# IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Chappell v. Loyie,*
2016 BCSC 1722

Date: 20160920
Docket: M134793
Registry: Vancouver

Between:

**Steven W. Chappell**

Plaintiff

And

**Daniel Martin Loyie and Patti Lynn Crocker**

Defendants

And

**Insurance Corporation of British Columbia**

Third Party

Before: The Honourable Madam Justice Fisher

## Reasons for Judgment

| | |
|---|---|
| Counsel for the plaintiff: | C. D. Martin<br>J. Fung |
| Daniel Martin Loyie, defendant: | Not Present |
| Counsel for the defendant Patti Lynn Crocker and the Third Party Insurance Corporation of British Columbia: | R. W. Haines<br>D. Madani |
| Place and Date of Trial: | Vancouver, B.C.<br>July 18-22, 25-29, 2016<br>August 2, 4 and 5, 2016 |
| Place and Date of Judgment: | Vancouver, B.C.<br>September 20, 2016 |

# Table of Contents

[1] On August 2, 2011, the plaintiff, Steven Chappell, was injured when his motorcycle struck a car driven by the defendant Daniel Martin Loyie and owned by the defendant Patti Lynn Crocker. Mr. Chappell was proceeding on a green light in a southerly direction when the defendants' vehicle, proceeding in the opposite direction, crossed his path while attempting to make a left hand turn. Mr. Chappell was thrown from his motorcycle and landed some distance away on the road. Fortunately, he did not suffer a serious head injury or any broken bones, but the multiple injuries he did suffer have been significant and quite complex, partly due to the fact that Mr. Chappell had some pre-existing conditions that became seriously symptomatic at various times after the accident.

[2] Liability was not contested by the defendant Patti Crocker and the third party, the Insurance Corporation of British Columbia. The defendant Daniel Loyie did not appear at trial although duly served.

[3] The central issues involve causation of damage and the extent to which Mr. Chappell's pre-existing conditions affect the assessment of damages. Before setting out the evidence, I will discuss the general legal principles for causation and assessment of damages.

## The law

### Causation in law

[4] Causation is established where the plaintiff proves on a balance of probabilities that the defendant caused or contributed to his injury. This general "but for" test is set out in *Athey v. Leonati,* [1996] 3 SCR 458 and confirmed in *Resurfice Corp. v. Hanke*, 2007 SCC 7. This test does not require scientific precision; causation is a question of fact that may best be answered by applying ordinary common sense: *Snell v. Farrell*, [1990] 2 SCR 311 at 328. Moreover, the plaintiff does not have to establish that the defendant's negligence was the sole cause of the injury. At para. 17 of *Athey*, the court stated:

> … There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring. ... As long as a defendant is

> *part* of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants remain liable for all injuries caused or contributed to by their negligence.

[5] Therefore, even where there are other potential non-tortious causes of an injury, such as degenerative changes, the defendant will still be found liable if the plaintiff can prove that the accident caused or contributed to the injury. The contribution must be material, in the sense that there is a substantial connection between the accident and the injury, beyond a *de minimus* range: *Farrant v. Laktin*, 2011 BCCA 336 at paras. 9-11.

[6] In *Blackwater v. Plint*, 2005 SCC 58, McLachlin C.J.C. discussed the difference between causation as the source of the loss and the rules of damage assessment in tort, at para. 78:

> … The rules of causation consider generally whether "but for" the defendant's acts, the plaintiff's damages would have been incurred on a balance of probabilities. Even though there may be several tortious and non-tortious causes of injury, so long as the defendant's act is a cause of the plaintiff's damage, the defendant is fully liable for that damage. The rules of damages then consider what the original position of the plaintiff would have been. The governing principle is that the defendant need not put the plaintiff in a better position than his original position and should not compensate the plaintiff for any damages he would have suffered anyway: *Athey*.

[7] In short, the essential purpose of tort law is to restore the plaintiff to the position he would have enjoyed but for the negligence of the defendants.

[8] It is not permissible to apportion liability between tortious and non-tortious causes, as the plaintiff would not be adequately compensated. However, where there are multiple causes of a plaintiff's injuries, the key factual question is whether the injuries are divisible or indivisible. Divisible injuries are those that can be separated so that their damages can be assessed independently. Indivisible injuries are those that cannot be separated: *Bradley v. Groves*, 2010 BCCA 361 at para. 20.

[9] If the injury is divisible, a plaintiff can recover from the defendant only the damages attributable to the injury caused or contributed to by that defendant. If the injury is indivisible, a plaintiff can recover from the defendant 100% of the damages

attributable to the injury caused or contributed to by that defendant regardless of the contribution to the injury by others: *Athey,* at para. 24; *Bradley; B.P.B. v. M.M.B*., 2009 BCCA 365 at para. 33; see also *E.D.G. v. Hammer*, 2003 SCC 52 at paras. 29-33.

**Causation of damage and pre-existing conditions**

[10] As the court said in *Blackwater*, a plaintiff is only to be restored to his original position, and not a better position. A defendant is not required to compensate a plaintiff for any debilitating effects arising from a pre-existing condition that the plaintiff would have experienced anyway, and if there is a measureable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence, this is to be taken into account in reducing the overall award: *Athey,* at para. 35; *Moore v. Kyba*, 2012 BCCA 361 at para. 43. In addition, damages caused by other non-tortious causes that occur after the defendant's wrongful act must be taken into account: *Blackwater,* at para. 80. This is referred to as the "crumbling skull" doctrine. It is important to note that any reduction made to take these factors into account does not reduce the damages; it simply awards the damages which the law allows: see *Blackwater,* at para. 84.

[11] In addition, a tortfeasor is liable for a plaintiff's injuries even if the injuries are unexpectedly severe owing to a pre-existing condition. As the court said in *Athey,* at para. 34, the tortfeasor must take the victim as he finds him, and is liable even though the plaintiff's losses are more dramatic than they would be for the average person. This is known as the "thin skull rule".

[12] There has been some confusion in the law with respect to these labels. In *A. (T.W.N.A.) v. Canada (Ministry of Indian Affairs)*, 2003 BCCA 670, the court clarified this at para. 30 by stating that the "simple idea" expressed in *Athey,* was clear and direct and "both latent and active pre-existing conditions must be considered in assessing the plaintiff's original position." At para. 48:

> …Whether manifest or not, a weakness inherent in a plaintiff that might realistically cause or contribute to the loss claimed regardless of the tort is relevant to the assessment of damages. It is a contingency that should be

> accounted for in the award. Moreover, such a contingency does not have to be proven to a certainty. Rather, it should be given weight according to its relative likelihood.

[13] Hypothetical and future events – how the plaintiff's life would have gone without the tortious injury – need not be proven on a balance of probabilities. They are given weight according to their relative likelihood, or the probability of their occurrence. A future or hypothetical possibility is to be taken into account "as long as it is a real and substantial possibility and not mere speculation": *Athey,* at para. 27.

## The evidence

### Background facts

[14] Steven Chappell, now aged 52, has worked as a firefighter for the Corporation of Delta since April 1989. He is a large, burly man formerly known for his strength, who loved his work and loved being physically active. In addition to his fire-fighting career, he enjoyed doing landscaping and home renovations for himself and others. For many years, he did this kind of work in his spare time and earned extra income to supplement his lifestyle. He also loved hunting, and spent considerable time planning his annual fall trips. In earlier years he was also very active in sports, particularly rugby and soccer.

[15] Mr. Chappell and his wife Cheryl Ann Chappell have been together for over eight years and married in 2010. Each brought their own children from previous marriages into the relationship: Mr. Chappell has two sons and Ms. Chappell has three sons, two who are considerably younger than the others. They managed to blend their families quite successfully and they share many interests, particularly home renovations. They are very committed to each other.

[16] For almost his entire career, Mr. Chappell's work as a firefighter was in the fire suppression division. In February 2010, he was promoted to Lieutenant and soon after, in June 2010, to Captain of Suppression. He was in this position at the time of the accident on August 2, 2011. He aspired to be the Battalion Chief of Suppression, the highest union position in that division. He enjoyed the camaraderie

amongst his co-workers and he enjoyed a four day on/four day off schedule, which allowed him time with his family and time to do landscaping and renovation projects.

[17] Mr. Chappell had some intermittent neck and back problems in the years prior to the accident, which were generally treated with chiropractic treatment and did not interfere with his activities. He also had several surgeries. In May 2003, he had surgery on his right elbow to correct a torn ligament, or tennis elbow; in May 2005, he had surgery on his right shoulder to correct a torn rotator cuff; in March 2009, he had a partial left knee replacement and anterior cruciate ligament (ACL) reconstruction; and in February 2011, he had nasal surgery. After each surgery, Mr. Chappell was off work for varying periods of time, the longest period (seven months) after the knee surgery in 2009. However, after rehabilitation, he was able to resume his duties at work and function as he had previously, albeit with periodic flare-ups for short periods of time that he would treat with anti-inflammatory medication. Whatever pain he experienced, he was able to deal with and it generally went unnoticed by his wife, friends and co-workers.

**The accident**

[18] The accident occurred shortly after 5:00 pm on August 2, 2011, at the intersection of Nordel Way and River Way in Delta, B.C., as Mr. Chappell was returning from a day shift at the fire hall. Police and ambulance arrived at the scene and Mr. Chappell was transported to Delta Hospital. Photographs taken of the vehicles indicate fairly extensive damage to the rear passenger door and rear wheel area of the defendants' Ford Escort and extensive damage to the front end of Mr. Chappell's motorcycle. The motorcycle was deemed to be a total loss.

[19] There was one witness to the accident. John Lowe was driving south on Nordel Way behind Mr. Chappell. He testified that the traffic light was green and Mr. Chappell was in the intersection travelling at 50 to 55 kph when the defendants' vehicle tried to turn left. He said that the motorcycle hit the right side of the Ford Escort near the rear door and Mr. Chappell "flew in the air" over the Ford at least 10 to 15 feet, 5 to 10 feet in the air. Mr. Lowe pulled over and ran towards the body

lying on the other side of the intersection. He described the body as motionless and he thought the person was dead because of the way he flew over the vehicle.

[20] Mr. Chappell's memory of the accident and the events immediately following it was patchy. He testified that he remembered seeing something to his left and then lying on his back on the ground. He did not recall the impact. He remembered thinking that he should get off the road and hearing someone calling behind him not to move. He remembered seeing two off duty firefighters at the scene and asking one of them to call his wife. He did not remember being placed on a spine board or in a neck brace, the ride to the hospital in the ambulance, or any details about what happened at the hospital. He was released later that night, at about 11:00 pm, in the care of his wife.

**The injuries and sequelae**

[21] Mr. Chappell said that his worst injuries immediately following the accident were to his feet, ankles, knees, hips and lower back. He could barely walk due to the pain in his feet. His head was "splitting", his shoulders were extremely tense and he had clicking in his right shoulder when he lay down. He said that he was in so much pain in the first few days he was afraid to move. He took the pain medication he was given at the hospital, spent most of the first five weeks on his back, and tried to get some relief in his swimming pool. He saw his family doctor two days after the accident and quite regularly thereafter. He began regular sessions of physiotherapy in early September, which continued until late January 2012.

[22] I address the injuries in more detail below. At this stage, I will briefly outline Mr. Chappell's evidence about the effects of his various injuries, his course of rehabilitation, and his attempts to return to work.

[23] Mr. Chappell said that the physiotherapy initially dealt with his feet and lower back. Within the first few weeks, his feet had improved significantly, and as he became more active, he noticed more symptoms in his knees, hips and arms. In consultation with his family doctor, he went back to work in January 2012. However,

he said that he was not functioning well. He thought he was functioning physically at about 40%, and mentally he was a “wreck”.

[24] The return to work was not successful. Mr. Chappell was still taking substantial amounts of narcotic pain medication, which made it difficult to focus on his tasks. When he got home at the end of a shift he was a “vegetable”, unable to do anything of note. By March, he went back on sick leave. At that time, his hands and his left knee were causing most of his problems.

[25] Mr. Chappell realized he was not physically capable of continuing as Captain of Suppression, so he took some training courses and in June 2012 was the successful candidate for the position of Captain of Training. Despite the fact that this was a more sedentary job, Mr. Chappell said that he was fighting himself physically to stay at work and mentally he found it overwhelming. In November 2012, he had surgery on his left hand to correct carpal tunnel syndrome. In January 2013, he had the same surgery on his right hand. Both of these surgeries were successful. However, his back, shoulders and knees were still a problem.

[26] Mr. Chappell said that the more he did, the more he hurt. By the end of 2012, he was quite dysfunctional. He avoided his wife and his children and he was unable to do anything useful at home, whether looking after the house, the garden or doing any projects in his shop. By early 2013, his “two big issues” were his right shoulder and left knee, and he also continued to have headaches, neck pain, and tense shoulders. He was becoming very depressed and his relationship with his wife was suffering.

[27] Mr. Chappell was frustrated with his progress and unhappy with his family doctor. He described himself as angry and impatient, not wanting to talk to anyone. He said, “I used to be able to do anything; now I want to kill myself. I feel worthless.” In May 2013, he had an unsuccessful surgery on his right shoulder. After that, he found a new family doctor, who took a fresh look and made a number of referrals to specialists to address Mr. Chappell’s various problems.

[28] In July 2013, Mr. Chappell was promoted to Battalion Chief of Training, also a sedentary job. While at first he thought he was doing well at work, he felt his condition was progressively getting worse. He was unable to concentrate and he continued to have headaches and pain in his back, knees and shoulders. His increasing anger was causing problems at home. In April 2014, he had an arthroscopy on his left knee, which confirmed the need for further surgery to reconstruct his ACL again. By the end of June 2014, Mr. Chappell was at his "wit's end" at work. He had been told that his performance had not been satisfactory, and on the advice of his family doctor, he went on extended sick leave. He has not returned to work since.

[29] Mr. Chappell then moved to the family's vacation home at Sheridan Lake, B.C. while his wife and stepson stayed in Delta, returning to the Lower Mainland for several surgeries. In September 2014, he had the ACL surgery on his left knee; in March 2015 he had his left shoulder repaired and in August 2015 his right shoulder. He is now waiting for a right knee replacement. Mr. Chappell said that his left knee and his shoulders are much improved now and he feels a little stronger physically, but he continues to have headaches and pain in his back and right knee, and he is angry and depressed. He has a hard time getting through the day and he feels mentally alone. He does not know what the future holds for him.

