling do not relate to AFib but instead arise from her difficulty sitting for long periods. However, she acknowledged that in 2014 (that is, prior to the accident) she told a hospital physician that she will not travel because she is concerned about having an AFib episode;
- c) she had sleep issues prior to the accident due to shift work and depression, but she said they were not as bad as they are now;
- d) she had some low back pain prior to the accident, although it was not ongoing;
- e) although at her examination for discovery she did not mention having back pain after the accident, she said "I definitely had back pain". She acknowledged there was no mention of low back pain in the RCH ER record of September 12, 2014. She also acknowledged she did not mention any low back pain to her family doctor on the first post-accident visit on October 2, 2014. She said "It was probably not significant so I didn't mention". She also acknowledged she did not mention low back pain to her massage therapist on November 22, 2014, saying "I probably had no pain that day";
- f) she acknowledged she said at her examination for discovery that her left groin or left hip was her "worst painful area from the first" and she would have reported that to her family doctor;
- g) she acknowledged there was nothing in the RCH ER records or in her family doctor's records about her left groin or left hip;
- h) she told Dr. Underwood that the onset of pain in her left groin occurred during physiotherapy when she was stretching her quad muscles;
- i) in the RCH AFib outpatient clinic notes from March 2014 (that is, pre-accident) she is recorded as saying: (1) she is able to go for walks although she does not climb hills as she is concerned about bringing on an AFib episode, and (2) she finds her AFib condition very anxiety-producing "and she will not travel as she is concerned about having an episode while away". The plaintiff admitted saying those things;
- j) she said that in the two years prior to the accident her weight was relatively stable at 54 kg., but when taken to her doctor's records she acknowledged that the listed weight for November 6, 2012 (148 pounds, or 67 kg.) would be correct;
- k) in July 2018 she was injured at work when she tripped over a telephone cord and landed on her left hip; and
- l) the maximum amount of time she would sit and complete charts at work would be one hour. That causes her discomfort "sometimes".

B. Cynthia Hartley

- [67] Ms. Hartley is Ms. Javanparast's former nurse manager. Ms. Hartley retired in December 2017. She worked with Ms. Javanparast for five years.
- [68] Ms. Hartley was on duty when Ms. Javanparast arrived at LGH following the accident. Ms. Hartley said Ms. Javanparast "looked shocky". She believed she told Ms. Javanparast to go home, but Ms. Javanparast stayed and worked her shift. She said, "that's what [Ms. Javanparast] would do".
- [69] Ms. Hartley observed Ms. Javanparast to be in pain during subsequent shifts. Ms. Javanparast needed more frequent rest breaks, and she held herself differently. She could tell Ms. Javanparast was uncomfortable. Ms. Hartley observed these same things until she retired in December 2017.
- [70] Ms. Hartley said Ms. Javanparast is a very hardworking nurse. She never said "no" to any task, but she did so at an expense to herself.
- [71] Ms. Hartley said Ms. Javanparast worked a lot of overtime, both by extending her shifts or by coming in on days off. She did not work as much overtime after the accident. Overtime work was almost always available.
- [72] At LGH, the current expectation is that all nurses are "cross-trained", meaning that they can work in both the prenatal and post-natal units. Some nurses who were not cross-trained had been grandfathered in. Having cross-trained nurses means that, if need be, they could "pull" nurses from one unit to work in the other unit.
- [73] If the maternity units were slow, they would take patients from the ER. This happened perhaps three to five times a week. The care of these patients would involve general nursing duties.
- [74] Ms. Hartley described the physical demands in the labour and delivery unit as being "very taxing". The demands in the post-partum unit were less taxing, involving such things as inserting IVs, helping mothers with toileting and transfers, pushing bassinets, and helping position mothers and babies for feeding. Computer charting was implemented in 2018; before that, charting was done on paper.
- [75] If a nurse requires accommodations at work, this is assessed and implemented through a team made up of representatives of human resources, medical staff and the nurses' union. The issue is whether the accommodation can be made without "undue hardship" to the unit. Restricting shifts to post-partum only would be one possible accommodation, as had been done with two other nurses.

- [76] In cross-examination, Ms. Hartley said Ms. Javanparast never worked in the labour and delivery unit at any point during the time Ms. Hartley was the nurse manager (2012 to 2017). She later added that she did not believe Ms. Javanparast assisted in that unit either. She was one of the nurses who was grandfathered and so she worked one unit only. There was never any request for any formal accommodations for Ms. Javanparast, and there were never any formal structures in place to reduce her duties or hours.
- [77] If a patient required heavier support and the attending nurse had limitations, usually the patient care coordinator, or the nurses themselves, would switch assignments. The limited capacity nurse would not be assigned the heavier load.

C. Anne Rogilds

- [78] Ms. Rogilds is a registered nurse in the maternity department at LGH. She has worked with Ms. Javanparast since early 2009.
- [79] Ms. Rogilds said Ms. Javanparast is a caring and knowledgeable nurse who is a good team member. She said she had nothing negative to say about her, except perhaps that Ms. Javanparast gets "stressed out" easily.
- [80] Ms. Rogilds described the roles and duties of nurses in both the labour and delivery and post-partum units. She noted in particular the additional burden that computer charting made on their duties, as it took a lot of time to get used to the new system. She said there are times that a nurse is pulled from the post-partum unit to work in the labour and delivery unit.
- [81] Ms. Rogilds was aware Ms. Javanparast was in a car accident. She has noted Ms. Javanparast having difficulties with such things as leaning over to help a mother breastfeed. At times, the plaintiff has complained of being "achy", and Ms. Rogilds has observed her "having a hard time" or looking tired at the end of a shift. Sometimes they give each other massages. Ms. Javanparast has mentioned pain in her groin on occasion.
- [82] In cross-examination, Ms. Rogilds said Ms. Javanparast has groin pain and upper back pain. Her complaints of groin pain have increased in the past few years.
- [83] Ms. Rogilds is not cross-trained in labour and delivery, so she does not work there, but at times she is asked to assist that unit, doing such things as assisting with patients who are recovering from a C-section or answering the telephone. She said Ms. Javanparast has assisted in that way too. Later, in cross-examination, Ms. Rogilds said "I only work there in little bits to assist".
- [84] Occasionally, post-partum nurses will be asked to go to another ward altogether. Ms. Rogilds did not believe that a nurse can refuse such a request.
- [85] In cross-examination, Ms. Rogilds said she knows something of the things that cause Ms. Javanparast pain because Ms. Rogilds herself was injured in a car accident in 2011, which caused pain in her neck and low back.

- [86] Ms. Rogilds agreed that the hospital protocol for patient transfers requires that three nurses be present. Sometimes there are only two nurses, and they have to ask for help from a civilian who is present.
- [87] Ms. Rogilds said the typical amount of time spent charting is 30 minutes. Although they have ergonomic (sit-stand) stations where they do their charting, Ms. Rogilds finds the movement of the computer mouse gives her difficulties.

D. Alireza Sabet

- [88] Mr. Sabet is Ms. Javanparast's estranged spouse. As noted earlier, they separated in 2010.
- [89] Mr. Sabet recounted much of the family history summarized earlier, including his difficulties finding suitable full-time employment. He said Ms. Javanparast was the primary income-earner for the family.
- [90] In December 2013, Mr. Sabet moved back in with Ms. Javanparast because of her AFib incident. He did so to take care of her. Later, he added that he stayed there about nine months. Once medications stabilized her condition and Ms. Javanparast regained her confidence, he moved out again.
- [91] Prior to the accident, Ms. Javanparast was "fine" and she had nothing wrong with her. She was concerned about her weight, and used a treadmill for exercise. She also walked the West Vancouver seawall, and she rode a bicycle.
- [92] Following her accident of September 2014, the plaintiff complained mostly of pain in her upper trunk area, with some tightness in her groin. In terms of activities, Mr. Sabet noticed that she moved slowly when trying to sit in a car, she could not bend when she was out shopping, she was not able to carry heavy things, she needed help cleaning her house and "her house was a mess". Prior to the accident, her house was very clean and neat.
- [93] Formerly, she never shouted at Mr. Sabet, but after the accident she has done so "many times". He has noticed other mood changes with her as well. Mr. Sabet is aware she is in pain because she complains about her groin, "upper chest" and shoulders (I noted that Mr. Sabet said "upper chest" but given his limitations in English, I suspect he meant upper back or torso). She does not walk normally (she limps while she walks) and she is not able to walk upstairs. She uses the car door to support her while she gets in or out of a car.
- [94] Mr. Sabet has helped her out by buying her a shopping cart with wheels, and he tries to do things for her such as housecleaning, laundry and window cleaning. He does this once or twice a month. He suggested that she hire cleaners, but she "got mad" at one of them and said "I'd rather stay with a mess than hire people".

- [95] In cross-examination, Mr. Sabet said he had taken Tylenol 3s on the day of his trial testimony, as he has injuries from a 2002 accident (his left foot, back and neck) and is in pain all the time. He also takes medication for depression and gastritis. He said he has attention deficit disorder. He agreed his memory from 2014 is quite vague. He also agreed that he and Ms. Javanparast did in fact have arguments prior to the accident because that is why they separated.
- [96] Mr. Sabet said the plaintiff's groin issues were on the left side, but then "it went to the right", so now she has pain on both sides. He was unable to say when these arose, stating "I am not good at dates". He did not recall whether these issues arose immediately after the accident. He also was unsure when she began having problems getting in and out of a car, saying, "very soon after", "four or five months after the accident", "I'm not sure" and "definitely not in the first week".
- [97] The groin pain, both left and right, causes Ms. Javanparast the most pain now. Her mood changes have become worse.