**Medical evidence**

[30] There is no question that Mr. Chappell suffers from a number of conditions. He has been assessed by specialists in physical medicine and rehabilitation, orthopaedic surgery, neurology, psychiatry and neuropsychology. Of the ten expert witnesses who gave evidence, three testified on behalf of the defendant.

[31] There is some agreement among the expert witnesses that some of the injuries Mr. Chappell suffered – to his neck, low back, feet and to some extent his psychological condition – were caused by the accident. There is disagreement regarding the cause of the injuries to his hands, shoulders and knees and whether he suffered a mild traumatic brain injury.

### *Dr. Spiro Polyhronopoulos*

[32] Dr. Spiro Polyhronopoulos has been Mr. Chappell's primary care family physician since May 30, 2013. At that time, he took a detailed history from Mr. Chappell that included his conditions before and after the accident, and he has since continued to treat Mr. Chappell's various problems. Dr. Polyhronopoulos provided both pre and post-accident diagnoses as follows:

a) Pre-Accident Diagnoses
    1. Pre-existing intermittent low back pain
    2. Pre-existing osteoarthritis of both knees
    3. Prior right shoulder surgery around 2008 [sic]
    4. Prior left knee surgery around 2009

b) Post-Accident Diagnoses
    1. Headaches
    2. Probable strains and transient bruising to both feet and both ankles
    3. Neck (cervical spine) strain
    4. Upper back (thoracic spine) strain
    5. Low back (lumbar spine) strain and transient bruising
    6. Internal derangement of right shoulder
    7. internal derangement of left shoulder
    8. Bilateral knee internal derangements
    9. Mood disorder characterized by anxiety and depression
    10. Deconditioning syndrome
    11. Obstructive sleep apnea
    12. Sexual dysfunction … probably secondary to depression or as a result of a side effect to antidepressant medications

[33] It was Dr. Polyhronopoulos' opinion that the accident was "probably responsible, directly or indirectly" for the post-accident diagnoses listed above. This opinion was based on the close temporal relationship between the accident and the onset of Mr. Chappell's symptoms "very shortly thereafter" and the medical plausibility that such symptoms would arise out of the type of forces in the accident that caused Mr. Chappell to be ejected from his motorcycle.

[34] Dr. Polyhronopoulos thought that Mr. Chappell would continue to need narcotic analgesics and anti-depressant medications and recommended that he remain under the care of a neurologist for his headaches, an orthopaedic surgeon for his knee condition, and a clinical psychologist and possibly a psychiatrist for his anxiety and depression. He recommended rehabilitation with the services of an occupational therapist, a kinesiologist, a rehabilitation consultant and vocational expert, as well as an evaluation by a multi-disciplinary pain clinic. His prognosis was poor with respect to the shoulders, knees, neck, back, depression and anxiety, and he thought that Mr. Chappell would remain permanently limited in his activities.

***Dr. Mark Adrian***

[35] Dr. Mark Adrian, a specialist in physical medicine and rehabilitation, assessed Mr. Chappell in October 2012. He concluded that the accident caused or contributed to the following injuries: mechanical neck and lower back pain with cervicogenic headaches (related to the neck); right shoulder rotator cuff tear; left knee pain; carpel tunnel syndrome in the left hand; and soft tissue injuries in both feet. It was his opinion that due to Mr. Chappell's pre-accident problems with his neck and lower back, right shoulder, left knee and left hand, these areas were probably vulnerable to injury but he thought it unlikely that persistent and limiting problems would have spontaneously developed had it not been for the accident. He did not think that the accident caused the problems in the left shoulder or the right hand due to the lack of a temporal relationship to the accident and the onset of symptoms.

[36] Dr. Adrian was not sure of the nature of the problems in the left knee but his examination revealed swelling and tenderness over the inner joint line and he was aware that Mr. Chappell did not begin to notice pain symptoms immediately after the accident but rather as his level of activity increased. His view that the injury to the right shoulder was a tear to the rotator cuff was based on Mr. Chappell's history and his examination findings. The history included Mr. Chappell having no consistent recurring symptoms in that shoulder in the time leading up to the accident, experiencing pain shortly after it while at Delta Hospital, and reporting pain and clicking symptoms to his family doctor within a month. He explained that one would

have symptoms within hours to days after an accident but that the pain would be variable; some people can function with rotator cuff tears with little pain while others may have severe pain.

[37] Dr. Adrian thought the prognosis for a spontaneous, full recovery of these injuries was poor and he encouraged Mr. Chappell to continue with light cycling exercises and try aquatic based exercise.

[38] Dr. Adrian re-assessed Mr. Chappell in January 2016. By that time, Mr. Chappell had undergone carpal tunnel release surgery in both hands, arthroscopic surgery to both shoulders, an ACL reconstruction in his left knee, and he was awaiting surgery to his right knee. He was experiencing persistent, regularly occurring and physically limiting pain in his neck with related headaches, pain in his lower back, right shoulder and left knee, as well as ongoing symptoms in the left shoulder and right knee. The right shoulder and left knee had partially improved after the surgeries and the carpel tunnel problem in both hands had resolved. Mr. Chappell was also experiencing ongoing psychological and cognitive symptoms; the daily pain was affecting his mood, concentration and memory.

[39] Dr. Adrian's prognosis for further recovery of the injuries to the neck and lower back was poor but he did not think these injuries would progressively deteriorate over time. His opinion on Mr. Chappell's functional capacity was the same. He encouraged Mr. Chappell to continue with physical therapy for his shoulder function, to continue with a home exercise program, and to attend a multidisciplinary pain clinic (for which he was wait-listed) to help with pain management and coping strategies.

***Dr. Zeeshan Waseem***

[40] Dr. Zeeshan Waseem, also an expert in physical medicine and rehabilitation, gave evidence on behalf of the defendant. He provided a responding opinion to that of Dr. Adrian based only on a review of the medical records.

[41] Dr. Waseem did not agree with Dr. Adrian that Mr. Chappell's right shoulder rotator cuff tear, his left knee ACL injury, or his left hand carpal tunnel syndrome were caused by the accident. It was his view that Mr. Chappell would have experienced immediate, severe pain if he had torn the rotator cuff in his right shoulder, and due to his history of a prior repair, he was at an increased risk of developing right shoulder problems independent of the accident due to degenerative changes. It was also his view that Mr. Chappell's issues with his left knee were due only to pre-existing osteoarthritic changes and the carpal tunnel syndrome in the left hand occurred absent any specific injuries documented to the left hand or wrist.

[42] Dr. Waseem stated that Mr. Chappell suffered only soft tissue injuries to his neck, lower back, feet and ankles, right shoulder, left knee, and abrasions to the right knee. He opined that only the neck and back pain were causally related to the accident but that Mr. Chappell's weight and "body habitus" were also contributing to his "spinal discomfort". He did not view Mr. Chappell's prognosis for the neck and back as poor and stated that his pain could be reduced with weight loss, exercise for posture, core and deep neck flexors, and cardiovascular training. He agreed that Mr. Chappell should continue with a home exercise program and should pursue treatment at a multidisciplinary pain clinic.

***Dr. John Arthur***

[43] Dr. John Arthur is an orthopaedic surgeon (now retired) who treated Mr. Chappell's left knee problems both before and after the accident. In 2009, he performed a partial knee replacement and ACL reconstruction, after which Mr. Chappell recovered and was able to resume almost all of his previous level of activity, although with some intermittent pain. Dr. Arthur saw Mr. Chappell again in October 2012, when he complained of pain and swelling, and examination revealed possible instability in the ACL. Further investigations followed and Mr. Chappell's symptoms worsened. In April 2014, Dr. Arthur determined, in an arthroscopic procedure, that the ACL was absent. In September 2014, Dr. Arthur performed another ACL reconstruction, which fortunately healed quite well. By November 2014 Dr. Arthur considered that knee to be stable.

[44] It was Dr. Arthur's opinion that Mr. Chappell sustained an injury in the accident to the left knee that involved the previously reconstructed ACL. He explained that a tear to a reconstructed ACL may not produce immediate pain, rather the patient may notice something not being right, but there should be some swelling within a few days. He believed that the accident probably caused the ACL to tear, after which a process evolved causing the ACL to dissolve.

[45] Dr. Arthur acknowledged that Mr. Chappell had some degenerative change in parts of the knee joint that were likely not related to the accident. He said that this degeneration, which was present before the accident, made the left knee more vulnerable to injury, but it was more extensive in 2014 and it was likely to progress in the ACL. He opined that Mr. Chappell will likely develop further arthritic symptoms in the left knee that may involve a total replacement within 15 to 20 years depending on his level of activity and attention to his weight.

***Dr. Shannon Samler***

[46] Dr. Shannon Samler is an orthopaedic surgeon who performed surgery on both of Mr. Chappell's shoulders in 2015. It was her opinion that Mr. Chappell re-injured his right shoulder and injured his left shoulder in the accident. This was based in part on an understanding that Mr. Chappell had pain in both shoulders immediately following the accident, subsequent limited mobility, and symptoms of catching, clicking and sharp stabbing pain. She considered his previous right shoulder rotator cuff repair surgery to be a remote issue, as she understood that Mr. Chappell had no ongoing problems before the accident, and she did not think that this made him more susceptible to a re-injury. She also considered that the mechanism of the accident, "a high energy injury that caused him to land on his shoulders", was consistent with the shoulder injuries she repaired.

[47] Dr. Samler opined that Mr. Chappell will likely have ongoing difficulties with his shoulders and would never regain non-painful function. She also noted osteoarthritic changes in the right shoulder and thought it likely that this condition will progress to become more symptomatic, regardless of the accident.

***Dr. Jordan Leith***

[48] Dr. Jordan Leith, an orthopaedic surgeon who gave evidence on behalf of the defendant, examined Mr. Chappell in November 2015. Based on his review of the clinical records and the history provided by Mr. Chappell, it was his opinion that Mr. Chappell suffered only a number of abrasions and contusions (scratches and bruises) to his feet and lower back and the top of his left hand as a result of the accident. He did not think that the left knee and right shoulder conditions and the left hand carpal tunnel syndrome were caused by the accident. This was based on the fact that Mr. Chappell made no complaints immediately following the accident related to the shoulders, knees or wrists that would be consistent with acute injuries.

[49] Dr. Leith explained that if there had been a tear in the right shoulder rotator cuff, the pain and loss of use of the shoulder would have been significant. He said that most rotator cuff tears occur through attrition and are degenerative in nature, and that Mr. Chappell's previous right shoulder surgery predisposed him to a higher re-tear rate and progressive problems with aging. In his view, a more likely causative event was a trip on September 28, 2011, after which Mr. Chappell complained to his physiotherapist of right shoulder pain, as recorded in the physiotherapy records. He stated that this event "meets the principles of injury and was the cause of the shoulder problems that eventually led to investigations and surgery".

[50] Dr. Leith opined that any of Mr. Chappell's current symptoms in his left knee are more likely related to the progression of his pre-existing degenerative process, exacerbated by his weight. If an acute injury had occurred to the knee, he would have expected immediate symptoms and disability arising from this joint that would have been continuous after the accident.

[51] With respect to the left hand, Dr. Leith stated that if the carpal tunnel had been caused by the accident, he would expect acute inflammation to have first occurred to cause compression to the medial nerve in both wrists immediately following the accident, and this was not apparent from the history or the clinical records.

[52] He acknowledged that Mr. Chappell continues to have a variety of problems "that seem to mostly be from non accident related problems". His prognosis as it related to the injuries caused by the accident was "excellent".

***Dr. Donald Cameron***

[53] Dr. Donald Cameron, a neurologist, assessed Mr. Chappell in February 2016. He was of the opinion that Mr. Chappell suffered a mild traumatic brain injury (TBI or concussion) and post-traumatic cervicogenic headaches as a result of the accident. He was also of the opinion that the accident was a contributing factor to the carpal tunnel syndrome in the left hand.

[54] Dr. Cameron's opinion regarding the mild TBI was based on the history Mr. Chappell provided of no recall of the accident itself beyond the first second of impact and patchy recall of the events immediately following it. He thought this mild TBI lasted for several months but did not cause any prolonged cognitive problems.

[55] Dr. Cameron based his opinion about the cervicogenic headaches on Mr. Chappell's history that they started immediately following the accident. He thought that Mr. Chappell had developed rebound headaches due to excessive use of Tylenol over a period of time, and he recommended that this be assessed by a neurologist with a view to a change in therapy.

[56] With respect to the left hand, Dr. Cameron opined that other factors were the predominant cause of the carpal tunnel syndrome but the soft tissue injuries to the left wrist area sustained in the accident probably contributed to its development or worsening over time. He explained that this syndrome usually develops as a result of ongoing wear and tear, and that Mr. Chappell's carpal tunnel syndrome probably developed as a result of his work related and recreational activities over several years. Dr. Cameron thought that the accident was an event that caused "the tip over" but that Mr. Chappell would probably have developed carpal tunnel symptoms in any event had he continued his work as a firefighter.

***Dr. Rehan Dost***

[57] Dr. Rehan Dost, also a neurologist, gave evidence for the defendant. He examined Mr. Chappell in January 2016 and initially opined on the nature of his headaches and the cause of his carpal tunnel syndrome. Subsequently, he reviewed Dr. Cameron's report and disagreed with the diagnosis of mild TBI.

[58] It was Dr. Dost's opinion that a diagnosis of mild TBI based only on a patient's patchy recall of an event in a history taken sometime thereafter is not supported in the literature or the criteria for such an injury. The criteria require that the most plausible explanation be brain trauma and in his view, Dr. Cameron did not consider other more plausible explanations for Mr. Chappell's "non-specific physical and cognitive complaints".

[59] Dr. Dost did not think that Mr. Chappell's headaches were cervicogenic but rather chronic tension type headaches and he was of the view that these headaches had not been optimally treated. He also did not think that Mr. Chappell's carpal tunnel syndrome was related to trauma from the accident in the absence of immediate symptoms or the onset of symptoms within days to weeks. Although he acknowledged that the medical records indicated some injuries to the left hand, Dr. Dost did not think any of these injuries were in the region of the wrist that would affect the medial nerve and carpal tunnel.

***Dr. Robert Miller***

[60] Dr. Robert Miller, a psychiatrist, was of the view that Mr. Chappell probably suffered a mild TBI at the time of the accident and that this explains the gaps in his recall of the accident. However, he thought it unlikely that this was the cause of Mr. Chappell's ongoing cognitive problems as there was nothing ongoing from this.