E. Dr. Heather Underwood - Physiatrist

- [98] Dr. Underwood saw the plaintiff for medical-legal assessment on January 31, 2019, but she also treated the plaintiff starting in April 2015. Dr. Underwood prepared a report dated the same day as her assessment, January 31, 2019.
- [99] In her report, Dr. Underwood noted the plaintiff's past history of breast cancer (diagnosed in 2003), AFib (2013 onward), "left shoulder calcification" (date not stated) and an episode of hip pain (approximately 2004) which was diagnosed as "malalignment syndrome". She also summarized the available imaging, which included an x-ray (March 2015), ultrasound (December 2015) and two MRIs (October 2015 and June 2018) of her left hip, and also a 2018 MRI of her right hip. A 2016 x-ray of the plaintiff's cervical spine revealed severe osteoarthritis at C5-C6.
- [100] Dr. Underwood performed various physical tests and examinations, which resulted in, among other things, reports from the plaintiff of stiffness in her shoulder and neck, low back pain, left groin pain, burning thighs (when doing lunges) and tenderness in the right trochanteric bursal region (the area of the bursa at the top of the iliotibial band on the outside of the leg and hip).
- [101] Dr. Underwood made the following diagnoses:
- a) myofascial pain in the paracervical and periscapular region, right greater than left, with aggravation of degenerative changes in the neck;
 - b) myofascial pain in the perithoracic region and paralumbar region;
 - c) right elbow soft tissue injury;

- d) left groin injury "during treatment for the motor vehicle accident";
- e) work-related thoracic injury post-accident (a reference to a workplace back injury that occurred in August 2016);
- f) chronic pain (somatoform disorder);
- g) insomnia with premorbid history;
- h) history of AFib;
- i) possible labral injury in her left hip; and
- j) right hip trochanteric bursitis.

[102] As to "somatoform disorder", in her testimony Dr. Underwood explained that Ms. Javanparast has had pain for years but she also focuses and perseverates over it to the point of affecting her mood, and life generally, on a daily basis.

Expanded Diagnoses

[103] Under the heading "Opinion", Dr. Underwood expanded on her diagnoses by area of complaint:

- a) Left hip and thigh: Dr. Underwood said:

In my opinion, she received a soft tissue injury during her therapies for her motor vehicle accident resulting in increasing peripelvic pain. Overall, her previous history of pelvic malalignment was further aggravated. This has become more chronic in nature.

Unfortunately, [the plaintiff] does not have good body awareness for the movements that are required for improvement of her myofascial pain, peripelvic pain and pelvic malalignment. Individuals generally require some loosening of the peripelvic area, realignment and strengthening. ... She has developed right trochanteric bursitis due to offloading of her left leg.

- b) Paracervical and periscapular pain: Dr. Underwood said the plaintiff experienced pain in these areas, which improved somewhat with therapy. Dr. Underwood noted, however, that the plaintiff has abnormal basic posturing, which makes relief of her symptoms more challenging. Her occupation also puts her at increased risk for pain aggravation, as happened with a work-related injury in 2016. She was having some improvement in her symptoms when this incident occurred.
- c) Right elbow (in her testimony, she corrected the "left elbow" reference in her report to "right elbow"): Dr. Underwood said this was likely due to a soft tissue injury, but noted this was not a major complaint during her assessment of the plaintiff. She said the plaintiff's discomfort appears to be more muscular in nature and originates from the shoulder region.

- d) Pain generally: Dr. Underwood said the plaintiff has had ongoing difficulties with pain since she first saw her in 2015. It has waxed and waned despite therapeutic interventions. She presents with reduced mood secondary to her chronic pain. Her history of peptic ulcer and her current anticoagulant medication limit some of the treatments available. Dr. Underwood suggested the plaintiff attend the Self-Management of Chronic Pain program and that she visit the Pain BC website, although Dr. Underwood understood the plaintiff has not done so to that point.
- e) Sleep difficulties: Ms. Javanparast has a longstanding history of sleep difficulties, which predate the accident. The plaintiff herself reports this has become worse since the accident, and with her poor sleep she has reduced mood.

Causation

[104] Based on the report that the accident was a "T-bone" accident that pushed the plaintiff's car into the oncoming lane, Dr. Underwood said, "Given the mechanism of impact, some asymmetry of her neck and periscapular pain would be expected". She added that the plaintiff's left elbow may have struck the door, although that comment no longer applies since Dr. Underwood corrected her references to an injured left elbow to an injured right elbow.

[105] Dr. Underwood also said the plaintiff's left hip and groin may have been "irritated by striking the door at the time of impact". She added:

This was not her primary complaint, but increasingly became an issue in the months that followed the motor vehicle accident. There appears to be some association when she was receiving therapeutic intervention.

[106] Dr. Underwood noted that in 2016 the plaintiff suffered an injury at work while lifting a patient. She said the plaintiff "was likely at increased risk for this developing given her previous history of soft tissue injury involving the neck and periscapular region". Dr. Underwood also said the plaintiff's longstanding difficulties with sleep were exacerbated by her chronic pain.

Prognosis

[107] Dr. Underwood said the plaintiff "has generally plateaued with regards to her recovery". She noted the plaintiff has poor body awareness and generally requires supervision for any exercise routine "in order to perform them well".

[108] Dr. Underwood said the plaintiff is in a "high-risk" occupation in terms of aggravating her chronic pain, and she is at increased risk for lost work as a result.

Recommendations

[109] Dr. Underwood made the following recommendations:

- a) Mood: the plaintiff may benefit from counselling for both mood and chronic pain. She should be evaluated for appropriate medication for both mood and chronic pain.
- b) Sleep: Counselling might be beneficial. Working day shifts only would likely help.
- c) Hip pain: the plaintiff should undergo an imaging injection (for diagnostic purposes) or a steroid-based injection to see if the latter provides her with any pain relief. Her hesitation to undergo injections given her use of anticoagulant medication is reasonable. Dr. Underwood said she suspects the plaintiff has a labral tear in her left hip. She also recommended a hip offloader, which is a brace that might help her with walking. She might also benefit from a customized foot orthotic to address the collapsing arch she has when performing a squat. That collapsing arch is likely further irritating her hip pain.

Cross-Examination

[110] In cross-examination, Dr. Underwood said:

- a) she first saw the plaintiff on April 8, 2015. At that time, the plaintiff said her most bothersome symptom was her left hip, which had its onset about four weeks prior;
- b) she was unaware of any later left hip injury the plaintiff may have had;
- c) she saw the plaintiff on various dates in 2015, 2016 and 2018. She last saw the plaintiff in September 2019;
- d) the plaintiff first reported increasing right hip pain on October 2, 2018;
- e) in her report of January 31, 2019, Dr. Underwood referred to the plaintiff's report of "further irritation of her left hip pain after a therapy session". When asked if this meant she experienced pain prior to the therapy session, Dr. Underwood said it was "somewhat unclear" whether it was completely absent prior to this session. Throughout her management of the plaintiff, the plaintiff's reports varied. At first, the plaintiff's report was more definitive - that the pain began with the therapy session - but this became more vague as time went on;
- f) the plaintiff made no mention of striking the door in the accident;
- g) she would not defer to a psychiatrist in the diagnosis of a mood disorder because physiatrists see more people with pain issues than psychiatrists do;
- h) she did not refer the plaintiff to a psychiatrist;
- i) she first offered her an intramuscular steroid injection in January 2016;
- j) she does similar injections "all the time" with people on blood thinners. Patients can always go off their blood thinners for a time, although there are risks;
- k) she told the plaintiff "multiple times" that there was a low risk associated with the type of injection proposed, but the Ms. Javanparast worries and perseverates over her health; and

- l) in her report, where she says the plaintiff's hesitation is "not unreasonable" in declining injections, she was referring to a magnetic resonance angiography (MRA), which has more risks because it is an intra-articular injection rather than an intramuscular (steroid) injection.

F. Dr. Christopher Babbage - Psychiatrist

[111] Dr. Babbage assessed Ms. Javanparast on March 26, 2019 and he prepared a medical legal report dated August 28, 2019. Dr. Babbage noted that after the accident Ms. Javanparast developed chronic musculoskeletal pain, anxiety, poor sleep, mood changes and fatigue. She has had anxiety and mild depression since the accident and she has reduced her daily activities due to concerns about exacerbating the pain.

[112] In his report, Dr. Babbage concluded that Ms. Javanparast meets the diagnostic criteria for "Somatic Symptom Disorder (SSD) with predominant pain". A diagnosis of SSD requires that an individual have persistent pain or somatic symptoms lasting for at least six months. He added:

Her chronic pain is intensely distressing. She has persistent anxiety and psychological stress about her health and pain. She has persistent thoughts about the seriousness of her pain and other symptoms. For Ms. Javanparast, her subjective experience of pain is the predominant clinical focus. At the same time, there are clinical indicators that psychological factors play a significant role in the perpetuation, maintenance and exacerbation of her pain and pain related distress.

[113] Dr. Babbage also concluded Ms. Javanparast meets the criteria for a diagnosis of Persistent Depressive Disorder (PDD), which had its onset after the accident and which Dr. Babbage concluded would not have developed in the absence of the accident.

[114] Dr. Babbage made the following recommendations:

- a) Ms. Javanparast should continue to have long-term access to a psychologist for ongoing psychotherapy every two or three weeks;
- b) she should be referred to a psychiatrist for possible trials of low-dose antidepressant medication;
- c) she should have long-term access to regular exercise guided by a personal trainer or kinesiologist; and
- d) she would likely benefit from a driver's education course to increase her driving confidence and ability to tolerate driving without anxiety.

[115] As for prognosis, Dr. Babbage said Ms. Javanparast is at higher long-term risk of developing major depression, and her psychiatric prognosis is guarded. He said the recommendations he has made "are likely to maintain her current function and prevent deterioration". He added:

Her symptoms of depression, chronic pain, sleep pattern change and fatigue remain. It is likely that Ms. Javanparast's SSD and PDD will continue to distract and negatively affect her mood and energy level long-term. On balance, the MVA of September 11, 2014 increased her vulnerability to psychiatric illness negatively affecting her ability to work overtime or durably in the future.

[116] In his testimony at trial, Dr. Babbage explained that "SSD with predominant pain" is any symptom that causes daily concerns or distress and causes disproportionate thoughts and behaviours, which persists for six months or more. In Ms. Javanparast's case, she demonstrates hypervigilance and worry about her pain, she worries about the seriousness of her pain, and she even worries that her lack of exercise will cause the recurrence of cancer.

[117] In cross-examination, Dr. Babbage said:

- a) Ms. Javanparast did not tell him of any sleep issues or pain issues she had pre-accident;
- b) she did not mention a 2010 car accident to him, although he asked her to relate any prior traumatic events;
- c) the areas of pain that caused her psychiatric symptoms were her shoulder, neck, hip and groin. The area of most concern to her was her groin, which started on the left side but which was now bilateral; and
- d) he agreed that anxiety and worry may not amount to a disorder if they are proportionate to the underlying condition. The important factor is the way the person is perceiving things.

G. Louise Craig - Functional Capacity Evaluator

[118] Ms. Craig was qualified to give opinion evidence on functional capacity as well as "life care needs", also known as cost of future care.

[119] Ms. Craig evaluated Ms. Javanparast on June 17, 2019, she wrote a report dated July 5, 2019, and she provided a supplemental report dated September 6, 2019 in which she commented on the recommendations made by Dr. Babbage.

[120] Ms. Craig concluded as follows:

- a) Ms. Javanparast did not demonstrate the capacity to meet the full physical demands of a Registered Nurse, as classified by the National Occupational Classification (NOC);

- b) her current position on a post-partum maternity ward allows her to minimize lifting, carrying and positional demands, although she has limitations with bending over and charting. Charting was aggravating to her hips and upper back;
 - c) she would not likely be able to meet the physical demands of a heavier ward and is limited to the very lightest nursing positions;
 - d) she recommends that Ms. Javanparast consider reducing her hours from full-time to part-time hours, with shorter shifts, such that she has a maximum workload of 24 hours per week;
 - e) Ms. Javanparast has a variety of specific limitations, including reaching at lower levels; sitting for prolonged periods (which causes her upper back and hips to stiffen and requires her to take more frequent postural or mobility breaks); sustained stooping, overhead reaching and standing. When standing, Ms. Javanparast shifts from side to side due to pain;
 - f) Ms. Javanparast showed measurable functional decline over the course of the testing;
 - g) Ms. Javanparast is very deconditioned;
 - h) in Ms. Craig's opinion, Ms. Javanparast provided a consistent and full physical effort during the evaluation;
 - i) Ms. Javanparast is likely at maximum physical rehabilitation (her conclusion was based on Dr. Underwood's report); and
 - j) she is independent with most activities of self-care, but does not meet the full physical demands for regular and seasonal household cleaning or maintenance, and requires assistance for these activities.
- [121] Ms. Craig recommended: (1) 24 to 30 physiotherapy treatments, with the goal of increasing Ms. Javanparast's activity level so that she can participate in therapeutic exercise; (2) 10 to 12 physiotherapy treatments annually to address symptom flares; (3) 24 to 30 supervised exercise sessions with a kinesiologist over the coming year, with periodic review for the next two or three years; and (4) participation in a chronic pain education program.
- [122] Ms. Craig also provided an opinion on Ms. Javanparast's future care needs and their associated costs. I will address those matters later.
- [123] In cross-examination, Ms. Craig said:
- a) she was not aware that Dr. Underwood had recommended Ms. Javanparast discontinue physiotherapy, but nonetheless Ms. Craig recommended that Ms. Javanparast have physiotherapy available to her deal with flare-ups of pain;
 - b) Ms. Javanparast was limited to carrying loads of 10 pounds because she lifts by bending over rather than lifting with her legs, as she should. She would likely be able to lift loads of 15-20 pounds if she lifted correctly;

- c) although Ms. Javanparast is limited in her ability to work in other nursing fields, she has not expressed an interest in working elsewhere;
- d) Ms. Javanparast's right hip is worse than her left hip;
- e) she acknowledged that Ms. Javanparast has performed all of her work duties for the past five years, although with limitations; and
- f) although in her report Ms. Craig said "she no longer works overtime", Ms. Craig now knows the plaintiff has been working overtime. However, Ms. Craig said this did not change her opinion that Ms. Javanparast should reduce her hours of work.

H. Darren Benning - Economist

- [124] Mr. Benning provided actuarial multipliers for future income loss and cost of future care. Mr. Benning said he used the data for adult males, not females, because he was instructed to do so.

VI. Defence Evidence - Damages

A. Dr. Venugopal Karapareddy - Psychiatrist

- [125] Dr. Karapareddy saw the plaintiff on August 1, 2019 and he prepared a report dated August 28, 2019.
- [126] In his report, Dr. Karapareddy noted the plaintiff reported mild road-related anxiety, reactive low mood and anxiety due to her physical health concerns (mainly accident-related health concerns) and financial insecurity, and secondary insomnia as a result of pain. He noted that her primary physical complaint at the time of assessment was pain in her right outer thigh.
- [127] Dr. Karapareddy said "there appears to be no clear DSM-5 diagnosis". He said the plaintiff's psychological issues are best classified as road-related anxiety and psychological concerns about her health.
- [128] In terms of prognosis, Dr. Karapareddy said the plaintiff's road-related anxiety "has largely settled" but noted she continues to have restriction around four-way stops, preferring instead to take routes controlled by traffic signals. He said if the plaintiff's pain symptoms were to improve, it is "more than likely" her sleep would improve which, in turn, would have a positive impact on her energy levels and ability to cope.
- [129] As for recommendations, Dr. Karapareddy said cognitive behavioural therapy (CBT) would help the plaintiff to cope better. He noted that her counselling sessions are mainly supportive in nature rather than CBT focused. He recommended a trial of sleep medication, but said he would not recommend antidepressant medications at this time. Finally, he recommended that the plaintiff's family doctor have a multi-professional meeting with Dr. Underwood and a cardiologist to address the issue of cortisone injections to help with the

plaintiff's right-side bursitis.

- [130] In cross-examination, Dr. Karapareddy agreed the plaintiff's insomnia is related to pain, which is why he described it as "secondary insomnia". He acknowledged the plaintiff expressed anxiety about not exercising and that this might lead to a recurrence of cancer, but he said this was "reactive anxiety" and it did not reach the intensity to meet any DSM-5 criteria. He noted as well that her reports of low mood disclosed she did not have these symptoms all the time, and persistence of symptoms is an important factor in meeting the criteria for a DSM-5 diagnosis. He said the plaintiff had a depressed mood, but this was different from Major Depressive Disorder. She also does not meet the diagnostic criteria for PDD because her functionality has not been substantively impaired. While she has some impairments, she was performing her regular duties at work.
- [131] Dr. Karapareddy said that in making a diagnosis of a psychological disorder, it was important to assess whether the plaintiff's psychological symptoms, as distinct from her physical symptoms, were affecting her functionality. He said "chronic pain" is a syndrome which has both a musculoskeletal component as well as psychological aspects associated with the chronic pain.
- [132] Dr. Karapareddy also disagreed that the plaintiff has SSD. While he agreed the plaintiff reported worrying a lot about her health, he said this symptomatology was episodic. In his report he noted that work distracted her from negative thoughts. He acknowledged that the plaintiff was distressed by her worries and anxieties, but said in order to meet the criteria for a disorder the distress must cause significant disruption to daily life, which was not present here.

B. Dr. Jemima Wasswa-Kintu - Family Physician

- [133] Dr. Wasswa-Kintu was the plaintiff's family physician from 2002 to 2017, when Dr. Wasswa-Kintu retired from full-time practice. She was called as a fact witness only and so she did not provide an expert report.
- [134] Dr. Wasswa-Kintu confirmed records showing the plaintiff's weight on several dates, those being: March 2014 -140 pounds; September 2015 - 64 kg (141 pounds); and June 2017 - 66.7 kg (147 pounds).
- [135] A RCH record dated March 12, 2014, noted that the plaintiff attended at the ER with complaints of a "burning sensation in between shoulder blades".
- [136] Records also showed the plaintiff filled prescriptions for paroxetine, an antidepressant and anti-anxiety medication, on December 1, 2013, and lorazepam (also known as Ativan) on a number of occasions from May 2013 to October 2014. Dr. Wasswa-Kintu agreed lorazepam is an anti-anxiety medication, but said the plaintiff used it more to aid her sleep.

[137] Dr. Wasswa-Kintu confirmed the records and notes she made on several dates, which I summarize as follows:

- a) May 5, 2010: The plaintiff reported ongoing pain in her left shoulder. Dr. Wasswa-Kintu ordered an x-ray of the lumbosacral spine, then added an order for an x-ray of the shoulder. The spine x-ray was normal; the shoulder x-ray revealed some calcification.
- b) May 20, 2010: The plaintiff reported being in a car accident in which a "big truck" hit her car in a T-bone fashion on the passenger side, which spun her car 360 degrees. She was transported to emergency, where x-rays were taken. On this visit, the plaintiff reported right lumbar/lower thoracic pain, pain in her right flank and pain and swelling in her right arm.
- c) March 3, 2011: The plaintiff reported: (1) left shoulder pain, which she had been experiencing for a few months; and (2) residual upper mid-back pain, both since the car accident of the previous year.
- d) November 6, 2012: The plaintiff reported pain in the left side of her thigh. She also wanted a referral to the breast cancer specialist because "her sister has just been diagnosed [with] lymphoma and it has been stressing her a lot". Although clinically the plaintiff was in remission, Dr. Wasswa-Kintu provided the referral because the plaintiff wanted it.
- e) February 4, 2013: The plaintiff complained of right side lower back pain that had been present for three days. At trial, Dr. Wasswa-Kintu said this visit was probably just for reassurance as the plaintiff had just started gym work.
- f) May 10, 2013: A cardiologist confirmed the plaintiff had AFib. Dr. Wasswa-Kintu said this was the first confirmation of AFib although there were earlier indications it was present.
- g) January 28, 2014: This was the date of a note sent to Dr. Wasswa-Kintu by the RCH AFib outpatient clinic. Dr. Wasswa-Kintu agreed that the plaintiff was anxious about AFib, although she said anxiety is common with AFib patients, and anxiety itself contributes to AFib.
- h) December 16, 2014: This was the date of a note from the cardiologist, indicating the plaintiff was discontinuing blood thinner medication in order to undergo a dental procedure. Dr. Wasswa-Kintu said the risks of stopping the medication depends on the procedure involved.
- i) March 16, 2015: This was the first mention by the plaintiff of any problem in her left groin. The plaintiff reported that it arose from a kinesiology session. Dr. Wasswa-Kintu diagnosed a left hip sprain and ordered an x-ray.

- j) March 23, 2015: The plaintiff reported that her accident symptoms were the same. Dr. Wasswa-Kintu said the symptoms in question were those as first reported, namely: (1) intermittent pain in her right elbow; (2) pain in the right side of her neck going to her right shoulder; and (3) pain and stiffness between her shoulders on waking up and lasting until noon, when it would start to improve. Dr. Wasswa-Kintu arranged an appointment with Dr. Underwood to address the plaintiff's left hip symptoms.
- [138] Dr. Wasswa-Kintu said the plaintiff's left groin pain was the most prominent issue as time went on. She said Dr. Underwood was in charge of the plaintiff's care, for the most part, after Dr. Underwood started seeing her.