[61] Dr. Miller opined that Mr. Chappell's symptoms of depression and anxiety were sufficient for a diagnosis of major depressive disorder. It was his view that Mr. Chappell's pain and physical limitations were the cause of this depression, his difficulties with concentration and drowsiness were likely caused by his narcotic pain

medications, and his motivation and work performance were impaired due to his depression. He thought that a complete recovery was improbable as it was linked to the prognosis for Mr. Chappell's continuing pain and physical limitations. He recommended continued treatment with anti-depressant medication and active rehabilitation.

***Dr. Melvin Kaushansky***

[62] Dr. Melvin Kaushansky, a neuropsychologist, conducted a neuro-psychological assessment of Mr. Chappell in March 2016. This involved a review of medical records, an interview of Mr. Chappell and his wife, and a series of tests. His test results did not indicate any cognitive problems secondary to a traumatic brain injury and found Mr. Chappell's overall level of functioning to be within the average range, with most cognitive skills commensurate with his level of intellectual functioning.

[63] However, Dr. Kaushansky assessed the reports of Mr. Chappell and his wife of problems with memory, attention and speed of processing information in the community as "cognitive inefficiencies" that are likely due to his depression, ongoing physical pain and the effects of his medications. He thought that Mr. Chappell had developed a severe depression as a result of his circumstances since the accident, which had become chronic, and his prognosis was poor given the primary issue of persistent physical pain with its very limiting consequences for his lifestyle.

[64] Dr. Kaushansky recommended ongoing psychological support, continuing anti-depressant medication, assessment for a multi-disciplinary pain clinic and vocational assistance with a view to being more active in community-based activities.

## Assessment and findings

### Reliability and credibility

[65] The defendant has raised issues regarding the reliability and credibility of Mr. Chappell's evidence. The reliability issues stem from inconsistencies between

Mr. Chappell's evidence about his injuries and the contents of the medical records, as well as what Mr. Chappell reported to the expert witnesses. The credibility issues arise from Mr. Chappell's failure to report for many years the income he earned from his construction side business.

[66] In personal injury cases, there is often little to no objective medical evidence supporting a plaintiff's self-reported symptoms. In such circumstances, judges must examine the plaintiff's evidence carefully and sometimes skeptically: *Price v. Kostryba* (1982), 70 BCLR 397 (SC); *Dhaliwal v. Greyhound Canada Transportation Corp*., 2015 BCSC 2147, aff'd 2012 BCCA 114 at para. 280.

[67] This is not a case where there is little to no objective evidence of injury, as all of Mr. Chappell's conditions are clearly supported by medical evidence. This is a case where the causation issues depend in large part on the plaintiff's evidence about the onset of symptoms. The defendant says that Mr. Chappell's evidence must be scrutinized with care because it is inconsistent with his reporting of symptoms as reflected in the medical records and expert reports.

[68] I agree that the court must scrutinize Mr. Chappell's evidence given the apparent inconsistencies in his reporting of symptoms. However, much of the defendant's challenge to Mr. Chappell's credibility was based on what was contained (or not contained) in the clinical records. In this regard, I agree with the comments of N. Smith J. in *Edmondson v. Payer*, 2011 BCSC 118 at para. 36, that the absence of a record is not, in itself, evidence of anything:

> … For example, the absence of reference to a symptom in a doctor's notes of a particular visit cannot be the sole basis for any inference about the existence or non-existence of that symptom. At most, it indicates only that it was not the focus of discussion on that occasion.

[69] Mr. Chappell testified that he did not remember what he told various medical professionals, particularly in the immediate aftermath of the accident and in the initial months following. He explained that he was first aware of his most immediate problems, which were focussed on his back and lower extremities, and although he noticed symptoms in his left knee and right shoulder, they did not become a focus

until some of the other symptoms improved and he was able to be more active. He said that he knew within a couple of days that his body hurt “from top to bottom”, he dealt with his immediate issues first, and he was not sure when his knee and shoulder became a problem.

[70] Given Mr. Chappell’s multiple injuries and conditions, and the length of time since the accident, I found his explanation credible. This man is clearly suffering and his pain - both physical and psychological - is palpably real. That said, it is difficult for him to differentiate between conditions that may have been caused by the accident and those that may not have been caused by the accident, and this is something that I have carefully considered in assessing the reliability of his evidence.

[71] Overall, I found Mr. Chappell to be a credible witness. Initially, he diminished to some extent the symptoms he was having before the accident due to his pre-existing conditions, but in cross-examination he acknowledged these conditions and their effect on him. He was at times reactive and unresponsive to questions, but more often he appeared exhausted and quite overwhelmed. The issue with respect to his non-reporting of income is certainly a concern that will affect his ability to prove damages for this loss of income, but it does not change my general assessment of his credibility as a witness.

**Adverse inference**

[72] Dr. Richard Bacchus was Mr. Chappell’s family doctor at the time of the accident and had been his doctor for many years before. He was not called as a witness. Because the primary issue in this case is causation, the defendant suggests that the court may draw an adverse inference from this, submitting that Dr. Bacchus was the witness best able to provide opinion evidence about Mr. Chappell’s pre-existing conditions and what injuries were caused by the accident.

[73] An adverse inference may be drawn if a litigant, without explanation, fails to call a witness who might be expected to give supporting evidence. In personal injury cases, this means that a plaintiff may be expected to call doctors who treated him for

the important aspects of his injuries: *Barker v. McQuahe* (1964), 49 W.W.R. 685 (BCCA). While a party is free to dispense with evidence that is relatively unimportant or repetitive, the same may not be the case for evidence that may be described as "superior in respect to the fact to be proved": *Buksh v. Miles*, 2008 BCCA 318 at para. 30, citing Wigmore's *Evidence in Trials at Common Law*.

[74] A trial judge is not bound to draw an adverse inference from the failure of a witness to testify, and one is not usually drawn if the witness is equally available to both parties and unless a *prima facie* case has been established: see *Thomasson v. Moeller*, 2016 BCCA 14 at para. 34-35, citing *Zawadski v. Calimoso*, 2011 BCSC 45.

[75] In *Buksh* at para. 35, Saunders J.A. identified a number of factors to consider when assessing whether an adverse inference should be drawn: (a) the evidence before the court; (b) the explanation for not calling the witness; (c) the nature of the evidence that could be provided by the witness; (d) the extent of disclosure of the doctor's clinical records; and (e) the circumstances of the trial, such as where there has been an agreement to introduce clinical records that may be contrary to the inference or where the witness' views are apparent in the report of another witness.

[76] Clearly, Dr. Bacchus could have provided pertinent evidence related to Mr. Chappell's pre-existing conditions and his immediate and ongoing symptoms following the accident. However, all of his clinical records are in evidence pursuant to a document agreement that provides as follows:

> a) The observations by the doctor … are facts and admissible as such without further proof thereof;
>
> b) The treatments prescribed by the doctor … are facts and admissible as such without further proof thereof;
>
> c) The statements made by the patient are admissible for the fact they were made but not for their truth;
>
> d) The diagnoses made by the doctor … are admissible for the fact they were made but not for their truth;
>
> e) The diagnoses made by the person to whom the doctor … has referred the patient are admissible for the fact that they were made but not for their truth;

> f) The Clinical Records are not admitted for the purpose of proving any opinions stated therein and no opinion contained therein may be relied upon as expert opinion evidence.

[77] Dr. Bacchus' clinical notes do contain a record of Mr. Chappell's visits before and after the accident. Many pages were referred to Mr. Chappell and to other witnesses in cross-examination. His notes from August 31, 2011 through to August 2012 refer to symptoms in the neck, back, feet, left hand, left knee and right shoulder as "ICBC follow up" or "f/u re MVA injuries", which implies that the nature of the evidence he could have provided may not have been adverse to Mr. Chappell.

[78] Counsel for Mr. Chappell explained that there was no need to call Dr. Bacchus because the doctor's records are before the court in accordance with the document agreement, there is a good record of Mr. Chappell's pre-existing conditions, and his evidence is generally consistent with the records. He pointed out that it was open to the defendant to call the doctor as a witness and there is no evidence that any attempt was made to do so.

[79] Counsel for the defendant submitted that it is not usually feasible for a defendant to obtain an opinion from a plaintiff's treating family doctor due to a general unwillingness to undermine the trust involved in the doctor-patient relationship. I accept that this may be a real and practical consideration, but in this case Mr. Chappell had stopped seeing Dr. Bacchus on a regular basis after July 2013, so it was open to the defendant to at least approach the doctor and consider whether or not to call him as a witness.

[80] I consider the circumstances here quite different from those in *Mohamud v. Yu*, 2016 BCSC 1138, a case relied on by the defendant. There, important parts of the plaintiff's evidence were inconsistent with statements she made (or did not make) to her family doctor and the experts who testified on her behalf, and the extent of the inconsistencies was of particular concern because there was no objective confirmatory evidence from *any* treating physician. In that context, it was especially troubling that the plaintiff's long-time and trusted family doctor, who saw her throughout all the relevant times, did not testify or provide an expert report. Here,

as I review below, there are actually few real inconsistencies between Mr. Chappell's evidence and the medical records, and there is also objective evidence from three physicians who treated him, the most significant being Dr. Arthur, who treated Mr. Chappell's left knee problems both before and after the accident.

[81] While it would have been helpful to have heard evidence from Dr. Bacchus, given the length of time since this accident, I would expect his testimony about his treatments and diagnoses to have relied mainly on his clinical records, all of which are in evidence for the purposes set out in the document agreement. Moreover, the records indicate that Dr. Bacchus did not see Mr. Chappell on all visits, most notably the first two after the accident in August 2011. In all of the circumstances here, I am not prepared to draw an adverse inference from the plaintiff's failure to call Dr. Bacchus as a witness.

**Assessment of the medical evidence**

[82] Most of the expert witnesses who testified at trial were not treating physicians for Mr. Chappell but rather had been retained and instructed by counsel. Where those witnesses examined Mr. Chappell, they did so long after the accident. As Johnston J. observed in *Meghji v. Lee*, 2011 BCSC 1108, varied on other grounds 2014 BCCA 105, at para. 214, a physician who examines a patient soon after an accident, and who regularly follows that patient thereafter, is in a better position to opine on causation than is a physician who examines months or even years later. It is therefore important for the court to carefully evaluate the expert evidence in determining how much weight to give it.

[83] Most of the expert witnesses who testified in this trial were professional and independent in their approach.

[84] With respect to the experts on physical medicine and rehabilitation, I found the opinion evidence of Dr. Adrian much more reliable and compelling than that of Dr. Waseem. While Dr. Adrian was not prepared to accede to a reasonable suggestion put to him in cross-examination (the possibility of reducing symptoms with weight loss), overall I found his approach to be fair and generally supported by

the evidence. In contrast, Dr. Waseem's approach was inconsistent and confusing. He denied opining about causation, stating that he was merely describing the injuries identified in the hospital and family doctor's records, yet he also stated that the neck and back pain were "causally related" to the accident. He agreed that Mr. Chappell's right shoulder and left knee were injured in the accident but he steadfastly maintained that these were soft tissue injuries only despite acknowledging that right shoulder "clicks" could involve derangement of the shoulder and some rotator cuff tears are asymptomatic, and without considering whether the impact from the accident could have contributed to the left knee ACL injury. Relying solely on the clinical records, he did not refer to a number of references that were inconsistent with his opinion, stating that he primarily relied on the diagnosis given by the doctors in the emergency room. Yet, he stated that the diagnosis was not the issue in this case but rather Mr. Chappell's level of disability. While I have considered Dr. Waseem's opinion throughout, I have generally given it little weight.

[85] I have given considerable weight to the evidence of Dr. Arthur and Dr. Samler, the orthopaedic surgeons who treated Mr. Chappell's left knee and shoulder conditions respectively. Each testified in an objective manner and each was prepared to consider alternative suggestions. Dr. Samler's opinion was not always clearly stated, but I attribute this to inexperience as a witness; she was obviously a knowledgeable and skilled surgeon. Dr. Leith, who challenged the opinions of Dr. Arthur and Dr. Samler, was critical of any suggestion that the left knee and right shoulder injuries were attributable to the accident and remained steadfast in his opinion that these injuries required immediate, acute symptoms to meet "the principles of injury". While he is obviously knowledgeable in his field, I found his approach closer to that of an advocate. He was not prepared to consider reasonable alternatives and he appeared to rely on the medical records in preference to the history he obtained from Mr. Chappell.

[86] Both neurologists who testified were clearly knowledgeable and both were firm in their opinions, but Dr. Dost also appeared to rely too heavily on the medical records. In my view, this caused him (as well as Drs. Leith and Waseem) to parse

too much detail from notes prepared by others, without considering the human element of the patient.

[87] Dr. Miller, the psychiatrist, and Dr. Kaushansky, the neuropsychologist, provided helpful and objective evidence. Dr. Kaushansky may have been a little too eager to explain his theory about the triad of pain, but I did not consider him to take on the role of advocate.

[88] Finally, Dr. Polyrhonopoulos, the current family doctor, was helpful in describing his course of treatment after May 2013. However, his opinion on causation was too broadly stated and did not properly consider Mr. Chappell's prior history, and I have given this aspect of his evidence little weight.

**What injuries were caused by the accident?**

[89] While there is some expert evidence that links Mr. Chappell's conditions in both shoulders and both knees to the accident, Mr. Chappell did not contest the weight of the evidence - primarily from his own expert, Dr. Mark Adrian - that his left shoulder and right knee conditions are not causally related. He also did not contest a lack of causation regarding his right hand carpal tunnel syndrome. Therefore, I will touch on those conditions only as they may or may not affect the constellation of Mr. Chappell's other symptoms and conditions.

[90] Both parties submitted, and I agree, that Mr. Chappell's physical injuries are divisible and can be assessed independently. They also agree that his psychological injuries are indivisible in the sense that they stem from pain issues related to both tortious and non-tortious causes. They disagree as to how these indivisible injuries are to be assessed.

[91] I will deal first with the physical injuries.

***a) Feet, ankles, neck, back, left hand***

[92] The evidence clearly establishes that Mr. Chappell suffered injuries to his feet, ankles, neck, back and left hand in the accident. Both the ambulance report

and the Delta Hospital emergency assessment record pain in both ankles, the lower back and upper buttocks. The pain was significant enough that narcotic pain medication was prescribed. The family doctor's clinical record on August 4, 2011 indicates injuries to both ankles (with bruising and swelling) and "Lt hand tender ++ over metacarpal index and fifth finger" with a plan to have it x-rayed. The notes do not indicate an examination of the back but there is a diagnosis of "closed fracture lumbar vertebra" apparently based on what Mr. Chappell was told by the emergency room physicians. On August 9, 2011, the clinical record notes lower back and pelvic pain ("Pain ++ lower back") and feet still painful, with continued narcotic pain medication.