C. Gerard Kerr - Work Capacity Evaluator

- [139] Mr. Kerr conducted a work capacity evaluation of the plaintiff and prepared a report July 2, 2019. He saw the plaintiff on two occasions: May 7, 2019, when he interviewed the plaintiff and conducted work capacity testing; and May 10, 2019, when he saw the plaintiff at her home in order to conduct a home assessment. His report includes a cost of future care assessment.
- [140] Mr. Kerr said the plaintiff participated in work capacity testing with high levels of effort, which caused Mr. Kerr to conclude that the test results should be considered an accurate measure of physical capacity.
- [141] Mr. Kerr found various limitations in the plaintiff's functioning, including: (1) overhead or extended reaching; (2) bending, kneeling or crouching; (3) stair climbing; and (4) moderate degree stooping. He said she is capable of work activity in the sedentary and light strength categories of the Dictionary of Occupational Titles (DOT), or in activities involving light strength demands as defined by the NOC.
- [142] Mr. Kerr concluded the plaintiff's reasonable standing tolerance was one to two hours, and her reasonable standing tolerance was also one to two hours. In terms of overall work endurance, Mr. Kerr said the plaintiff is able to perform full-time work where the physical demand requirements are within the plaintiff's functional limitations as identified in his report.
- [143] During the testing, the plaintiff's reported complaints related to right hip pain, right thigh pain (or bursitis) and mid-back symptoms. During the testing, the plaintiff demonstrated functional limitations related principally to right and left hip pain, with the right being worse than the left, right lateral thigh pain and mid to upper back pain. To a lesser extent, she reported some issues with knee pain and pectoral pain.
- [144] Mr. Kerr noted that while the NOC indicates the strength demands for a nurse are in the medium category, the plaintiff's work as a perinatal nurse likely fell within the sedentary to light categories.

[145] Mr. Kerr concluded that the plaintiff is able to meet the specific physical demands of her work and, based on that, he also concluded the plaintiff can continue to work in her current capacity.

[146] Mr. Kerr acknowledged that exposure to certain physical demands "likely aggravates her reported symptoms", and he referred specifically to static bending while working with new mothers. He said:

She has been willing to work with some level of pain and assuming this remains the case and she [continues] to mitigate where possible, I would anticipate she will be able to continue with her current, regular full time hours. Based on her response to the assessment activity it is my view she would be unlikely to sustain additional 12 hours work shifts on a durable basis.

[147] When asked about the condition of the plaintiff's home at the time of his home visit, Mr. Kerr said "her home was very tidy. Immaculate".

[148] In cross-examination, Mr. Kerr said he had the plaintiff do work simulations in order to assess, as accurately as possible, her capacity for her actual work. He said the plaintiff reported the percentage of sitting and standing in her work to be 50-50.

[149] Mr. Kerr said the plaintiff reported that her symptoms at the end of testing (which took just over seven hours) were better than they are at the end of a typical work shift. He agreed she was "quite tired" at the end of the assessment.

[150] Mr. Kerr said the plaintiff has demonstrated she is tolerating her pain because she has done so for five years. Some activities bother her, but she is able to mitigate these by varying her activities.

D. Sharon Singh - Kinesiologist

[151] Ms. Singh treated the plaintiff in 2015. The plaintiff's first visit was on January 27, 2015 and her last visit was on March 31, 2015.

[152] Ms. Singh's treatment of the plaintiff involved a stretching routine and exercises with resistance bands. She did not have the plaintiff work with any machines or weights. She also did not do any manual therapy or manipulation with the plaintiff. She said she would not describe her treatment of the plaintiff as "intense".

[153] Ms. Singh said she had no independent recollection of treating the plaintiff and, in giving testimony, she relied on her charting notes. Ms. Singh said charting was mandatory at her firm (Karp Rehabilitation) and she made chart notes after every session.

[154] Ms. Singh did a brief assessment of the plaintiff on the first day. These sorts of assessments typically take 45-50 minutes. As part of this assessment, she asked the plaintiff about her current complaints. The plaintiff reported intermittent neck pain, occasional lower back pain, and pain in her middle back, upper back, right elbow and right shoulder.

- [155] Ms. Singh testified that the plaintiff told her she no longer does overtime work.
- [156] Ms. Singh gave her diagrams of the exercises the plaintiff was to do, she demonstrated the exercises to the plaintiff, and she had the plaintiff do the exercises with her. She explained to the plaintiff the benefits of the stretching exercises, and told her she should do them even if she was sore, but not to the point of hurting herself. The instruction was to stop before discomfort or soreness becomes pain.
- [157] In the second treatment session, the plaintiff reported she had not done any stretching exercises since the earlier session. The plaintiff said she was "too sore" and she "had to work", and she said she was not sure she should even be doing the exercises, even though she was advised to do them.
- [158] In the third and fourth sessions, the plaintiff reported she was stretching daily. She had "moderate stretch recall" in terms of doing the exercises correctly. She said the stretches were getting easier. Because she was 40 minutes late for the third session, the physical work the plaintiff did at that time was limited to five minutes on a treadmill and the rest of the time was spent discussing the plaintiff's symptoms.
- [159] The plaintiff was a "no show" for the fifth session. At the sixth session, the plaintiff had a poor recall of the stretches and she conceded she was probably doing them wrong. In the seventh session, which took place on March 24, 2015, the plaintiff was 25 minutes late and she had no recall of the stretches. Notably, the plaintiff complained that her left hip was sore "due to a previous injury". Ms. Singh told her that they would have to discontinue the program if the plaintiff continued to be late.
- [160] In the eighth session, the plaintiff was nine minutes late and she had a poor recall of the exercises and stretches. Her technique was poor and she was not even counting the repetitions. The plaintiff said she had not been stretching on her own and had only used the exercise band once. She also said there had been no change to her symptoms.
- [161] The plaintiff did not schedule any further sessions and so Ms. Singh's office closed the file.

E. Dr. Bassam Masri - Orthopedic Surgeon

- [162] Dr. Masri assessed the plaintiff on April 16, 2018 and he provided a report dated April 19, 2018. He also provided two response reports, one dated October 7, 2019 and the other dated October 9, 2019.
1. Report of April 19, 2018
- [163] In his first report, Dr. Masri reviewed the plaintiff's relevant medical history, based both on the information supplied by the plaintiff and on the medical records. He noted in particular the plaintiff's reports of left groin pain in both 2005 and 2013, prior to the accident. The plaintiff told Dr. Masri that by the end of her shift on the day of the accident she felt pain and stiffness in her right elbow, intermittent pain in her left groin and pain in her mid-back

area. She said she awoke the next morning with severe pain in her right elbow, upper back pain between her shoulder blades, pain in her left groin, and "slight pain" in her low back and neck.

[164] Dr. Masri summarized the plaintiff's then-current symptoms, as reported by the plaintiff, as being: (1) stiffness between her shoulder blades; (2) mild neck pain; (3) left groin pain, which was minimal and intermittent at first, but which became prominent in March 2015; (4) occasional (a few days each month) mild pain in her right elbow; and (5) episodic right wrist pain, for which she was now wearing a splint.

[165] Dr. Masri noted the plaintiff told him she no longer had low back pain. She also said she had no right groin pain, although Dr. Masri noted she had stiffness in her right hip when he examined her. In fact, he noted there was significant stiffness in both hips. In his testimony, Dr. Masri explained that by using the term "stiffness" he means a loss of range of motion. He said, "whenever you see that, you always suspect osteoarthritis".

Opinion

[166] Dr. Masri provided his opinion by addressing the areas of complaint:

- a) Left groin: Dr. Masri noted that there was no clear documentation of any significant left groin pain immediately after the accident. He also noted the plaintiff had two pre-accident episodes of left groin pain. He concluded:

Therefore, on a purely temporal basis, I cannot associate the left groin pain, which has become more significant over time, with the motor vehicle accident. If she had a significant hip injury, the pain should have been more significant early on to denote [an] acute injury, which was not the case.

- b) Right wrist: Dr. Masri said he could not associate right wrist pain with the accident because it appeared to have worsened only a couple of weeks ago.
- c) Neck: Dr. Masri diagnosed Whiplash Associated Disorder Type II, which was caused by the accident and which he said has significantly improved. He said her current neck disability is minimal as it only arises with overwork or if the plaintiff lies down in an awkward posture. It does not cause her any disability.
- d) Mid back: Dr. Masri noted this was a more significant source of pain and bothers the plaintiff at work, particularly with leaning forward while teaching new mothers. He diagnosed persistent myofascial pain after a soft tissue injury, caused by the accident. Because the mid back and neck injuries had plateaued and were still present three years after the accident, he believed they would not improve over time, although neither would they get worse.

- e) Right elbow: He noted the right elbow was "fairly good" at present in that the plaintiff has only very intermittent pain. He said the most likely diagnosis is healing lateral epicondylitis, also known as tennis elbow.

2. Recommendations

[167] For the plaintiff's neck and upper back pain, Dr. Masri recommended a second active rehabilitation program. He said the use of narcotics over the long term is not helpful, referencing the plaintiff's ongoing use of Tramadol and, instead, Cymbalta should be tried. Although Cymbalta is an antidepressant, it also has a pain modulating effect. Finally, he recommended a trial of low dose amitriptyline to help with sleep, as this would be beneficial for her pain and overall wellbeing.

[168] For the plaintiff's right elbow, Dr. Masri recommended wrist extensor strengthening exercises, which would also help her wrist pain.

[169] For the plaintiff's hips, Dr. Masri said stiffness in both hips may indicate the presence of osteoarthritis. Any osteoarthritis in her right hip would be subclinical, meaning that it is apparent from imaging but is asymptomatic. If osteoarthritis is noted on updated x-rays, and the plaintiff is disabled by the pain, she can be helped by a left hip replacement.

[170] Dr. Masri said he saw no reason why the plaintiff cannot continue to work. In his testimony, he said he meant "in a full-time capacity", and not in an overtime capacity. He noted that the plaintiff was continuing to work and there was no medical reason why she should not continue to work.

[171] Finally, Dr. Masri said it would be reasonable for her to have assistance to help her with the heavier aspects of housework, although he noted that if her housework limitations were related to her left hip or groin pain, these were not related to the accident.

3. Report of October 7, 2019

[172] Dr. Masri prepared this report in order to respond to the reports of Dr. Underwood and Ms. Craig. I summarize his responses by subject matter:

- a) Dr. Underwood's diagnosis of right trochanteric bursitis: Dr. Masri observed that Dr. Underwood made no actual mention of any right hip pain. He also noted that Dr. Underwood did not identify the location of the pain if present. Dr. Underwood's finding of restricted range of motion in the right hip was consistent with his own findings, but since the plaintiff did not report any right hip problems at that time, he assumed the right hip symptoms arose after he saw the plaintiff.

Dr. Masri said Dr. Underwood's findings on examination (restricted range of motion, pain in the thigh on rotation) suggest that these are actually symptoms of osteoarthritis. He noted that x-rays taken after his earlier report confirmed "left greater than right osteoarthritis of the hips", which also supports his diagnosis.

Dr. Masri noted that an MRI showed a small amount of fluid or effusion in the right hip, which is not consistent with bursitis and is instead consistent with osteoarthritis. The MRI also showed a small trace of fluid in the left trochanteric bursa, which is consistent with bursitis, but no abnormality in the bursa of the right hip, "which effectively rules out the diagnosis of right trochanteric bursitis".

In summary, Dr. Masri said the imaging and physical examination support a diagnosis of osteoarthritis of the right hip, not bursitis.

Dr. Masri also disagreed with Dr. Underwood's opinion that the right hip condition was caused by offloading of the left hip. He said:

I see a very large number of patients with painful unilateral hip conditions. They do not present with contralateral symptoms in otherwise normal hips. Therefore, her theory that [the plaintiff] was offloading her left hip and thus had right hip pain is incorrect.

- b) Dr. Underwood's recommendation for a hip offloader: Dr. Masri said that over his 25-year career and having evaluated thousands of patients with osteoarthritis of the hip, he has never prescribed a hip offloading brace and he has never seen a patient who had been prescribed such a brace. He noted there were no medical studies or articles concerning offloader braces. For that reason, an offloader brace would not be medically supported.

Dr. Masri also noted that the mechanics of the joint do not support the use of a brace. The hip is a ball and socket joint that can only be offloaded by pulling it apart, and "a fair bit of force" is needed to do that, as demonstrated by the level of force needed for a procedure such as a hip arthroscopy. That level of force cannot possibly be applied by a brace.

- c) Dr. Underwood's recommendation for orthotics: Dr. Masri said that in his entire career he has never prescribed orthotics for hip pain, although he has done so to correct leg length inequality. He added that, from a common sense point of view, an orthotic inserted inside a shoe cannot have an effect on a ball and socket joint. In summary, Dr. Masri said that Dr. Underwood's recommendation for a foot orthotic for hip pain is not medically supported.
- d) Ms. Craig's recommendation that the plaintiff reduce her work to part-time: Dr. Masri said there is no medical reason to reduce her workload from full-time to part-time hours as long as she is tolerating the work. Working full-time hours will not affect her medical prognosis in any way and it will not affect any future need for a hip replacement.

4. Report of October 9, 2019

- [173] Dr. Masri's second response report dealt with two subjects: the efficacy of steroid injections to address the plaintiff's hip pain, and the risks of those injections in light of the plaintiff's use of anticoagulant medication.

- [174] Dr. Masri noted that updated x-ray imaging would likely confirm the diagnosis of osteoarthritis. As to Dr. Underwood's suggestion the plaintiff might have a labral tear, Dr. Masri said the plaintiff does not have the features of an isolated labral tear, and so an MRA is not called for. He said an MRA would undoubtedly show labral pathology, which will be part of her degenerative condition (osteoarthritis), but not a labral tear.
- [175] In his testimony, Dr. Masri explained that the labrum is a cartilaginous feature around the socket that has a ligament at its bottom. He said that a labral tear, in the absence of some other condition, is extremely uncommon, occurring only in injuries where the hip is almost dislocated. Another situation where you might get a labral tear is if you have osteoarthritis, but in that case treating the labrum will not fix the issue because the underlying cause is osteoarthritis in the joint.
- [176] A diagnostic injection (which would also provide pain relief) would be a good idea, provided updated x-rays were obtained first in order to assess the severity of the arthritis. If the arthritis was mild, an injection would be expected to give pain relief for a period of time ranging from a few days to a few months. If the arthritis is severe, an injection would not be useful. If the pain was severe enough, a hip replacement may be needed.
- [177] Dr. Masri said that in his practice he uses the same blood thinner medication as the plaintiff and he sees numerous patients who are on that medication for AFib. Using a "skinny needle" he performs injections on patients who are taking that medication with no sequelae or problems. A needle that fine does not cause bleeding of any consequence. If the plaintiff was adamant about not having an injection while on the medication, she could discontinue the medication for two days and then resume it on the same day as the injection, as many patients do. The risk of stroke due to stopping the blood thinner medication for two days "is almost non-existent".

VII. Positions of the Parties - Damages

A. Plaintiff

- [178] The plaintiff submits she is a credible witness whose testimony was not undermined in cross-examination. The injuries she suffered to her upper, mid and lower back, neck, right elbow and left hip/groin (which later caused right hip/groin pain), cause her to struggle at work and to limit her home and social activities. She lives in daily chronic pain, which limits her sleep, impairs her ability to deal with the pain and negatively affects her mood. She is depressed and does not enjoy life.
- [179] As for her left hip/groin pain, the plaintiff submits that she suffered an injury in this area, as evidenced by the tightness she felt after the accident, and it became acute as a result of her active rehabilitation treatment. The plaintiff says that causation is established because it falls within the foreseeable consequences of the accident, as contemplated in *Athey v. Leonati*, [1996] 3 S.C.R. 458 [Athey].

- [180] The plaintiff submits the medical evidence led by the plaintiff establishes that she suffered injuries causing myofascial pain in her neck, periscapular region, mid-back, low back, right elbow and left groin. She has chronic pain, insomnia and a possible labral injury to her left hip. She developed right hip trochanteric bursitis as a result of offloading her left leg.
- [181] In terms of psychiatric injuries, the plaintiff says the evidence shows she meets the diagnostic criteria for both SSD and PDD.
- [182] The plaintiff submits that an appropriate award of non-pecuniary damages is \$125,000, citing *La Porte v. Earl*, 2016 BCSC 2298; *Kam v. Van Keith*, 2015 BCSC 1519; and *Hollyer v. Gaston*, 2016 BCSC 1401.
- [183] As to past income loss (or loss of capacity), the plaintiff notes that she has soldiered on, working with pain, because of her financial situation. Her primary financial loss relates to her inability to work overtime shifts as she did pre-accident. She also utilized sick days due to pain, and although the reasons for every sick day are not known, the majority of sick days taken (she suggests 75 percent) were for accident-related problems. The plaintiff claims \$33,865.16 under this heading.
- [184] The plaintiff's claim for loss of future earning capacity is based on the loss of overtime work, continued utilization of sick leave due to pain and the medical evidence that shows she should reduce her hours from full-time to part-time. The plaintiff submits this loss should be assessed on a capital asset basis at \$200,000.
- [185] The plaintiff also claims damages for cost of future care (\$127,881) and loss of housekeeping capacity (\$13,000), as well as special damages (\$13,197.54).
- [186] In summary, the plaintiff's claims are as follows:
- Non-pecuniary damages:
- \$125,000.00
- Past loss of earning capacity:
- 33,865.16
- Loss of future earning capacity:
- 200,000.00
- Cost of future care:
- 127,881.00
- Loss of housekeeping capacity
- 13,000.00

Special damages:

13,197.54

Total:

\$512,943.70

B. Defendant

- [187] The defendant submits the plaintiff was not a credible witness, citing her variable testimony in a number of key areas. The defendant does not deny that the plaintiff suffered soft tissue injuries to her neck, upper back and right elbow, but she submits the plaintiff's disabling hip condition, which is now the primary factor in her limitations, was not caused by the accident. The defendant notes that the injuries to the plaintiff's right elbow and neck have substantially resolved.
- [188] The defendant says non-pecuniary damages ought to be assessed in the range of \$50,000 and \$65,000 if the plaintiff's left hip problems are not associated with the accident, and between \$70,000 and \$85,000 if her left hip problems are found to have been caused by the accident. The cases cited in this regard are *Bilanik v. Ferman*, 2014 BCSC 732; *Sylte v. Rodriguez*, 2010 BCSC 207; *Bove v. Lauritzen*, 2009 BCSC 1698; *Neyman v. Wouterse*, 2013 BCSC 741; and *Olson v. Farran*, 2016 BCSC 1255.
- [189] As to past income loss, the defendant says the evidence does not show why the plaintiff took sick leave at any particular time, and so it is not clear whether the plaintiff was ill on any given sick day, or whether she took time off due to problems with her hips or, more recently, her knees. The defendant submits that 20 percent of total sick days taken would be an appropriate estimate of the sick days attributable to accident-related issues. No amount should be awarded for any loss of overtime work because the plaintiff's limitations concerning overtime are related to AFib (which requires her to minimize stress) and to her degenerating hips and knees.
- [190] As to the claim for future losses, the defendant notes the plaintiff is already at retirement age, the plaintiff did not provide any estimate about her retirement plans, she continues to work full-time, and her limitations are primarily related to physical issues that are not related to the accident. In the event the Court concludes that the plaintiff's capacity to work overtime has been impaired by accident-related injuries, the defendant says the assessment should be based on an annual loss of either 22 or 55 overtime hours each year (depending on the Court's finding concerning left hip causation) for three years, by which time the plaintiff would be 68 years old. This results in future loss amounts of either \$3,725 or \$9,312, net of taxes.

[191] As for cost of future care, the defendant responded to each of the items claimed, noting some expenses would have been incurred in any event, some were related to her hip problems, and some were not medically recommended or justified. The defendant concedes an award in the range of \$2,500 to \$4,840.

[192] The defendant agrees with the special damages claimed.

[193] The defendant submits the awards for non-pecuniary damages, past loss of income and loss of future earnings ought to be reduced as a result of the plaintiff's failure to mitigate her damages by undergoing the therapeutic injections that were recommended for her hip problems.

[194] The defendant says an appropriate award would be as follows:

Non-pecuniary damages:

\$50,000.00 to \$85,000.00

Past wage loss:

3,466.00

Loss of future earning capacity:

3,725.00 to 9,313.00

Cost of future care:

2,500.00 to 4,840.00

Special damages:

13,198.00

Total:

\$72,889.00 to \$115,817.00

VIII. Discussion

A. Credibility and Reliability

[195] Some of the issues in this case turn on the credibility and reliability of the plaintiff's testimony, and so it is necessary that I comment on those matters.