[93] There was no dispute among the expert witnesses who testified about these injuries. Each of Dr. Adrian, Dr. Polyhronopoulos, Dr. Waseem and Dr. Leith agreed that Mr. Chappell's injuries to the feet, ankles, neck and back were caused by the accident. Each also acknowledged injuries to the left hand, although Drs. Waseem and Leith maintained that all of these were either scratches, bruises or soft tissue injuries only.

#### *i) Feet and ankles*

[94] The injuries to the feet and ankles appear to have significantly resolved by late 2011. Mr. Chappell said that his feet improved a lot after a few weeks of physiotherapy, and the physiotherapy notes indicate that the feet problems were "essentially resolved" by November 17, 2011. Dr. Adrian noted in his October 22, 2012 report that Mr. Chappell was still experiencing mild intermittent right foot and ankle pain. There is a clinical note by Dr. Bacchus on February 27, 2013 that "the feet/ankles are good right now".

[95] I find that Mr. Chappell's injuries to his feet and ankles caused severe pain initially, which substantially resolved within about four months.

***ii) Back and neck***

[96] The continuing records of the family doctors and the physiotherapist consistently refer to ongoing back and neck pain. Mr. Chappell reported ongoing pain and stiffness to Dr. Polyrhonopoulos in May 2013 and following. Examination on May 30, 2013 indicated moderate to severe spasm in the paracervical muscles and generally decreased range of motion in the neck and lumbar spine, which continued in subsequent visits. There is nothing in any of the records that is inconsistent with Mr. Chappell's evidence of continuing back and neck pain, and I accept his evidence about this.

[97] The main point of disagreement among these experts relates to Mr. Chappell's prognosis regarding his back and neck injuries. Dr. Adrian and Dr. Polyhronopoulos provided a poor prognosis given the length of time the pain symptoms have persisted. In contrast, Dr. Waseem and Dr. Leith were optimistic about these injuries. On this issue, I found the opinions of Drs. Adrian and Polyhronopoulos much more compelling.

[98] Dr. Waseem's opinion was based solely on his review of the medical records, which clearly put him at a disadvantage, and his optimistic prognosis is simply unsupported by the evidence before this court. Dr. Leith's approach to these injuries was also unsupported by the evidence.

[99] There is evidence that Mr. Chappell had neck and back symptoms before the accident. The history obtained by both Drs. Adrian and Polyhronopoulos indicates that there were some pre-existing neck and lower back issues but these occurred infrequently, roughly yearly, were controlled with periodic chiropractic treatments, and did not affect Mr. Chappell's activity levels. The chiropractic records are consistent with this history, recording sporadic visits between July 2002 and September 2009 and nothing again until after the accident. An MRI of the spine taken in April 2012 revealed some degenerative changes that Dr. Adrian agreed were probably there before the accident.

[100] Dr. Adrian opined that Mr. Chappell's spine was probably vulnerable to injury due to his history of symptoms but it was unlikely that he would have spontaneously developed regularly occurring pain in his neck and back had it not been for the accident. He explained that pre-existing degenerative changes in the spine do not relate to symptoms and would not in themselves have rendered Mr. Chappell vulnerable to injury. Dr. Polyrhonopoulos did not think that the pre-existing back pain made Mr. Chappell more susceptible to injury.

[101] Given that Mr. Chappell's symptoms since the accident are profoundly more debilitating than they had ever been, I accept Dr. Adrian's opinion about this and I find there would have been only a minimal measureable risk that he would have developed serious neck and back symptoms in the absence of the accident.

[102] I find that Mr. Chappell continues to suffer back and neck pain that affect not only his level of activity but also his ability to cope with his other injuries. I will come back to this latter point.

***iii) Left hand carpal tunnel syndrome***

[103] With respect to the injuries to the left hand, there is substantial disagreement among the experts that the accident was causally related to Mr. Chappell's left hand carpal tunnel syndrome. Dr. Cameron and Dr. Adrian were of the view that the accident contributed to the development of this condition due to physical forces to the left hand in the accident. Dr. Dost and Dr. Leith disagreed, both opining that trauma to the median nerve would have had to be more severe than the soft tissue injuries recorded and would have caused immediate symptoms, which were not present.

[104] Mr. Chappell said only that his hands were causing him a lot of problems in March and April 2012 and he had no memory of when his symptoms started. He admitted that he had some symptoms of left hand numbness prior to the accident.

[105] Dr. Cameron thought that the accident was an event that caused "the tip over". His opinion was based on the assumption that Mr. Chappell had symptoms of

pain and discomfort in the left wrist and left hand immediately after the accident and developed sensory symptoms within about a month following. There is evidence of immediate symptoms in the Delta Hospital records, which record pain and a burning sensation in the left hand "around pinky finger 8/10" and in the family doctor's records two days later, which record pain over the index and fifth fingers. There is also evidence of continuing pain on August 31, where the doctor's notes indicate "sore left index finger" although x-rays had been normal. By March 2012, his symptoms were worse. The doctor's note of March 10, 2012 indicates "increased numbness in left fingers 3, 4, 5 which did bother him a bit pre accident but is a lot worse post accident". Mr. Chappell was seen by an orthopaedic surgeon in August 2012, who recorded left hand symptoms in the index, long and ring fingers, diagnosed left carpal tunnel syndrome, and queried right carpal tunnel. Nerve conduction studies done in September 2012 confirmed severe carpal tunnel syndrome in both hands. All of this is consistent with Mr. Chappell's evidence that he was having a lot of trouble with his hands by March 2012, after he went back to work.

[106] Dr. Adrian saw Mr. Chappell shortly after the nerve conduction studies were done, in October 2012. His examination revealed carpal tunnel symptoms in both hands, but to a lesser degree on the right. Given Mr. Chappell's history of symptoms in the left hand only, he concluded that the soft tissue injuries in that hand probably rendered Mr. Chappell prone to developing carpal tunnel syndrome and thus contributed to its development.

[107] Dr. Leith did not opine about indirect trauma. Dr. Dost acknowledged that indirect trauma due to soft tissue injuries could result in a delayed onset of carpal tunnel syndrome but opined that such trauma would have to be more significant than that recorded in the medical records. He did not think that there had been any trauma to the medial nerve (the nerve associated with carpal tunnel) and explained that the symptoms recorded by the family doctor on March 10, 2012 revealed a left hand ulnar nerve issue which has nothing to do with carpal tunnel. He also said that

trauma to the left hand does not explain why Mr. Chappell had symptoms in both hands.

[108] The evidence does establish that Mr. Chappell indeed suffered carpal tunnel syndrome in both hands, but it also establishes that his symptoms were more pronounced in the left, these symptoms were evident right after the accident, and they progressed following it. The records indicate numbness ranging from the index to the fifth fingers in the left hand, and despite some confusion as to whether these symptoms related to the ulnar or medial nerve, the subsequent diagnosis shows that there was a relationship between those symptoms and the carpal tunnel. While Mr. Chappell developed the same condition in both hands, his symptoms were more pronounced in the left.

[109] Based on this evidence, and the opinions of Drs. Cameron and Adrian, I am satisfied that the accident was a contributing cause of Mr. Chappell's left hand carpal tunnel syndrome. The question is whether it was a contributing cause beyond a *de minimus* range. Dr. Adrian simply opined that the accident "probably materially contributed" to the development of the carpal tunnel. Dr. Cameron was more explicit. He agreed with Dr. Dost that work related activities over several years were the predominant cause. He was reluctant to quantify this, as from a medical point of view, he regarded the accident as a significant contributing factor. However, he allowed that the condition was probably 80 to 90% due to work related activities.

[110] Under the "but for" test for causation, it is necessary to have both the accident and the prior work-related activities for the carpal tunnel syndrome to occur. *Athey* imposes a fairly low threshold for determining causation: did the act complained of cause or contribute more than *de minimus* to the injury complained of, here the left hand carpal tunnel syndrome? The Merriam Webster dictionary defines *de minimus* as "lacking significance or importance: so minor as to merit disregard". In the criminal context, conduct that is in the *de minimus* range is conduct that is insignificant or trivial: see *R. v. Nette*, 2001 SCC 78.

[111] Given the temporal connection between the accident and the onset of symptoms, I cannot conclude that the contributing cause of the accident was so insignificant or trivial to merit disregard. I find that the accident was more than a *de minimus* contributing factor; the forces from the accident to the left hand aggravated the wear and tear in the medial nerve to the point that the acute symptoms manifested themselves.

[112] That said, both Dr. Adrian and Dr. Cameron opined that Mr. Chappell would probably have developed carpal tunnel in his left hand in any event had he continued working as a firefighter. I find this measureable risk to be high, particularly in light of the fact that he developed the same condition in his right hand, and I would assess this risk at 80%.

[113] With respect to the nature of this injury, I find that the carpal tunnel syndrome caused significant pain to Mr. Chappell, which was resolved by the end of 2012, after carpal tunnel release surgery in November 2012 and a period of rehabilitation.

***b) Headaches***

[114] Mr. Chappell testified that his head was “splitting” the night of the accident and by December 2011 headaches were continual, along with tension in his shoulders. He was not specific about timing but he referred to having headaches throughout 2013 and at the time of trial he was still getting them.

[115] The defendant made much of the absence of any mention of headaches in the clinical records until April 2012, which noted, “he is getting headaches that last for a few hours; they come about daily; they began about nov or so”. The defendant also pointed out that Mr. Chappell had headaches before the accident, thus complicating the causation analysis.

[116] On this latter point, there is very little evidence of any ongoing pre-existing problems with headaches. Mr. Chappell said that he had gone to the chiropractor for headaches occasionally, which may not be outside the range of common experience. I do not consider this to have any material bearing on the analysis here.

[117] Both Dr. Adrian and Dr. Cameron concluded that Mr. Chappell's headaches were cervicogenic in nature. Dr. Adrian based this on reported symptoms of pain spreading from the occipital (upper neck) area and right side of the head, which were present when he examined Mr. Chappell in October 2012 and again in January 2016. Dr. Cameron based this on reported headaches immediately or within a few days to a week following the accident. He also thought that Mr. Chappell had developed rebound headaches from excessive use of Tylenol over a long period of time. Dr. Dost thought Mr. Chappell was suffering from chronic tension type headaches. He disagreed that they were post-traumatic headaches on the basis that there was no report of headaches within a week after the accident.

[118] I find that Mr. Chappell did experience headaches immediately following the accident, and they were present in some form, on and off, in the days, weeks and months following. The fact that they were not mentioned in the medical records does not diminish the weight of Mr. Chappell's evidence about this. I accept his explanation that in this period of time he was focusing on his most acute problems and was probably not paying much attention to his headaches. Moreover, given the nature of the symptoms and the injuries to his neck and cervical area, it is reasonable to conclude that the headaches, at least initially, were related to the neck injury. I accept the opinions of Drs. Adrian and Cameron on this issue. I also accept Dr. Cameron's opinion that Mr. Chappell has probably developed rebound headaches from his use of medication, given the fact that they have increased in frequency over time.

[119] I find that Mr. Chappell's headaches were caused by the accident, that they are cervicogenic in origin and have become chronic partly as a result of his long term use of pain medication.

### *c) Left knee*

[120] The weight of medical opinion establishes that Mr. Chappell's pre-existing condition in his left knee rendered him vulnerable to re-injury. He had a history of problems in that knee for many years that resulted in a partial knee replacement and

ACL reconstruction in March 2009. According to Dr. Arthur, who performed the surgery, Mr. Chappell had no complications, underwent physiotherapy and was cleared for a gradual return to work in September 2009. In March 2010, Mr. Chappell reported intermittent pain and in April, increased pain after pulling off his boot, and on both occasions Dr. Arthur advised him to consider administrative work with the fire department. Dr. Arthur said that the knee would usually be "pretty sensitive" within a year following surgery and sometimes a bit longer, so these symptoms were not unusual.

[121] Mr. Chappell acknowledged that Dr. Arthur had advised him to find a more sedentary line of work, but he did not want to do that and instead pushed himself through his rehabilitation. He said that he understood this advice but was not going to be limited by it, and by the fall of 2010 his left knee was stable and "extremely strong". He avoided squatting, kneeling and running but it did not otherwise limit his activities and he was fully functional at work, in construction projects, landscaping work and hunting trips. If the knee got sore, he would treat it with Advil or Tylenol and it would resolve.

[122] I accept Mr. Chappell's evidence that his left knee condition did not limit his activities prior to the accident. This was confirmed by all of the witnesses who testified about his pre and post-accident functioning. While they did not know how many surgeries Mr. Chappell had before the accident and did not see him during his rehabilitation periods, they said that he always returned to work and always appeared to be able to do any of the physical tasks he set out to do, whether at work, in construction or other activities.

[123] The main issue in dispute is whether the accident had any causative effect on Mr. Chappell's subsequent knee symptoms and eventual need for a second surgery to reconstruct another ACL. Dr. Waseem and Dr. Leith were of the view that it did not, in the absence of any complaints of immediate, acute and continuous symptoms in the left knee after the accident, and in light of Mr. Chappell's pre-existing condition and degenerative changes.

[124] Dr. Waseem attributed Mr. Chappell's knee condition to pre-existing osteoarthritic changes, which was at increased risk due to his "[b]eing overweight and having an ACL deficient knee".

[125] Dr. Leith did not think that "a very weak temporal relationship to the development of pain and swelling to the knees" at a time after the accident was "evidence" that the accident was the cause of those symptoms, especially given the pre-existing state of his knee joints.

[126] Dr. Arthur and Dr. Adrian were of the view that the accident did have a causative effect. Dr. Adrian thought that the physical forces to the left knee during the accident resulted in an injury to the knee joint. Dr. Arthur was more specific; he thought that Mr. Chappell sustained an injury that involved his ACL.

[127] What were Mr. Chappell's symptoms following the accident? He testified that "everything hurt" in the first few days and he had difficulty walking. He remembered his feet being very painful as well as his ankles, knees, hips and lower back. He did not recall specific symptoms in that first month but he did recall that once his feet began to improve he noticed pain in his knees. After he returned to work in January 2012, he was having significant problems with his left knee. He said by March this was probably his worst problem, and by January 2013 it was one of his two big issues (the other being his right shoulder).