[196] I agree with the defendant that the plaintiff gave significantly varying versions of events on some important issues. I will not list all of these but will provide a few examples: (1) she told others that she did not work overtime after the accident, which was not true; (2) on several occasions she provided different times for the onset of her low back pain. At trial, she asserted she had low back pain from the beginning, but when records were put to her she agreed she might not have had low back pain in the early post-accident period; and (3)

most significantly, she provided substantially different onset times and descriptions for her left hip/groin pain, to the extent that, at her examination for discovery, she described her left groin pain as being her "worst pain" at a point 24 hours after the accident and she had reported that to every health practitioner. The latter assertion was not substantiated in any of the clinical records or by the testimony of the health care professionals.

[197] I conclude, however, that Ms. Javanparast's varying accounts do not stem from a deliberate intention to deceive. Instead, I conclude that her preoccupation with her health issues, which cause her to ruminate excessively (or in Dr. Underwood's words, "perseverate") over them, causes her to arrive at a belief that is different than what actually happened. This is illustrated by the testimony of Dr. Underwood, who said that at the beginning of her treatment the plaintiff unambiguously reported the onset of her left hip/groin symptoms as having occurred during a kinesiology session, but the plaintiff's reports of the onset timing became more "vague" over time. This conclusion is also supported by the fact that, at times during her testimony, the plaintiff appeared to be reconstructing evidence rather than recounting her actual recall (she said "probably" a fair amount), and she became mildly assertive or argumentative when challenged on cross-examination. Finally, my conclusion is also consistent with Dr. Babbage's observation that the plaintiff magnifies or "catastrophizes" her pain.

[198] In brief, I conclude that on key elements of medical history, the plaintiff's account is not reliable and that a much more accurate and reliable history is found in the clinical and other records.

B. Findings

Onset of Left Hip/Groin Symptoms

[199] The most significant factual issue on damages is the matter of the plaintiff's left hip/groin. For the reasons articulated in the previous section, I am unable to accept the plaintiff's evidence that she had any "tightness" or other symptoms in her left hip/groin after the accident. Her evidence on this point is simply not reliable. There is no mention of it in any of the records. No witness testified that the plaintiff said anything to that effect. In fact, the first mention by the plaintiff of any problem in her left hip/groin was on March 16, 2015, as Dr. Wasswa-Kintu testified and as recorded in her clinical records. This was six months after the accident.

[200] Based on the evidence I accept, I conclude that: (1) the plaintiff did not have left hip/groin symptoms in the aftermath of the accident; and (2) her post-accident left hip/groin symptoms first arose in mid-March 2015.

Hip/Groin Diagnosis

- [201] Dr. Underwood did not make a definitive diagnosis of the plaintiff's left hip/groin problem. Although she diagnosed "soft tissue injury [received] during her therapies", other than querying a possible labral injury she did not offer an explanation why the soft tissue injury has both persisted and deteriorated.
- [202] Dr. Underwood also said the plaintiff's "left hip and groin pain may have been irritated by striking the door at the time of impact", which may have been an attempt to reconcile the plaintiff's vague and varying accounts of symptom onset, but that statement seems inconsistent with Dr. Underwood's diagnosis of soft tissue injury arising from therapy. As to the point about the plaintiff's groin pain being "irritated" by striking the car door, I note: (1) the "striking the door" theory was also Dr. Underwood's explanation of the possible cause of the plaintiff's left elbow injury, which she later acknowledged was in error insofar as it was the plaintiff's right elbow that was injured; (2) the plaintiff did not have left hip and groin pain at the time of the accident and so it is difficult to see how it was "irritated" unless Dr. Underwood was referring to the plaintiff's past history of peripelvic myofascial pain and alignment dysfunction; and (3) the plaintiff did not mention anything to Dr. Underwood about striking the door of her car.
- [203] Dr. Masri explained why he felt the plaintiff's hip condition was not due to an isolated or standalone labral tear (that is, a labral tear not associated with some other condition, such as osteoarthritis), given the forces needed to injure the joint in that way and the fact that onset of pain would have been significant "early on". He noted a 2018 MRI showed an effusion (fluid) in the right hip, which he said is consistent with osteoarthritis, and which is relevant insofar as Dr. Underwood referred to an October 2015 MRI showing an effusion in the plaintiff's left hip. Finally, Dr. Masri said his physical examination of the plaintiff showed she had "significant stiffness" in her hips, and he said "whenever you see that, you always suspect osteoarthritis".
- [204] I found Dr. Masri's evidence to be clear, cogent and well-reasoned, and I felt the stated bases of his opinion were not effectively answered by Dr. Underwood. Although not perhaps a decisive point, Dr. Masri's extensive experience in joint replacement arguably puts him at an advantage in terms of hip joint etiology. For those reasons, I prefer Dr. Masri's opinion over that of Dr. Underwood insofar as the plaintiff's left hip/groin is concerned.
- [205] As a result, I conclude that the plaintiff's left hip/groin symptoms are rooted in the osteoarthritis present in the joint. Although the evidence on this is not ideal, on a balance of probabilities I also conclude her left hip symptoms became symptomatic as a result of stretching exercises done as part of her accident-related therapy.

Causation and Foreseeability

- [206] The parties do not agree on legal causation. The plaintiff says an injury that occurs in the course of treatment following a car accident is a reasonably foreseeable consequence of that accident. The defendant says the plaintiff's left hip was not an area that was being treated; in other words, it is unrelated to the accident. The defendant also says that left hip symptom onset was the result of the plaintiff doing the exercises incorrectly and so it was not reasonably foreseeable.
- [207] A plaintiff must prove on a balance of probabilities that the defendant's negligence caused or materially contributed to an injury. The defendant's negligence need not be the sole cause of the injury so long as it is part of the cause beyond the de minimus range. There is no requirement that causation be proven with scientific precision: *Athey*, at paras. 13-17. I pause to note that *Athey* itself involved an injury suffered by a plaintiff during rehabilitative exercise. The test for causation is whether, but for the defendant's negligence, the plaintiff would have suffered the injury. The "but for" test recognizes that compensation for negligent conduct should only be made where a substantial connection between the injury and the defendant's conduct is proven: *Resurface Corp. v. Hanke*, 2007 SCC 7, at paras. 21-23.
- [208] Here, I am satisfied there is a substantial connection between the onset of the plaintiff's left hip symptoms and the car accident. Although the defendant says the stretches were being done to a part of the plaintiff's body that was not injured in the accident, the unreliability of the plaintiff's evidence generally, and the absence of evidence on this point from Ms. Singh, prevent me from concluding that symptom onset occurred as a result of stretching exercises specific to the plaintiff's left hip or as a result of the plaintiff doing the assigned stretching exercises improperly. The most I can conclude on the reliable evidence before the Court is that the plaintiff's left hip became symptomatic as a result of stretches or mild exercises that were being administered as part of the plaintiff's accident-related treatment. This, I conclude, meets the test of both foreseeability and causation.

Right Hip/Groin

- [209] The experts disagreed about the etiology of the plaintiff's right hip symptoms. Dr. Underwood thought the plaintiff's right hip symptoms stemmed from bursitis caused by the plaintiff offloading her symptomatic left hip. Dr. Masri noted the plaintiff's right hip symptoms arose after he examined her in April 2018 (given that the plaintiff then reported no right hip symptoms) and, at that time, he concluded she had subclinical (that is, asymptomatic) osteoarthritis in her right hip. He said his physical examination of the plaintiff (revealing restricted range of motion), x-rays (showing osteoarthritis in both hips) and MRI results (fluid in the right hip joint) all supported a diagnosis of osteoarthritis of the right hip, not bursitis. He also said that offloading on one hip would not create opposite-side symptoms in "otherwise normal" hips.

- [210] For reasons similar to those expressed earlier, I prefer the opinion of Dr. Masri over that of Dr. Underwood. He provided a full and well-grounded explanation why the plaintiff's right hip symptoms are not due to bursitis, an explanation that was not answered by Dr. Underwood. For these reasons, I conclude it is more likely than not that the plaintiff's right hip problems are caused by osteoarthritis in the joint.
- [211] Dr. Masri's opinion that offloading on one side would not create symptoms in an "otherwise normal" opposite-side hip begs the question about a situation where the other hip is not normal, as is the case here. Unfortunately, that question was never put to Dr. Masri. Given what appears to be the careful wording used by Dr. Masri, I consider it fair to conclude that offloading on one side could result in an opposite-side asymptomatic osteoarthritic hip becoming symptomatic, in the way that Dr. Underwood described.
- [212] The pre-existing and progressive nature of the plaintiff's hip problems raises another issue, which I discuss under the next heading.

Left Hip History and Deteriorating Hip Condition

- [213] It is relevant to note that the plaintiff had previous peripelvic pain and left hip alignment dysfunction prior to the accident. Importantly, x-rays indicated a progression of osteoarthritis in both hips between 2015 and 2018.
- [214] The fact that the plaintiff's left hip symptoms became symptomatic as a result of mild exercises or stretching done under the guidance of a kinesiologist suggests that it was not going to take much for her osteoarthritic hip to become symptomatic even absent the accident. A similar comment applies to the plaintiff's right hip, which became symptomatic nearly four years after the accident.
- [215] I conclude that the rehabilitative stretching (left hip) and offloading (right hip) caused the plaintiff's advancing osteoarthritis in her hips to become symptomatic, but that that they would have become symptomatic at some point in any event. Put another way, I conclude that the stretching and offloading advanced the onset of symptoms in her hips.
- [216] This is a factor that I will take into account in the assessment of damages.

Psychological Injuries

- [217] Dr. Babbage concluded the plaintiff meets the diagnostic criteria for SSD and PDD. Dr. Karapareddy concluded she does not.
- [218] The essential difference between the two psychiatrists comes down to a matter of degree. Both SSD and PDD diagnoses require persistence of symptoms and substantial impairment of function as a result of the symptoms.

- [219] Dr. Babbage said the plaintiff has persistent thoughts about the seriousness of her pain, and she has had to reduce her work, social and household activities as a result of her musculoskeletal pain. Her pain and discomfort has also become a perpetuating factor for her persistent depression, leading to loss of sleep, weight gain and low energy.
- [220] Dr. Karapareddy noted that the plaintiff's psychological symptoms were episodic in that the plaintiff was distracted from her health or other worries during her work hours, and she was able to function adequately at work (in that she worked full-time) and attend to many, though not all, household duties. He said the plaintiff did not meet the diagnostic criteria for the two disorders because her psychological symptoms were not persistent and did not cause significant disruption to her daily life.
- [221] I am not satisfied that the plaintiff has shown she has either SSD or PDD. I come to this conclusion for the following reasons:
- a) Dr. Karapareddy said it was important to assess whether the plaintiff's psychological symptoms, as distinct from her physical symptoms, affected her functionality;
 - b) in my view, Dr. Babbage failed to adequately distinguish between the physical and psychological causes of the plaintiff's limitations. Most, if not all, of the limitations he listed were related to her physical symptoms. The plaintiff was not, for example, substantially limited in her work functioning by intrusive worries about her health or by her negative mood; instead, her limitations were and are primarily physical in nature; and
 - c) Dr. Babbage himself agreed that anxiety and worry do not amount to a disorder if they are proportionate to the underlying condition. The plaintiff had, and has, a lot of health anxieties and worries, many of which stem from non-accident causes;
 - d) Dr. Babbage was not aware the plaintiff had suffered from longstanding sleep problems that predated the accident; and
 - e) similarly, the evidence in this case establishes that the plaintiff ruminated excessively about her health prior to the subject accident. To give two examples: (1) she insisted her family doctor make a referral for her to see a cancer specialist because her sister had been diagnosed with lymphoma, even though the plaintiff herself was in remission from breast cancer (which occurred 10 years prior) and there was no medical reason for such a referral; and (2) she was excessively concerned and inhibited in her activities by her AFib, telling others that AFib was the reason she could not travel, and declining for asserted AFib-related reasons to undergo objectively safe injections to help with her hip problems. In short, the plaintiff was an excessive worrier before the accident, and she remained an excessive worrier after the accident.

[222] In concluding that the plaintiff has not established she suffers from psychological disorders, I am by no means rejecting the evidence that she has suffered psychologically as a result of the accident. I am satisfied that her injuries added considerably to her anxieties, worries and difficulties with low mood.

[223] I summarize my findings on this and her other injuries under the next heading.

Summary of Findings

[224] I summarize my findings as follows:

- a) as a result of the accident the plaintiff suffered injuries to her neck and shoulder, which caused her pain and stiffness. Her neck pain was intermittent by March 2015 (as per Ms. Singh's records), by April 2018 it was "mild pain only" (as per Dr. Masri's report), and it was "occasional" by the time of trial (as per the plaintiff's testimony);
- b) she suffered injuries to her upper back and mid back between her shoulder blades. These injuries seem to be the most serious and persistent of the original complaints. The pain in these areas is exacerbated by, for example, leaning over a patient, by charting and by heavier housework activities;
- c) she suffered an injury to her right elbow. The pain from this injury was intermittent by March 2015 (as per Dr. Wasswa-Kintu's clinical notes) and had resolved completely by the time of trial (as per the plaintiff's testimony);
- d) she also suffered an injury to her lower back. Although the plaintiff did not report low back pain early on and was inconsistent in her reports of its first onset, there are sufficient references to it throughout the evidence that I am satisfied she has suffered low back pain as a result of the accident. By March 2015 her low back pain was "occasional" (as per Ms. Singh's clinical notes), and although she told Dr. Masri in 2018 that she had no low back pain, at trial she testified she still has low back pain. I conclude she probably continues to have occasional mild low back pain;
- e) the plaintiff's left hip/groin symptoms first arose in mid-March 2015, six months after the accident;
- f) the plaintiff first reported right hip pain in October 2018;
- g) the primary cause of the plaintiff's left and right hip pain is osteoarthritis in each joint;
- h) the plaintiff's left hip osteoarthritis became symptomatic as a result of doing some mild exercise or stretches as part of her accident-related rehabilitation, and her right hip osteoarthritis became symptomatic because of offloading of her left hip;
- i) given the minor nature of the events that prompted symptom onset, the plaintiff's hips would likely have become symptomatic in any event due to her osteoarthritis;

- j) the pain the plaintiff experiences in both hips is the most significant factor in terms of her current limitations;
- k) the plaintiff has also developed problems in her knees, which cause her pain or otherwise limit her when squatting or kneeling. These issues are not related to the accident; and
- l) the plaintiff has failed to establish that she developed SSD or PDD as a result of the accident, although I accept that she developed a mild driving anxiety as a result of the accident.

IX. Assessment of Damages

A. Non-Pecuniary Damages

- [225] Based on the findings I have made, I am satisfied that the plaintiff suffered soft-tissue injuries, some of which are chronic in nature. I am also satisfied that her injuries, in combination with her pre-existing conditions (AFib, sleep problems, other medical conditions and tendency to ruminate excessively over her health) have caused her to have low mood and more anxiety and, in particular, more anxiety about her health and financial security. The osteoarthritis in her hips greatly complicates the overall picture, and the assessment of damages in particular, as I have concluded the osteoarthritis in her hips would have become symptomatic at some point even if the accident had not occurred, with accident-related events having accelerated the onset of her hip symptoms.
- [226] She is a hardworking and dedicated nurse who has soldiered on well at work, but symptoms from her various injuries and conditions mean that full-time work is at her reasonable limit of physical capacity. Despite that, she continues to work overtime, albeit at a reduced level from the pre-accident period. She also struggles with a number of household tasks, particularly the heavier tasks or ones that involve reaching.
- [227] The plaintiff has undergone a great many treatments for her symptoms. From the list of special damages (and in the case of kinesiology sessions, from Ms. Singh's testimony), it appears the plaintiff has had 64 physiotherapy treatments, 46 massage treatments and seven kinesiology sessions. She also had a number of counselling sessions, which were available to her through her employment benefits.
- [228] In assessing an appropriate sum for non-pecuniary damages, I have taken into account the factors set out in *Stapley v. Hejslet*, 2006 BCCA 34, and I have reviewed the authorities cited by the parties. The plaintiff's authorities were not entirely relevant as they were based on two assumptions I have not accepted, those being that the plaintiff's hip complaints were entirely caused by the accident and the accident caused her to have the psychological disorders of SSD and PDD.
- [229] I assess non-pecuniary damages at \$75,000.

B. Past Income Loss

[230] As noted earlier, there are two components to the plaintiff's claim for what is often described as past income loss (the preferable term is "past loss of earning capacity": *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141): (1) loss of overtime income; and (2) use of sick leave for accident-related matters. The latter is a subrogated claim as the plaintiff is obliged under her collective agreement to repay any amounts reimbursed to her for sick leave taken.

Lost Overtime

[231] The plaintiff estimates her overtime loss by taking the difference between her four-year pre-accident average of overtime hours (156 hours per year) and her actual post-accident overtime hours. Applying the appropriate hourly rate for each year brings about a total loss, before taxes, of \$30,326.

[232] The defendant's primary position on past income loss is that no amount should be awarded because the plaintiff's overtime limitations are related to her AFib and to her degenerating hips and knees. The defendant did not provide an alternative position, but in her submissions on loss of future income-earning capacity, she suggested future loss ought to be assessed by taking the difference between the plaintiff's average pre-accident overtime hours (132 to 154 hours per year) and her post-accident average overtime hours (77 to 132 hours per year).

[233] Unfortunately, the two approaches, while similar, are difficult to compare directly because: (1) the parties used different time periods to calculate pre-accident average overtime; and (2) the parties used different figures for post-accident overtime worked (the plaintiff used actual hours worked, while the defendant used average hours worked).

[234] Before moving to the actual assessment of pre-trial income loss, I will address some further findings. First, I am satisfied the plaintiff was rendered less capable of working overtime as a result of the accident and so she accepted less overtime work. Second, although the plaintiff was motivated to earn money to save for retirement, I am satisfied that her AFib, diagnosed in late 2013, was also a likely factor that limited the amount of overtime she was prepared to work. For that reason, I do not consider it appropriate to use the high overtime hours she worked in 2011 and 2012 in calculating the pre-accident average of overtime hours. Finally, at some point her hip problems would have impaired her even if the accident had not happened. Just when that would have occurred is a difficult matter and is, by its nature, somewhat speculative, but it is also a matter of judgment that is needed in order to assess damages.

- [235] Doing the best I can on the available evidence, I conclude that, absent the accident, the plaintiff's left hip symptoms would have emerged in late 2018, four years after the accident, with right hip symptoms following after that. In other words, I conclude that accident-related events advanced the onset of hip symptoms by about four years. My conclusion is based on an assessment of all of the evidence, including the fact that by 2018 fluid had been detected in both of the plaintiff's hips.
- [236] I return to the arithmetic analysis. As already noted, I do not consider it appropriate to include 2011 and 2012 overtime hours in the calculation of pre-accident average overtime hours. The plaintiff worked an average of 192.5 hours of overtime in those two years, but she worked only 101 hours in the 11 months pre-AFib in 2013 (which is 110 hours, annualized). This is a significant reduction in hours from those of the prior two years. Post AFib, but pre-accident, she worked 80.5 hours in 7.5 months, or 129 hours on an annualized basis. I conclude the average of those latter two figures (which is 120 hours, rounded) more accurately reflects the likely overtime the plaintiff would have worked but for the accident.
- [237] Inserting the figure of 120 average annual overtime hours into the plaintiff's calculations (shown at page 35 of the plaintiff's written submissions), results in an income loss figure of \$7,821 to the end of 2018, which is the time I conclude the plaintiff's hip osteoarthritis would have become symptomatic in any event.
- [238] The pre-trial period in 2019 (about 11 months) is not as straightforward. As I have found, by this point the plaintiff's hip symptoms would have been manifest even absent the accident. It is not clear whether her hip problems alone would have prompted her to reduce her overtime hours had the accident not happened because her current inability to work all of the overtime available to her is the result of a combination of factors and symptoms. It is clear, however, that her hip problems are her primary limiting factor.
- [239] Adopting the earlier arithmetic approach, but adjusting for the fact that the pre-trial period in 2019 ended in late November, results in a "no accident and no hip problems" overtime average of 106 hours (adjusted from the full year average of 120 hours). Actual overtime hours worked adjusts to 48 hours for the relevant time period (44 hours were actually worked in 9.5 months, which adjusts to 48 hours to extrapolate it to 10.5 months), which is a difference of 58 lost overtime hours. At her 2019 pay rate, this equates to \$5,305 in overtime pay. Given the prominence of her hip problems in the plaintiff's presentation, I would reduce that figure by 60 percent to reflect the contingency that her hip problems would have prompted her to reduce her overtime work even if the accident had not happened. The resulting figure is \$2,122 ($\$5,305 \times .4$).
- [240] The total of the two "foregone overtime" figures is \$9,943 ($\$7,821 + \$2,122$). I leave it to the parties to determine the net loss, with leave to address the matter in the event of disagreement.