[128] The defendant again made much of the absence of any mention of left knee pain in the ambulance crew report, the hospital records, or the first two visits with the family doctor. However, at his third visit with the family doctor (and the first with Dr. Bacchus), there is a note of swelling in the left knee. This is in the context of a record stating this:

> can bearly [sic] stand on his feet in the morning
> Rt big toe pain
> Top of Lt foot sore
> Lt knee edemetous
> Rt buttock pain and hip
> Pelvis is extremely painful in middle

Back pain in last 4 days

[129] Given all of these problems in the lower extremities, it is no wonder that Mr. Chappell was not able to focus on one symptom or another. In this context, I do not find that the absence of any note of knee pain before this to be inconsistent with Mr. Chappell's evidence that he did have symptoms. I say the same regarding the symptoms recorded by the physiotherapist in September and October 2011. Mr. Chappell was clearly dealing with intense feet and back pain during this period of time, but by October 4, the physiotherapist noted left knee pain and swelling, which continued on and off after that, along with some indications of left knee locking and clicking. The family doctor noted that the left knee was still an issue in August 2012, and it was after this that Mr. Chappell was referred back to Dr. Arthur to assess that knee.

[130] Both Dr. Adrian and Dr. Arthur saw Mr. Chappell in October 2012. By then, he was having pain and swelling over the medial aspect of his knee with some indications of instability. An MRI taken in November 2012 was inconclusive. His symptoms waxed and waned over the following year but by January 2014, the left knee was clearly unstable. This led to Dr. Arthur performing an arthroscopy in April 2014, which revealed that the ACL had in fact dissolved.

[131] Dr. Arthur found it difficult to assess Mr. Chappell's left knee after the accident. He explained that his examinations were not conclusive regarding instability and that symptoms could improve and worsen with an ACL tear. He said that instability is not always noticed in the first few weeks or months of a tear, but as time goes on and symptoms settle down, it can then become apparent that something is wrong. He thought that the ACL was torn as a result of the accident and there followed an evolving process that caused it to disappear; this is because after a rupture or tear, fluid in the knee joint can cause the ACL to dissolve. He was not able to determine precisely when that occurred, as it was only when he performed the arthroscopy in April 2014 that the problem was confirmed. He also explained that with a reconstructed ligament, one would not necessarily notice pain

since some of the nerve endings are gone. Some swelling would be apparent within a few days of a tear but he said that a lot of general practitioners miss this.

[132] Dr. Arthur acknowledged that Mr. Chappell has degenerative changes in the compartments of his left knee that were not replaced and this was not related to the accident. He did not think these degenerative changes were the cause of his knee pain and he was not aware of any mechanism for the ACL injury other than the accident. While he agreed that a twist or trip could have done something to the ACL, it would be speculative to base any finding on such evidence. A “twist or trip” was noted in the physiotherapy records on September 29, 2011, with a notation of left knee pain and swelling on October 4, 2011. Mr. Chappell described this event as a rather benign trip while walking to his pool. In the absence of any other evidence, I find it improbable that such a minor event could have been a mechanism for the injury to the ACL, particularly in the context of a rather serious motor vehicle accident only two months earlier and evidence of swelling long before this trip or twist.

[133] Dr. Arthur opined that the degenerative changes will likely continue to progress and will progress more quickly if Mr. Chappell does not lose any weight and does not stop activities that stress the knee. He thought that Mr. Chappell may require a total knee replacement in the next 15 to 20 years.

[134] Dr. Adrian’s opinion was consistent with Dr. Arthur’s, and so were his findings on examination in October 2012. While his examination of the left knee was not conclusive, he said that it was an abnormal exam and the ACL may or may not have been present at that time.

[135] I found Dr. Arthur’s opinion compelling. He was the only treating physician and he had direct experience with Mr. Chappell’s left knee issues. He described the accident as a setback for Mr. Chappell, and I am satisfied that it was. No doubt, this is an unusual case, but I accept Dr. Arthur’s assessment that the accident was the mechanism that caused an injury to the reconstructed ACL and that injury began a

process in which the ACL gradually dissolved. It would be speculative to find any other mechanism for this injury on the evidence before me.

[136] I do not accept the opinions of Drs. Waseem and Leith. Dr. Waseem did not consider whether the impact from the accident could have contributed to the left knee injury and his sole reliance on the medical records provided a weak basis for his opinion. Dr. Leith, too, relied too extensively on the medical records. His report of January 30, 2016 does not include any details of the history he obtained from Mr. Chappell as it may have pertained to the left knee and he did not specifically opine on this knee. He was subsequently asked for an opinion on mitigation of knee injuries through weight loss, and his report of April 12, 2016 includes a discussion about causation of the knee injuries, again not focussing specifically on the left knee. His opinion was based on the absence of "a story of an injury to that knee" and again, the absence of immediate, acute symptoms, yet he acknowledged that an injury to a reconstructed ACL may not always present with a lot of pain given the lack of nerve fibres in the graft.

[137] I find that Mr. Chappell's pre-existing condition in his left knee made him vulnerable to re-injury and the accident materially contributed to the injury to the ACL in that joint, causing it to eventually dissolve and require replacement.

[138] Since the surgery in September 2014, the left knee symptoms have significantly improved. Mr. Chappell saw Dr. Arthur in November 2014 and did not complain of pain. Dr. Arthur thought that the knee was stable and the wounds had healed well. In January 2015 Mr. Chappell told Dr. Polyrhonopoulos that the left knee had markedly improved but he still had intermittent stabbing pains. In November 2015 he told Dr. Leith that his left knee was "pretty good" and the pain was tolerable but in January 2016 he told Dr. Adrian that he had physically limiting left medial knee pain. Mr. Chappell testified that his left knee is now in good shape but he still gets pain; initially he said that it gets sore once in a while but in cross-examination he described his left knee as being "in a state of nauseating pain that is always there". I found this last statement to be an over-reaction to cross-

examination, as it is inconsistent with his own prior testimony. In any event, he said that he can control this pain with medication.

[139] I accept Dr. Arthur's opinion that the degenerative changes in the knee joint compartments that were not replaced (i.e. other than the medial joint) are not the cause of Mr. Chappell's current knee pain. I find that Mr. Chappell continues to experience intermittent pain as a result of the injury to the left knee ACL and subsequent to surgical repair.

[140] Dr. Adrian thought it unlikely that Mr. Chappell would have developed persistent and physically limiting left knee problems had it not been for the accident. Dr. Arthur did not specifically opine about the risk of the reconstructed ACL spontaneously dissolving absent the accident, or some mechanism of injury, but the evidence shows that Mr. Chappell had a reasonably uneventful recovery from his 2009 surgery and was functioning at close to normal activity levels at the time of the accident. However, he did lead an active lifestyle and he continued with his firefighting work despite Dr. Arthur's advice, and he is a large man. On this basis, I find there was some measureable risk of damage to the reconstructed ACL regardless of the accident, which I assess at 20%.

[141] There was, and remains, a measureable risk that Mr. Chappell will continue to experience degenerative changes in the rest of his left knee, none of which is related to the accident. These changes may necessitate a total knee replacement sometime in the future. However, given Dr. Arthur's evidence that he envisaged this happening in the next 15 to 20 years, this risk does not have a material bearing on the assessment of damages.

### *d) Right shoulder*

[142] Mr. Chappell's right rotator cuff was repaired in 2005, six years before the accident. After rehabilitation, he was able to resume all of his regular activities. He said that he would have occasional flare-ups when doing overhead lifting, which would last at most a couple of days. There is nothing in the clinical records that is inconsistent with this. There are only two cryptic notes that refer to shoulder pain,

one in August 2007 and the other in August 2008, and neither relate specifically to the right shoulder.

[143] I accept Mr. Chappell's evidence that his right shoulder condition did not limit his activities prior to the accident, and while he experienced intermittent flare-ups, they would resolve within a short period of time. As with the left knee, this was also confirmed by the witnesses who testified that Mr. Chappell always returned to work after his surgeries and rehabilitation and appeared to be able to do any of the physical tasks he set out to do.

[144] Dr. Samler, who treated Mr. Chappell's right shoulder and performed another rotator cuff repair in August 2015, did not think that the 2005 surgery made him more susceptible to injury given its apparent success and remoteness from the accident. Dr. Adrian, Dr. Leith and Dr. Waseem disagreed. Dr. Adrian was of the view that Mr. Chappell's right shoulder was probably vulnerable to injury given his pre-accident symptoms. Dr. Leith stated that the prior rotator cuff repair predisposed the shoulder to a higher re-tear rate and progressive problems with aging. Dr. Waseem stated that this past history put Mr. Chappell at increased risk of developing right shoulder problems due to degenerative and age-related tendon problems.

[145] While the 2005 surgery was quite remote from the accident, I accept the weight of medical opinion that Mr. Chappell's pre-existing condition in his right shoulder probably rendered him vulnerable to re-injuring his rotator cuff tendon. However, the evidence establishes that Mr. Chappell's current shoulder problems are complex and multi-faceted, as he has developed degenerative changes in two of the joints in that shoulder, apparently since 2012. There is no medical evidence about the actual state of his right shoulder from 2005 to 2012. Some of the medical reports indicate that imaging done in July 2012 revealed some osteoarthritic changes in the acromioclavicular (AC) joint, which had progressed by November 2014. More recent imaging, in May 2015, revealed early osteoarthritis in the glenohumeral joint. The medical evidence does not suggest that these arthritic

changes were caused by the accident, as it is not possible to determine when they started.

[146] The main issue in dispute is whether the accident had any causative effect on Mr. Chappell's rotator cuff injury in his right shoulder. Dr. Samler and Dr. Adrian were of the opinion that it did, based in part on Mr. Chappell's report that he had immediate symptoms following the accident. Dr. Leith and Dr. Waseem again differed, based on the absence of immediate and acute complaints.

[147] Mr. Chappell accepted that he did not report any shoulder complaints to the ambulance attendants or the staff at Delta Hospital. He testified that he was aware of clicking in his shoulders when he got home from the hospital but he could not say when his right shoulder became an issue. He said that by the fall he was on "so many drugs" he was not sure what was going on. He accepted that his right shoulder problems were noted in the clinical records as going up and down in the fall of 2011 but said that it became one of the areas that bothered him the most after he returned to work in January 2012.

[148] This evidence is consistent with the history Mr. Chappell gave to Dr. Adrian in October 2012, where he reported experiencing a snapping sensation in the right shoulder shortly following the impact and ongoing symptoms during activities that physically loaded the right shoulder. It is not consistent with the history he gave to Dr. Samler in November 2014 in so far as he referred to symptoms in both shoulders. Dr. Samler recorded his symptoms as immediate pain and significant immobility to both shoulders post-accident, with the mobility improving over time but continued sharp, stabbing pain as well as catching and clicking.

[149] There is no reference in the clinical records or any other expert report to left shoulder pain symptoms prior to October 2013. The clinical records do record symptoms in the right shoulder starting within a month of the accident (August 31, 2011 noted clicking when raising arm) and mostly ongoing pain and restriction of movement from mid-September, some improvement in October, continued problems in November, some improvement in December, but continuing issues in January

2012 and following. These continued to the point where Mr. Chappell had surgery in May 2013, which unfortunately was not successful. By the time he saw Dr. Samler in November 2014, both shoulders were symptomatic. She performed surgery on the left shoulder in March 2015 and on the right shoulder in August 2015.

[150] Dr. Leith was firm in his view that the pain and loss of use of the right shoulder would have been obvious and significant had Mr. Chappell torn the rotator cuff in the accident. Dr. Samler did not disagree with this premise but said that there are patients who do not notice this kind of pain immediately. Dr. Adrian also said that the pain would be variable in that some people can function with rotator cuff tears with little pain while others have severe pain. He said that it was not unusual for injuries like this to fluctuate and pointed out that the majority of rotator cuff tears do not require surgery. Even Dr. Waseem acknowledged that some rotator cuffs tears are asymptomatic.

[151] When Dr. Samler performed the surgery in August 2015 she described a small tear that just needed to be sewn together; she also discovered a defect in the cartilage on the head of the humerus, and imaging in 2012 and 2014 showed arthritis in the AC joint. Given the complexity of the conditions in these joints and tendons, I find it entirely plausible that Mr. Chappell did not experience acute pain in the right shoulder immediately following the accident. While I accept Dr. Leith's opinion that the majority of rotator cuff tears occur through attrition and are degenerative in nature, Dr. Samler found no evidence of any osteoarthritis in the shoulder prior to the accident, and the degenerative changes revealed subsequently are not in the same area as the rotator cuff but rather in the AC joint (noted as significant by November 2014) and the glenohumeral joint (noted as "very early" in May 2015).

[152] I disagree with Dr. Leith's suggestion that the "injurious event" noted in the physiotherapy records as a "twist or trip" in September 2011 was the probable cause of Mr. Chappell's right shoulder problems. I accept Mr. Chappell's evidence that this was a rather benign trip and I find it improbable that it could have had the causative

effect attributed by Dr. Leith. Such an “injurious event” pales in comparison with a motor vehicle accident in which an individual is thrown a considerable distance from a moving motorcycle. Both Dr. Samler and Dr. Adrian considered this improbable. Dr. Adrian did not consider the information about this “twist or trip” to provide a sufficient basis on which to draw any conclusions, but he did consider the right shoulder symptoms as recorded in the records to be consistent with an injury to the rotator cuff. Mr. Chappell’s shoulder pain was apparent before this “twist or trip”.

[153] In her report, Dr. Samler described the accident as a “high energy injury” that caused Mr. Chappell to land on his shoulders. This appears to have been an error. Mr. Chappell denied telling her this, and she testified that she was aware that he had landed on his buttocks, adding that this could be consistent with an injury to the shoulders.

[154] I find that Mr. Chappell’s pre-existing right shoulder condition and previous surgery made him vulnerable to re-injury and the accident materially contributed to the injury to his right rotator cuff, necessitating the surgical repair that was attempted in May 2013 and carried out in August 2015. I also find that the accident was not causative of the degenerative changes that were subsequently identified in the AC and glenohumeral joints.

[155] Mr. Chappell’s condition has since improved, but Dr. Samler was of the view that he will continue to have ongoing pain, some of which will be related to the osteoarthritic changes in the shoulder. Mr. Chappell said that the August 2015 surgery “resolved almost everything” in his right shoulder but he now has sporadic pain and clicking.

[156] Dr. Adrian thought it unlikely that Mr. Chappell would have spontaneously developed persistent and regularly occurring problems in his right shoulder had it not been for the accident. This opinion is too broadly stated given the complex nature of the problems in this shoulder. Due to his pre-existing condition and consequent vulnerability, I find that there was a measureable risk that Mr. Chappell would have re-injured the rotator cuff in any event, which I would assess at 20%. I find a more

substantial risk that Mr. Chappell would have had problems in his right shoulder overall, as evidenced by the other degenerative problems that are now present, although it is not clear if or to what extent these problems would have affected his level of activity. I assess this risk at 80%.