Sick Leave Taken

- [241] According to the employer's records, the plaintiff took sick leave totalling \$17,330 between September 12, 2014 and September 5, 2019. The plaintiff acknowledges some specific dates that involved sick leave taken for unrelated reasons (totalling \$2,843), and submits that 75 percent of the remaining sick leave was taken for accident-related reasons. The resulting figure is \$10,865.
- [242] The defendant says the evidence does not reveal why the plaintiff took sick leave at any particular time, and so we do not know whether sick time was taken for accident-related problems or for the plaintiff's other health problems. The defendant says 20 percent of all sick days would be appropriately attributed to the accident.
- [243] The plaintiff testified that most of the sick time taken was for accident-related reasons, including appointments. While I have concluded I must be cautious before accepting the plaintiff's evidence, I also take into account the extensive treatments listed in the schedule of special damages (Exhibit 3) as corroborating the plaintiff's evidence to some extent. This persuades me that the plaintiff's figure of 75 percent is appropriate. Taking into account that some of the sick time would likely relate exclusively to hip-related matters that by the end of 2018 would have manifested themselves in any event, I assess this aspect of loss at \$10,000.

Failure to Mitigate

- [244] Before proceeding further, I will address the defendant's submission that the plaintiff, in declining to undergo therapeutic injections in her hips, failed to mitigate her loss. I conclude the defendant has not met the burden of proof on this issue. The evidence showed that the prospect of any symptom relief was uncertain and highly variable. Although I agree that the plaintiff's refusal to try these injections was not objectively reasonable, the prospect of any substantial relief was not sufficiently established.

C. Loss of Future Income-Earning Capacity

- [245] The plaintiff submits she should no longer be working overtime and that she has only been doing so because of her financial concerns. She notes that elimination of overtime is supported by Ms. Craig, Mr. Kerr and Dr. Underwood. Further, she argues that she should only be working part-time, as recommended by Ms. Craig and Dr. Underwood and she should not have to work full-time at the expense of her health. Eliminating overtime and reducing her hours by 25 percent would result in annual losses of about \$17,600 in overtime income and \$24,250 in regular income, which with the application of the relevant actuarial multiplier (4.455) would result in a total loss of about \$186,500 to the end of her working life.

- [246] The defendant emphasizes the following: (1) the plaintiff is already at retirement age; (2) her pre-accident retirement plans are unknown because the plaintiff provided no evidence on that issue; and (3) the plaintiff not only continues to work full-time, she continues to work overtime shifts. The defendant also submits the plaintiff's limitations are primarily related to physical issues unrelated to the accident. The defendant's alternative argument is that loss of future earning capacity ought to be on an annual loss of either 22 or 55 overtime hours each year (depending on the Court's finding concerning left hip causation) for three years, by which time the plaintiff would be 68 years old. This results in future loss amounts of either \$3,725 or \$9,312, net of taxes.
- [247] Neither of the parties' submissions addresses the facts and findings as I have determined them to be. I have concluded that, had the accident not happened, the plaintiff's hips would have become symptomatic and would have limited the plaintiff's work capacity in any event. The plaintiff was 65 years old by the time of trial and was not the healthiest of individuals even leaving aside accident-related injuries and symptoms. Had the accident not happened, I expect her overtime hours would have declined over time and, specifically, she would not have worked an average of 120 overtime hours per year, which is the figure I used to derive her past income loss. Finally, on an assessment of all of the evidence, I conclude that, absent the accident, the plaintiff would have worked to age 68 at the latest.
- [248] These and my earlier findings make it unnecessary for me to address the plaintiff's submission that her loss of future income-earning capacity should be derived from an actuarial calculation based on loss of overtime work and the difference between full-time and part-time income. Given the variables and contingencies, the income approach (that is, based on an actuarial calculation) is not appropriate here.
- [249] I am, however, satisfied the plaintiff has shown a real and substantial possibility that her earning capacity has been impaired: *Perren v. Lalari*, 2010 BCCA 140 at paras. 30-32. Furthermore, I am satisfied that the plaintiff meets the factors set out in *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d) 353 at para. 8. Specifically, I am satisfied that her accident-related injuries will likely cause her to work less overtime. Given my findings, I am not satisfied those injuries require the plaintiff to reduce her hours to part-time work, as it is primarily her hip problems that prompt that recommendation from some of the professionals.
- [250] Based essentially on the approach already used for the assessment of the plaintiff's 2019 loss of income (but extrapolated to three years), and taking into account the likelihood she would continue to use some sick days for accident-related reasons, I assess damages for loss of future income-earning capacity at \$10,000.

D. Loss of Housekeeping Capacity

- [251] The law relating to loss of housekeeping capacity was discussed by the Court of Appeal in both *O'Connell v. Yung*, 2012 BCCA 57 [O'Connell] and *Kim v. Lin*, 2018 BCCA 77 [Kim].

[252] In O'Connell, the court said:

[67] As I understand the principle, it is the loss of a capacity - an asset - that is compensated. Accordingly, because the award reflects the loss of a personal capacity, it is not dependent upon whether replacement housekeeping costs are actually incurred. Damages for the cost of future care serve a different purpose from awards for loss of housekeeping capacity. Unlike loss of housekeeping capacity awards, damages for the cost of future care are directly related to the expenses that may reasonably be expected to be required .

[253] In Kim, the court said:

[33] Therefore, where a plaintiff suffers an injury which would make a reasonable person in the plaintiff's circumstances unable to perform usual and necessary household work -- i.e., where the plaintiff has suffered a true loss of capacity -- that loss may be compensated by a pecuniary damages award. Where the plaintiff suffers a loss that is more in keeping with a loss of amenities, or increased pain and suffering, that loss may instead be compensated by a non-pecuniary damages award. However, I do not wish to create an inflexible rule for courts addressing these awards, and as this Court said in Liu [Liu v. Bains, 2016 BCCA 374], "it lies in the trial judge's discretion whether to address such a claim as part of the non-pecuniary loss or as a segregated pecuniary head of damage": at para. 26.

[254] The plaintiff claims the sum of \$13,000 under this heading, which is in addition to the amount she claims for the actual cost of future homemaking services, which I discuss below. She does so on the authority of Schenker v. Scott, 2014 BCCA 203, at paras. 93-94, which upheld awards under both headings.

[255] The defendant's submissions focused on the cost of future care aspect of the homemaking services claim, not the loss of capacity aspect, arguing that the plaintiff would have needed help with housekeeping anyway due to the problems she has with her hips and knees.

[256] I am satisfied the plaintiff has a diminished capacity to perform household tasks, even leaving aside her problems with her hips and knees, although limitations caused by her hips and knees are part of that diminished capacity. I consider it appropriate to make a separate award for this loss because her loss is more than just a loss of amenities but is a loss of the plaintiff's ability to fully contribute to the pleasure of a clean household.

[257] I award the sum of \$7,500 for the plaintiff's diminished housekeeping capacity caused by the accident.

E. Cost of Future Care

[258] Many of the items claimed under this heading relate to the plaintiff's problems with her hips and knees and to her claims of psychological disorders. In light of my earlier findings, those items are disallowed.

- [259] There is overlap in the claims for physiotherapy, massage therapy, kinesiology sessions and personal training sessions. Dr. Underwood said physiotherapy should be discontinued. Ms. Craig disagreed, saying the plaintiff needed physiotherapy for strengthening and conditioning, and also for symptom relief. The plaintiff said she found personal training and massage therapy to be helpful, although it is clear from the evidence she derived no benefit from, and demonstrated no commitment to, the kinesiology sessions she had in 2015.
- [260] I conclude that it would be appropriate for the plaintiff to have massage therapy on occasion for relief of accident-related symptoms (though not for symptoms associated with her hips). I conclude as well that she should have supervised exercise for a time (I use the term "supervised exercise" to encompass both the recommended kinesiology and the plaintiff's preference of personal training), with an allowance for periodic review, as generally outlined by Ms. Craig. She did not recommend that supervised exercise continue to age 80, which is the time frame claimed in the plaintiff's submissions.
- [261] I assess the damages for these future care costs at \$10,000.
- [262] Most of the plaintiff's medication needs relate to her hip-related issues. I would allow \$1,000 for over-the-counter pain medication needed to address any ongoing accident-related symptoms. I decline to make any award for those items related to her sleep problems as she had substantial sleep problems prior to the accident and her hips are the predominant current source of pain and discomfort.
- [263] I do not see a need for driver training for the plaintiff. Her driving anxiety is really quite mild as it manifests itself merely through a preference in taking alternative routes.
- [264] I consider it appropriate to make an award for housekeeping assistance. While the defendant submits the plaintiff's housekeeping limitations also arise out of non-accident causes (hips and knees), the evidence indicated that a substantial part of her limitations stem from her difficulties in reaching, as when cleaning windows, mopping, vacuuming or dusting. I acknowledge that two tasks she mentioned, vacuuming under the bed and cleaning the bathtub, can also be hard on the knees, but they involve reaching as well. I do not include in the award any amount for handyman services, as there was no evidence the plaintiff did that sort of work prior to the accident.
- [265] Taking into account the present value of housekeeping assistance, along with the fact that some of these tasks would have been problematic for the plaintiff even if the accident had not occurred, I conclude an appropriate award here is \$15,000.
- [266] The total award for cost of future care is \$26,000.
- F. Special Damages
- [267] The parties have agreed on special damages at \$13,197.54.

X. Conclusion

[268] I conclude that the defendant is wholly liable for the accident. I award damages to the plaintiff as follows:

Non-pecuniary damages:

\$75,000.00

Past income loss (gross):

9,943.00

Reimbursement of sick leave:

10,000.00

Loss of future earning capacity:

10,000.00

Loss of housekeeping capacity:

7,500.00

Cost of future care:

26,000.00

Special damages:

13,197.54

Total:

\$151,640.54

[269] The parties have leave to address any adjustments that may be needed to finalize the award.

[270] Costs may be spoken to, if necessary.

"Blok J."

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