### *e) Mild traumatic brain injury*

[157] When Mr. Chappell was taken to Delta Hospital from the accident scene, he was not diagnosed with a mild TBI or concussion. His neurological assessment was normal and he was noted to be alert by both the ambulance crew and emergency staff. No CT or MRI brain scan was taken. Despite this, both Dr. Cameron and Dr. Miller diagnosed a mild TBI on the basis of Mr. Chappell's history of a lack of recall of the details of the accident and the events shortly thereafter.

[158] Dr. Cameron thought that Mr. Chappell probably lost consciousness briefly, although he said that was not necessary to meet the diagnostic criteria. He explained that any period of amnesia following an event is sufficient to diagnose mild TBI, and a person remains in a period of post traumatic amnesia until he is able to have continuous recall. He said this was so even where a person is assessed as normal on the Glasgow Coma Scale, is observed as alert, and is able to speak in full sentences and obey commands. Dr. Cameron also considered symptoms within the first two weeks following the accident.

[159] Mr. Chappell's reported symptoms were of decreased attention, concentration and memory, difficulty finding words, irritability, mood swings, angry outbursts and sleep disturbance. Dr. Cameron thought it probable that Mr. Chappell suffered these symptoms for several months after the accident but he did not have any prolonged cognitive problems as a result of the mild TBI. He estimated that the effects of the mild TBI probably wore off in a couple of months.

[160] Dr. Miller's opinion was essentially the same. He thought there was "sufficient evidence to suggest the probability of a mild TBI at the time of the accident" but he thought it unlikely that this was the cause of Mr. Chappell's ongoing cognitive problems.

[161] Dr. Dost disagreed that a diagnosis of mild TBI can be based only on a patient's lack of recall of an event in a history taken sometime thereafter. He maintained that Dr. Cameron did not consider other plausible explanations such as the attrition of memory with time, psychological amnesia, psychological stress reaction, or the effects of pain, each of which he said were more plausible explanations for Mr. Chappell's "non-specific physical and cognitive complaints".

[162] The defendant suggested that the opinions of Drs. Cameron and Miller are undermined by the unreliability of Mr. Chappell's evidence about the extent of his recall, submitting that he gave inconsistent versions to the doctors as well as to the court. I have considered all of this, and I do not find the inconsistencies to be substantial enough to render Mr. Chappell's evidence about this unreliable. First, we are dealing with evidence about a patchy memory, where Mr. Chappell has been required to repeat his history many times to many people over a long period of time. In these circumstances it may be difficult to discern what one actually remembers from what one may have reconstructed with other information. Second, we are dealing with statements made by a plaintiff to others as recorded by them, which may or may not be entirely accurate. Finally, there is actually little discrepancy between the versions of events provided by Mr. Chappell at trial or to these doctors. Essentially, Mr. Chappell remembered little of the accident other than seeing something to his left prior to impact and then lying on his back on the ground. He heard people around him and saw two off-duty firefighters. He did not remember details about the ride to the hospital in the ambulance or what happened there.

[163] It is unknown how long Mr. Chappell was lying on the road before the ambulance crew attended to him. Mr. Lowe, the one witness to the accident, described him as lying motionless on the road after flying through the air. In such circumstances, Dr. Cameron's opinion that Mr. Chappell probably suffered some alteration or loss of consciousness is entirely plausible.

[164] Dr. Dost's criticism of Dr. Cameron's opinion raises issues about the nature of memory that were not fully addressed in the evidence, and he made statements

(such as “Memory is reconstruction with gaps (physiological amnesia)”) that were not within the terms of his qualification as an expert in neurology.

[165] I accept the evidence of Dr. Cameron, supported by Dr. Miller, that Mr. Chappell probably suffered a mild TBI in the accident. However, the evidence does not establish that Mr. Chappell’s cognitive symptoms as reported to Dr. Cameron were present in the first few weeks after the accident. Certainly, Mr. Chappell was suffering from many things during that time, some of which may have included things like irritability and sleep disturbance, but it is not at all clear that these cognitive symptoms arose until some time later. I consider this lack of cognitive symptoms to be consistent with the opinions of both Drs. Cameron and Miller that this diagnosis is at the low end of the scale of mild TBI.

[166] Therefore, I find that Mr. Chappell suffered a mild TBI in the accident, but this did not cause significant symptoms and the condition resolved within about two months.

### *f) Depression, anxiety, cognitive problems*

[167] Dr. Miller diagnosed Mr. Chappell with major depressive disorder. It was his view that Mr. Chappell’s pain and physical limitations and the need to move from his job in suppression to a training position were the underlying causes of his symptoms of depression and anxiety. His prognosis was linked to the prognosis for his physical limitations and pain symptoms, and he stated that complete recovery appeared improbable.

[168] Dr. Kaushansky’s opinion was essentially the same. He thought that Mr. Chappell had developed a severe depression as a result of his circumstances since the accident, which has become chronic. His prognosis was poor given the primary issue of persistent physical pain with its very limiting consequences for Mr. Chappell’s lifestyle.

[169] Dr. Miller did not think that Mr. Chappell had any prolonged neurocognitive disorder. This was confirmed by Dr. Kaushansky’s neuropsychological testing. Both

attributed Mr. Chappell's reported cognitive difficulties with concentration, memory, processing information, drowsiness and work performance to his depression and the effects of his medications.

[170] There is no question that Mr. Chappell is very depressed. This was obvious from his presentation in court and his evidence, as well as the evidence of his wife and the other witnesses. This is a man who formerly loved his active life, loved his work as a firefighter, and was proud of his abilities to plan, create and build things. He now appears as a broken man, emotionally isolated, suffering in constant pain, ashamed of his physical limitations and his inability to cope, and desperate for solutions.

[171] The defendant does not dispute the diagnosis of depression but challenges whether the accident was a cause and if so, whether there was a measureable risk of depression in any event. This challenge is based on the underlying link between the depression and Mr. Chappell's physical conditions and need to leave the fire suppression division, and depends in part on what physical conditions are found to have been caused by the accident. This is a difficult argument to make in light of the defendant's position that this psychological injury is indivisible in the sense that it arises from pain issues related to both tortious and non-tortious causes. Under the principles in *Athey* and *Blackwater*, the defendants are liable for all injuries caused or contributed to by their negligence.

[172] In any event, the evidence shows that Mr. Chappell's depression became a problem by the end of 2012. As noted above, he was quite dysfunctional by then, avoiding his family, having intimacy problems with his wife, unable to do anything useful at home, and trying to cope with ongoing headaches, neck and back pain, and his "two big issues" - the right shoulder and left knee. As I have found all of these injuries to be causally related to the accident, it follows that the resulting depression is also causally related to the accident. The fact that Mr. Chappell subsequently developed serious conditions in his left shoulder and right knee that

were not related to the accident does not change the causation analysis, but must be considered in restoring him to his original position.

[173] I do agree with the defendant on the issue of Mr. Chappell's move to a training position in the fire department, but I do not think this affects the analysis of damages for depression. As I have found, Mr. Chappell was at risk of developing symptoms arising from degenerative changes in his left knee and right shoulder regardless of the accident, and he has since developed serious conditions in his right knee and left shoulder (which are described below). There is therefore a real and substantial possibility that Mr. Chappell would have had to move to a more sedentary position in the fire department in any event. However, absent the accident, this move would have been much later than June 2012.

[174] Would Mr. Chappell have experienced a major depressive disorder regardless of the accident? I think not. Had the accident not occurred, it is likely that Mr. Chappell would have dealt with each condition as he had before: one at a time. It was the constellation of injuries and symptoms that began a cumulative process that simply spun out of control for this man. His chronic back and neck pain has made it more difficult for him to deal with the injuries to his left knee and right shoulder. His rehabilitation has taken longer and his slow progress has worn him down. His move to a training position occurred within this context and at a time when he was clearly not ready for such a change.

[175] I find that Mr. Chappell's depression and anxiety were caused by the accident. While Dr. Miller indicated that the depression was in partial remission, it is obvious that Mr. Chappell remains seriously depressed and requires ongoing treatment. Dr. Miller recommended a continued course of anti-depressant medication and access to a pain and rehabilitation clinic. Dr. Kaushansky also recommended ongoing psychological support. All of these recommendations are well founded. While the prognosis is not positive, Mr. Chappell has been slow to access regular psychological counselling and while there are no guarantees, it is my view that his symptoms can improve with a concentrated treatment program.

**Summary of injuries**

[176] I find that Mr. Chappell sustained the following injuries as a result of the accident:

a) injuries to his feet and ankles which caused severe pain initially and substantially resolved within about four months;

b) soft tissue injuries to the back and neck with chronic, ongoing pain that affects his level of activity and his ability to cope with his other injuries;

c) carpal tunnel syndrome in the left hand, which caused significant pain over time but resolved within a month following carpal tunnel release surgery in November 2012, with an 80% risk that he would have developed carpal tunnel in his left hand in any event;

d) headaches that are cervicogenic in origin and have become chronic partly as a result of his long term use of pain medication;

e) injury to the previously reconstructed ACL in the left knee, which caused it to eventually dissolve and require replacement and which continues to cause intermittent pain, but with a 20% risk of damage to the reconstructed ACL regardless of the accident;

f) injury to the rotator cuff in the right shoulder that eventually required surgical repair, which has substantially resolved but continues to cause intermittent pain, but with a 20% risk of re-injury in any event and an 80% risk of problems in the right shoulder due to degenerative problems, some of which are now present;

g) a mild TBI that did not cause significant symptoms and resolved within about two months following the accident; and

h) severe depression and anxiety that developed over a year after the accident, is ongoing, and may improve with concentrated treatment.

[177] In addition to the degenerative changes in the right shoulder, Mr. Chappell has suffered problems in his left shoulder and his right knee that are not causally related to the accident. These conditions have also contributed to his pain and suffering as well as his vocational disability, so it is important to outline the timing and extent of these problems.

[178] Mr. Chappell did not report any symptoms with his left shoulder until October 2013, when he told Dr. Polyrhonopoulos that these problems had been worsening for about six months. An MRI in November 2013 revealed a partial thickness tear in the rotator cuff and severe osteoarthritis in the AC joint. By January 2014, Mr. Chappell said that the left shoulder was worse than the right. Dr. Samler did a surgical repair in March 2015, which improved the condition but did not produce a complete recovery. Mr. Chappell continues to struggle with left shoulder pain on a regular basis.

[179] There is little evidence about the right knee. Mr. Chappell said that it began to bother him sometime after he went back to work in January 2012 and after he started to be more active. Dr. Polyrhonopoulos noted right knee symptoms in July 2014 and subsequent investigation apparently revealed osteoarthritis in the medial compartment and other internal derangements. By November 2015 his symptoms had become severe enough that he is now scheduled to have surgery on that knee.

**Mitigation**

[180] The defendant suggested that Mr. Chappell failed to mitigate his damages by not following medical advice to attend counselling for his depression and not taking steps to lose weight.

[181] The onus is on the defendant to establish that the plaintiff could have avoided some or all of his loss. In a personal injury case, the defendant must prove (1) that the plaintiff acted unreasonably by failing to take a course of treatment recommended by medical professionals, and (2) the recommended treatment would likely have provided some benefit to the plaintiff: *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at paras. 53-56.

[182] I am not satisfied that the defendant has met the onus of proving a failure to mitigate.

[183] Mr. Chappell did see a psychologist from December 2013 to July 2014, but stopped when he went to Sheridan Lake. He was slow to resume counselling despite Dr. Polyrhonopoulos' recommendation to do so but he did find a new counsellor in March 2016 and has been seeing her periodically since. Dr. Miller thought it was possible but not probable that Mr. Chappell would have been better had he continued with counselling during this gap. Importantly in my view, the gap was caused by a decision made by Mr. Chappell and his wife that he would do better if he could spend time in what he called his "happy place" at Sheridan Lake. While Dr. Miller did not see evidence in January 2016 that this change had been beneficial, I find that Mr. Chappell was motivated to do what was necessary to improve his condition. I also find that he was capable, with the input of his wife, of making a rational decision about this, a factor to be considered in cases involving mental health issues: see *Castro v. Krause*, 2015 BCSC 2074 at para. 92.

[184] Mr. Chappell is a large man who has always been heavy, weighing approximately 320 pounds at the time of trial. Although he denied gaining weight since the accident, he acknowledged that his muscle mass has turned into fat, which shows a lack of conditioning. While some of the recommendations for treatment involve exercise and conditioning, the issue of weight was raised primarily by the defendant's experts who opined generally about the benefits of weight loss for alleviating joint pain. I accept this as common sense. However, there is no evidence that specifically establishes the extent of the benefit Mr. Chappell would have obtained in respect of his various injuries had he lost weight. Moreover, some of the experts acknowledged that the ability to lose weight can indeed be hampered by chronic pain and depression.

[185] Mr. Chappell testified that he has not refused any treatment offered to him and is willing to undergo any treatments recommended now and in the future. While he may have been slow to engage in some recommended programs, such as

counselling, there is ample evidence confirming Mr. Chappell's testimony that he has followed the medical advice provided to him to the best of his abilities. Accordingly, there is no basis to reduce his damages for a failure to mitigate.

**Non-pecuniary damages**

[186] An award for non-pecuniary damages is to compensate the plaintiff for pain, suffering, loss of enjoyment of life and loss of amenities. Each award is specific to the particular plaintiff and the circumstances of the case. Courts commonly take a number of factors into account when assessing these damages, such as the age of the plaintiff, the nature of the injury, the severity and duration of pain, the extent of any disability, the extent of emotional suffering and, more generally, impairments to the plaintiff's life, including impairments of family, marital and social relationships, physical and mental abilities and loss of lifestyle: *Stapley v. Hejslet*, 2006 BCCA 34 at para. 46.

[187] Mr. Chappell seeks non-pecuniary damages in the range of $150,000 to $180,000 on the basis of the cumulative effect of his injuries, the treatments and surgeries which have been required and the chronic and permanent effect of many of his pain symptoms. He submits that all of this has had a profound effect on his enjoyment of life, as he is no longer able to participate in the physical endeavours he did before, nor is he able to carry on his dream job as a firefighter in the suppression division.

[188] In support of this position, Mr. Chappell relies on five cases involving comparable multiple injuries where non-pecuniary damages were awarded in amounts between $130,000 and $200,000: *Hubbs v. Escueta*, 2013 BCSC 103; *Cebula v. Smith*, 2013 BCSC 1939; *Sirak v. Noonward*, 2015 BCSC 274; *Cornish v. Khunkhun*, 2015 BCSC 52; and *Tompkins v. Bruce*, 2012 BCSC 266.

[189] In *Hubbs*, the 43-year-old plaintiff suffered pain to the head, injuries to the neck, arm, shoulder, leg, knee, back, wrist and ankle, and low mood. The most serious injury was to the ankle, which required two surgeries and resulted in ongoing, permanent pain. His ability to continue working in a job that required

strength, agility and balance had been impaired. Given the active lifestyle of this plaintiff, the court considered his injuries to be life changing, and awarded $130,000 for non-pecuniary damages.

[190] Damages of $150,000 were awarded in *Cebula*, where the 48-year-old plaintiff suffered injuries requiring surgery to the neck and ankle and she had ongoing neck and back pain, headaches, ankle, knee and shoulder pain, tingling down the arm, muffled hearing, and swallowing problems. Her recovery plateaued and it was accepted that she would likely have functional and psychological limitations for the rest of her life. Her ability to return to work as an elementary school teacher was also impaired.

[191] In *Sirak*, the 45-year-old plaintiff suffered from herniated disks, soft tissue injuries, headaches, numbness and tingling in his hands and legs, back and neck pain. He had pre-existing degenerative spondylosis in his spine, but there was no evidence that it would have become symptomatic, and it was not clear whether his spine symptoms would improve with surgery. He was not able to return to his work as a painter and because of his limited education and functionality he had limited options in finding more sedentary work. The court awarded $160,000.

[192] An award of $160,000 was also made in *Cornish*. The plaintiff, aged 58 at the time of the accident, suffered from a major depressive disorder and a somatic symptom disorder. She had chronic pain, confusion and memory loss. The injuries had a significant effect on her life.

[193] *Tompkins,* involved more serious injuries but similar effects on the plaintiff's life, and the award was $200,000.

[194] On the basis that Mr. Chappell's injuries were generally as I have found them, the defendant submits that non-pecuniary damages should be in the $100,000 to $115,000 range, relying on the following cases: *Moussa v. Awwad*, 2010 BCSC 512; *Kralik v. Mt. Seymour Resorts Ltd.*, 2007 BCSC 258, overruled on other grounds

2008 BCCA 97; *Foster v. Kindlan and Pineau*, 2012 BCSC 681; and *Macdonald v. Hazel*, 2012 BCSC 2079.

[195] In *Moussa*, the 52-year-old plaintiff suffered injuries to his neck, left shoulder and left arm. Most of the injuries resolved, but even after surgery on the shoulder, the plaintiff continued to suffer pain and limitation in the shoulder joint. The impact of the injuries was significant, and the court awarded $75,000 for non-pecuniary damages.

[196] *Kralik,* involved a plaintiff with a shoulder fracture and a torn rotator cuff injury that completely disabled him for six months, caused him ongoing pain and disabled him from working as a painter. The award for non-pecuniary damages was also $75,000.

[197] The same award was given in *Foster*, where a 47-year-old plaintiff had soft tissue injuries to her neck, back, knee and shoulder and a labral tear to her hip that was unlikely to require surgery.

[198] Finally, in *Macdonald*, the plaintiff received $80,000 for injuries that included headache, neck, wrist and low back pain, jaw pain, SI joint pain, and a hip condition that was rendered symptomatic as a result of the accident. She had ongoing symptoms and her prognosis was guarded.

[199] In my view, the cases provided by the defendant were not very helpful because they generally involved less complex and fewer multiple injuries than those in this case. I assume this explains the defendant's position that non-pecuniary damages should be higher than the $75,000 range shown in these cases. In contrast, the cases provided by Mr. Chappell were reasonably comparable, so far as any case can be, especially where injuries are multiple and complex.

[200] Mr. Chappell's multiple injuries are serious and cumulative, the prognosis for a pain-free existence is poor, and their effect on Mr. Chappell's life has been profound. His colleagues and friends who testified described him before the accident as a positive, active "larger than life" individual who was "happier building a fence for

you than watching a movie". He was known for his strength. Tab Buckner, one of his oldest friends who worked with him in construction, said he was very physical, proficient and could think outside the box. Steve Raby, one of his fellow firefighters, described Mr. Chappell as "one of the biggest, strongest people" he knew, a happy person who liked to socialize, and "not a complaining kind of guy". Todd Roberts, another firefighter and hunting friend, said that Mr. Chappell organized all the gear for their hunting trips and all he had to do was "jump in the truck". Mr. Chappell's wife, Cheryl Ann, testified about the deep happiness and intimacy they had found together, the joys and challenges of blending their families and their common interests in home renovation projects. She said that her husband loved his work as a firefighter, could do "pretty much anything" when it came to renovations, and was very particular about his lawn and garden.

[201] The picture painted by these witnesses of Mr. Chappell after the accident stands in stark contrast to these descriptions. They all said that Mr. Chappell is no longer active, doing either construction work, hunting or social activities, and the most he does is to take an advisory role in projects. Many thought he was coping with what they perceived as pain and fatigue. Todd Roberts described his activity level as "next to none" and his personality as drastically changed, "he just seems his mind is elsewhere". Tab Buckner noticed that Mr. Chappell had difficulty getting in and out of chairs, could barely move at times, seemed angry with the world, and was not coping well with his wife and stepsons. Anthony Tanner, his oldest stepson, observed that the relationship between his mother and Mr. Chappell had become more strained. Mrs. Chappell described the course of Mr. Chappell's injuries and recovery since the accident, his obvious pain, his growing frustration and then sadness at his lack of progress, and the personal difficulties that developed between them as he became more irritable, impatient and argumentative. There is no longer any intimacy in their relationship, which is obviously a very difficult issue for both of them.

[202] I found all of these witnesses to be honest and straightforward, but Mrs. Chappell was quite exceptional. Throughout her testimony she was responsive

and respectful, and while of course she was supportive of her husband, she did not overstate the positive or understate the negative. Her evidence was entirely consistent with Mr. Chappell's evidence about the nature and quality of their lives together and what has happened to their relationship since the accident.

[203] All of this evidence is consistent with how I have already described Mr. Chappell: after five years of dealing with his physical injuries, he is a broken man, emotionally isolated, suffering in constant pain, ashamed of his physical limitations and his inability to cope, and desperate for solutions.

[204] Moreover, by June 2012, Mr. Chappell was forced to give up his career as Captain of Suppression and abandon his ultimate goal of becoming Battalion Chief of Suppression. This loss of a job he loved caused him great personal distress. As I indicated above, while there was a measureable risk that he would have had to do this at some point in any event, this change occurred much sooner than it would have absent the accident. I will come back to this when I address future loss of capacity.

[205] In these circumstances, I award of $150,000 for non-pecuniary damages, after taking into account the extent of the risks outlined above that some of Mr. Chappell's conditions would have occurred regardless of the accident.

## Loss of the capacity to earn income

### Past wage loss

#### *a) Firefighter employment*

[206] Before the accident, Mr. Chappell was engaged in steady, long-term employment as a firefighter with the Corporation of Delta. In circumstances like this, past wage loss should be measured by reference to the actual earnings Mr. Chappell would have received had his employment continued to the date of trial, with deductions taken for the income he did or should have earned during that period. Any hypothetical possibilities that might have affected his past earning

scenario must be real and substantial possibilities and not mere speculation: see *Cook v. Symons*, 2014 BCSC 1781 at para. 201.

[207] Although Mr. Chappell received sick leave and long term disability benefits for all past wage loss, the parties agree that these are collateral benefits that are subject to a subrogation agreement and are not to be deducted from an award. This is in accordance with the principles set out in *Cunningham v. Wheeler*, [1994] 1 SCR 359.

[208] Given the injuries I have determined were caused by the accident, there is little dispute about Mr. Chappell's past wage loss until June 30, 2014. With the exception of the discreet period of time he was required to be off work for the carpal tunnel surgery on his right hand, all of the sick days taken are attributable to the injuries related to the accident. The records from the Corporation of Delta establish a loss to June 30, 2014 of $80,255.63 for all sick days taken in relation to his injuries from the accident.

[209] With respect to the sick leave taken after June 30, 2014, the defendant accepts that Mr. Chappell was having difficulty performing his employment, but stresses that his employer did not require him to take sick leave. That may be so, but the issue of sick leave is one for a medical opinion, which was provided by Dr. Polyrhonopoulos on July 2, 2014.

[210] In my view, Mr. Chappell was justified in taking sick leave at that time. He clearly struggled with his work after he first returned in January 2012. He was still experiencing significant pain that he was trying to control with narcotic medication. Within six months he realized he was no longer able to continue as Captain of Suppression and he was able, through his seniority, to make a lateral move to the position of Captain of Training, a more sedentary position. About a year later, in July 2013, he was also able, for the same reason, to be promoted to Battalion Chief of Training.

[211] However, Mr. Chappell continued to struggle with various symptoms and had to take intermittent sick leave for the surgeries on his hands, right shoulder and the left knee arthroscopy. All of this took its toll on him. In early June 2014, the Deputy Fire Chief told him that his job performance was unsatisfactory, and by the end of that month he was “at his wit’s end” and obviously seriously depressed. When Dr. Polyrhonopoulos saw him on July 2, 2014, he thought that Mr. Chappell was unemployable due to the severity of his pain symptoms, his knee and shoulder problems and the need for orthopaedic surgeries, and his depression and anxiety. The doctor described this visit as a “defining day” when Mr. Chappell was experiencing a multitude of problems, and he recommended to the Delta Fire Department that Mr. Chappell should not work until released to do so by his orthopedic specialist following surgery. His note to the employer did not refer to the totality of the medical and emotional problems, some of which Mr. Chappell was apparently reluctant to reveal to his employer. I appreciate that by this time, Mr. Chappell was also experiencing symptoms in his left shoulder and right knee, but all of his other problems, particularly his depression, were clearly a major part of his symptomology.

[212] The defendant suggested that Mr. Chappell had no intention of returning to work after June 2014 because he had already sold his home in Cloverdale and purchased the home at Sheridan Lake. I do not accept this. As Mrs. Chappell explained, their plan was to use Sheridan Lake as a vacation home and a place for her husband to get some peace and quiet. At the end of June, they signed a lease for a home in Delta very close to the fire hall, and they moved in there July 15. However, by that time, Mr. Chappell had booked off work and was waiting for surgery on his left knee, so he spent most of his time at Sheridan Lake, returning to the lower mainland for his surgeries and periods of rehabilitation. By the following summer, Mrs. Chappell reluctantly moved to Sheridan Lake to be with her husband, but their intention, while unclear, is not to stay there for the long term.

[213] In my view, it is remarkable that Mr. Chappell was able to carry on with his employment for 2 ½ years. His tenacity in doing so demonstrates to me his

commitment to the fire department and his desire to continue working there. Since June 2014, Mr. Chappell has had surgery on his left knee (September 2014) and right shoulder (August 2015), and in between surgery on his left shoulder (unrelated to the accident). In February 2016 he went on long term disability. There is no medical opinion that his overall condition had improved sufficiently as of the time of trial to return to work, although Dr. Miller expressed the view that Mr. Chappell should try a graduated return to work.

[214] Accordingly, I am satisfied that Mr. Chappell is entitled to past wage loss that includes the period from June 30, 2014 to trial. I would not make any deductions for the period of time related to the left shoulder surgery given that the other problems were continuing throughout this period of time. The records from the Corporation of Delta establish a loss for this period of $273,168.50.

[215] The total past loss of income to trial is $353,424. This is a gross figure, and I leave it to counsel to calculate the net loss after tax.

***b) Construction income***

[216] Given my findings, Mr. Chappell's injuries causally related to the accident clearly rendered him unable to carry on with his side construction business, even though he has also suffered from other conditions. The primary issue here relates to the proof of this loss. Mr. Chappell never reported this income to the Canada Revenue Agency and was unable to produce any records related to his revenues and expenses other than a few pages of invoices. The defendant submits that the limited evidence provided is insufficient to prove any loss, or alternatively any such loss is minimal.

[217] Clearly, the court cannot countenance the failure of a plaintiff to honestly report income to the taxation authority, but there is no public policy basis to bar a claim for wage loss based on unreported income. One consequence of this failure to report is that the plaintiff will have a difficult burden to prove such a loss where there is no corroborating evidence such as tax returns and financial statements: see

*Iannone v. Hoogenraad* (1992), 66 BCLR (2d) 106 (CA) and *Wepruk v. McGarva and Butt*, 2006 BCCA 107.

[218] Mr. Chappell bases this past income loss claim on the actual earnings he would have received had he continued his construction work to the date of trial, but his evidence about this was vague. He said that on average he worked one to two days out of his four days off from the fire department and earned between $30,000 and $40,000 per year. He allowed that he worked less for others after he met Cheryl Ann in 2007, as he then focused more energy on renovating their own homes, but he maintained that his income after that would have been in the lower end of this range.

[219] Of the five invoices Mr. Chappell produced, one did not distinguish between materials and labour and the others included labour charges at $25 or $30 per hour for total amounts of $420, $630, $3,150 and $3,350. One receipt was undated; two were dated in June 2010, one in July 2010 and one in January 2011. The only other evidence about this income source came from Tab Buckner, who had worked with Mr. Chappell in construction in earlier years, and Steve and Kelly Raby, for whom Mr. Chappell had built substantial parts of their house in Lac La Roche in 2006 and 2007. However, Mr. Buckner said nothing about the amount of income they earned, stating only that the purpose of the side jobs was to supplement their income. Kelly Raby said that most of the times they went to Lac la Roche were work parties, where her husband would pay for all the food and drinks, and she understood that any amounts paid to Mr. Chappell were not substantial. Steve Raby did not know how much he paid Mr. Chappell, stating only that he would pay $500 or sometime $1,000 either at the end of a job or when they were up at the house.

[220] The evidence establishes that Mr. Chappell was competent and industrious, that he did work for others, and that he did earn some income at an hourly rate of $25 to $30. Considering Mr. Chappell's evidence that he worked on average one to two days per week, and Mr. Raby's evidence that he would pay him what could be considered nominal amounts for the work done, I do not consider his estimate of

$30,000 to $40,000 to be reliable. In my view, the evidence supports an estimate of earnings no more than $15,000 to $20,000 per year.

[221] The estimation of past earnings of $35,000 as claimed is $159,126 ($93,769 net of tax). Counsel for Mr. Chappell submitted that a reasonable award for past loss of this income would be 50% of the net amount. I consider a reasonable award for past loss of income to be 50% of the gross income, which is $80,000, and I leave it to counsel to calculate the net amount after tax.

**Future loss of capacity**

[222] An award for future loss of income is to compensate a plaintiff for his loss of earning capacity. This kind of loss is also proven, not on a balance of probabilities, but if the plaintiff establishes that it is a real and substantial possibility that he will suffer a future income loss: *Athey* at para. 27.

[223] General factors for courts to consider in assessing a loss of earning capacity were set out in *Brown v. Golaiy* (1985), 26 BCLR (3d) 353 (SC) at para. 8:

> 1. The plaintiff has been rendered less capable overall from earning income from all types of employment;
>
> 2. The plaintiff is less marketable or attractive as an employee to potential employers;
>
> 3. The plaintiff has lost the ability to take advantage of all job opportunities which might otherwise have been open to him, had he not been injured; and
>
> 4. The plaintiff is less valuable to himself as a person capable of earning income in a competitive labour market.

[224] These factors must be considered in the context of each case in order to determine what a particular plaintiff would realistically have done in the future had the injuries not occurred. If the plaintiff proves a real and substantial possibility of a future event leading to an income loss, that loss may be quantified either on a capital asset approach (where the loss is not easily measurable) or an earnings approach (where it is easily measurable): *Perren v. Lalari*, 2010 BCCA 140 at para. 32. This assessment should also take into account both positive and negative contingencies to be given weight according to their relative likelihood: *Cook* at para. 218.

[225] A future loss of capacity may be established even where a plaintiff continues in the same job and continues to earn the same income as he did before the accident: *Pallos v. Insurance Corp. of British Columbia* (1995), 100 BCLR (2d) 260 (CA); *Chang v. Feng*, 2008 BCSC 49. However, unless there is evidence that the plaintiff is disabled from performing some of his duties, or is unable to perform a realistic occupation, a future loss will not be proven: *Steward v. Berezan*, 2007 BCCA 150; *Perren*, at para. 32; *Kathuria v. Wildgrove*, 2015 BCCA 186 at para. 34.

***a) Firefighter income***

[226] Mr. Chappell claims a future loss of earning capacity on the basis that he is permanently disabled from working for the fire department in any capacity. While he admits that he is physically able, with accommodation, to do the job of Battalion Chief of Training, it is his depression and the consequences flowing from that which he says renders him incapable of returning to that position. The defendant says that Mr. Chappell is no longer disabled from returning to that position, has a secure position, and therefore has not proven a future loss of income.

[227] Clearly, Mr. Chappell is no longer capable of working as a firefighter in the suppression division. The Captain of Suppression work involves heavy physical demands that include prolonged standing, intermittent walking or running, climbing ladders, stooping, and low level task intensive postures when administering first aid. Cheryl Black, an occupational therapist who assessed Mr. Chappell for the purpose of a functional and work capacity evaluation, concluded that he does not meet the full scope of strength demands required for this position.

[228] This conclusion is supported by the medical evidence. Dr. Adrian was of the view that Mr. Chappell is permanently, partially disabled and not suited to employment that involves physical activity such as heavy or repetitive lifting, reaching above the shoulder, forceful pushing and pulling, prolonged walking, repetitive kneeling, squatting, stair climbing, or even prolonged sitting. Dr. Samler thought that Mr. Chappell’s ongoing problems with his shoulders will prevent him from vocations that require any form of physical activity, especially with overhead

lifting. My view is that would be so whether his problem was in one shoulder or both, in combination with all of his other accident-related problems.

[229] However, as I indicated above, there was a measureable risk that Mr. Chappell would not have been capable of continuing as Captain of Suppression at some point in any event. He has degenerative and age-related conditions unrelated to the accident, some of which have already manifested themselves. In my view, this risk had become a near certainty by the time of trial but it is not clear when he would have had to leave the Suppression Division absent the accident.

[230] I am not satisfied, however, that Mr. Chappell is no longer capable of working in the training division and returning to his position as Battalion Chief of Training. There is little, if any, medical opinion that Mr. Chappell is unable to do so, whether physically or mentally.

[231] Dr. Polyhronopoulos was of the view that Mr. Chappell was at a serious disadvantage in respect of his ability to advance his career as a firefighter. However, with respect to a more sedentary training position, he said only that there would be periods of time, due to intermittent episodes of neck or back pain, when Mr. Chappell would be unable to safely perform his duties. Dr. Kaushansky did not see Mr. Chappell as being competitively employable due to his severe depression and chronic pain but he did not specifically opine on his ability to return to his position as Battalion Chief of Training. Dr. Miller thought that Mr. Chappell should try a graduated return to work despite his depression.

[232] Only Cheryl Black concluded that Mr. Chappell does not meet the demands of the Battalion Chief of Training position. This was based on her assessment that he could not meet the full range of heavy strength demands and standing capacity and he could not manage the cognitive demands.

[233] On a strict application of work capacity demands, Ms. Black’s assessment is supportable. However, the Corporation of Delta’s Deputy Fire Chief testified that this position is largely sedentary and others would be available to assist with any

physical demands in the field, and the Manager of Human Resources confirmed that Mr. Chappell would be accommodated for any of his physical requirements. With respect to the cognitive issues, Ms. Black's opinion was based only on the testing she administered, which included a behavioural memory test and a modified multiple errands test. Although her results indicated some difficulties, this kind of testing is quite limited, and I do not consider Ms. Black to be sufficiently qualified to assess whether the problems she identified render Mr. Chappell permanently disabled from his position. To her credit, Ms. Black said that she would defer this issue to a neuropsychologist. In any event, despite these findings, Ms. Black was of the view that Mr. Chappell is capable of full-time employment within certain limitations and restrictions to accommodate his capacity.

[234] I am satisfied that Mr. Chappell has established a real and substantial possibility that he will suffer a future income loss. The evidence is clear that he has been rendered less capable as a result of his injuries. In addition to being disabled from working in the suppression division, he is disabled from performing some of his duties as the Battalion Chief of Training. I am not satisfied, however, that he is permanently disabled from performing all of those duties. Mr. Chappell said that he was very happy when he was promoted to this position and he thought he was doing well in the first six months. Dr. Miller thought that Mr. Chappell's psychiatric prognosis would probably have been better if he could have continued in his job.

[235] To address his depression, the essence of the recommendations from both Dr. Miller and Dr. Kaushansky is that Mr. Chappell requires a concentrated treatment program that includes continued monitoring on anti-depressant medication, ongoing psychological counselling, and active rehabilitation at a multi-disciplinary pain clinic. It is my view that with this kind of focused treatment, there is a substantial possibility that Mr. Chappell's psychological condition will improve sufficiently to allow him to return to his position as Battalion Chief of Training. I encourage him to do this, as my clear impression is that this man will be a happier one if he is able to make a successful return to work.

[236] The defendant submitted that with effective treatment, Mr. Chappell could return to work within one year. However, there is no medical evidence that assists me to determine how long this will take. In such a circumstance, how do I assess Mr. Chappell's future loss of capacity? Both counsel assumed an earnings approach, which makes sense here. In *Pallos* at para. 43, the court referred to various means of assigning a dollar value to the loss of capacity to earn income:

> One method is to postulate a minimum annual income loss for the plaintiff's remaining years of work, to multiply the annual projected loss times the number of years remaining, and to calculate a present value of this sum. Another is to award the plaintiff's entire annual income for one or more years. Another is to award the present value of some nominal percentage loss per annum applied against the plaintiff's expected annual income. In the end, all of these methods seem equally arbitrary. It has, however, often been said that the difficulty of making a fair assessment of damages cannot relieve the court of its duty to do so.

[237] In the circumstances here, I consider it appropriate to award Mr. Chappell his annual income for a period of approximately two years, to the end of 2018. This takes into account the positive contingencies that he may be capable of working sooner as well as the negative contingencies that he may continue to have difficulty with his depression for a longer period of time. It also takes into account the fact that Mr. Chappell will be disabled for up to six months due to his impending right knee surgery and rehabilitation, which is unrelated to the accident but which will likely have a negative effect on the progression of his treatment program for depression.

[238] The annual salary for Battalion Chief in Training in 2016 is $132,384. The present value of this annual amount to the end of 2018 is $317,589.

### *b) Construction income*

[239] Mr. Chappell claims a future loss of capacity to earn construction income on the basis that he would have carried on with this work until the age of 70. The defendant says that there is no future loss because Mr. Chappell would have been prevented from carrying on any construction projects due to his unrelated injuries.

[240] My view is that Mr. Chappell has established a substantial possibility of a future loss of this income stream but not to the age of 70. The wear and tear on this man's body from his work as a firefighter as well as all of his other activities has been quite significant, and due to the physical demands of construction work, I do not think there is a real possibility that Mr. Chappell would have continued to work for others beyond the age of 65, and if he did, he would not have continued at the same pace as previously. The approximate present value of an income of $17,500 per year until age 65 is $197,505. There are positive contingencies (he would have earned more) and negative ones (he would have earned less, and there is a measureable risk that he would not have been able to resume this work to the same extent or at all due to his degenerative and age-related injuries, particularly to the left shoulder and right knee). I consider the negative contingencies to be a more substantial possibility, justifying a deduction to this amount by 40%, for a loss of $118,503.

### *c) Pension*

[241] Mr. Chappell seeks compensation for a notional pension loss, based on the principles discussed in *IBM Canada Limited v. Waterman,* 2013 SCC 70. Because his pension entitlement under the Municipal Pension Plan was protected under the terms of his collective agreement, he says that such a "collateral benefit" should not accrue to the defendants. The defendant disputes this on the basis that the principles regarding collateral benefits do not apply in this circumstance since Mr. Chappell has not yet received his pension and has suffered no loss.

[242] The parties agree that Mr. Chappell will suffer no actual loss on the basis of an agreed statement of facts, which I summarize as follows:

a) From June 30, 2014 to February 16, 2016, Mr. Chappell received short and long term sick leave benefits, during which time he continued to accrue pensionable service, both employer and employee contributions to his pension plan continued, and his salary and cost of

living adjustments counted towards the five best years in calculating pension benefits.

b) Since February 16, 2016, Mr. Chappell has received long term disability benefits, during which time he continues to accrue pensionable service but he is not required to make contributions to the pension plan and his salary and cost of living adjustments do not count towards the five best years in calculating pension benefits.

c) While receiving long-term disability benefits, any losses to Mr. Chappell's pension entitlement are offset by the savings in pension contributions.

[243] The amount of this claim depends in part on the court's determination of when Mr. Chappell would have retired absent the accident and when he will actually retire and start collecting pension benefits. It is not necessary to make those determinations, as I have concluded that there is no basis for this claim.

[244] As I understand Mr. Chappell's position, the issue is whether he should be compensated for the pension loss he would have incurred had his employment benefits not indemnified him. He says the continuation of his pension entitlement is part of an employment benefit that should not be taken into account in calculating his damages. His estimated pension loss is $325,531 to $108,612 (based on a retirement age of 55 and 60 respectively).

[245] *IBM Canada Limited* involved a wrongful dismissal action in which the plaintiff was required to draw on his pension at the time of his dismissal. The issue was whether the receipt of those benefits reduced the damages otherwise payable for breach of contract. The court held that there should be no deduction. Cromwell J., for the majority, discussed the principles of "collateral benefit" or "compensating advantage" in relation to various kinds of payments. He defined a collateral benefit as "a gain or advantage that flows to the plaintiff and is connected to the defendant's breach" (at para. 15) and a collateral benefit problem as "whether some

compensating advantage that was in fact received by the plaintiff … should be taken into account in assessing the plaintiff's damages" (at para. 22).

[246] It is important, in my view, that before there can be any consideration of these principles, the plaintiff must have actually received a benefit, and that benefit must constitute some form of excess recovery for his loss. This is clear from the judgment throughout. For example, at para. 23:

> Not all benefits received by a plaintiff raise a collateral benefit problem. Before there is any question of deduction, the receipt of the benefit must constitute some form of excess recovery for the plaintiff's loss and it must be sufficiently connected to the defendant's breach of legal duty.

[247] In this case, Mr. Chappell has not retired and has not received any pension benefits; he simply retains the right to receive those benefits when he chooses to retire. That his entitlement to those benefits is not reduced due to the application of the sick leave and disability provisions in the collective agreement does not constitute a form of excess recovery. Thus no collateral benefits problem arises in the first place.

[248] Mr. Chappell submits that the employment benefits contained in the sick leave provisions in the collective agreement, which have negated a pension loss, constitute a collateral benefit or compensatory advantage that is akin to private insurance, within the principles set out in *Cunningham v. Wheeler* (cited above) and confirmed in *IBM Canada Limited*.

[249] There is no dispute here that the sick leave and long-term disability benefits contained in the collective agreement are collateral benefits that are not to be deducted from an award for loss of income. I also accept that any pension benefits received under the Municipal Pension Plan would likely fall into the category of benefits that would not be deducted from a damage award. *IBM Canada Limited* establishes that the receipt of pension benefits that are not intended to be an indemnity for lost wages, or where the plaintiff has made contributions to his entitlement, should not be deducted. However, these are different benefits that must be analyzed in their own right. *IBM Canada Limited* does not establish that a

collateral benefits problem arises where a plaintiff suffers no loss of entitlement to a pension right, whether that right is protected by sick leave or long term disability benefits or otherwise.

[250] The defendant's characterization of this claim as a "reverse" insurance exemption to the collateral benefits rule that attempts to create a loss where one does not exist is probably apt. A similar argument was rejected in *Wangert v. Saur*, 2013 BCSC 99. The plaintiff claimed a pension loss based on a contribution he had to make in order to maximize the amount of his pension. He argued that the collateral benefits principle applied so that his actual pension benefits should not be used to calculate his loss, otherwise he would be forced to share the benefits of his contributions with the defendant. Abrioux J. concluded (at para. 80) that *Cunningham v. Wheeler,* did not apply because the case did not involve the type of wage loss or disability benefits paid to a plaintiff under a plan of insurance:

> Rather, it involves the operation of CP Rail's pension plan and the calculation of benefits thereunder. In calculating the benefits, the retiree receives credit for monies actually earned together with notional credits for certain types of leave including being sick or unfit to work. There is no element of insurance. There is also no link or nexus between the pension amount paid and the alleged losses flowing from the injuries sustained in the Accident. The plaintiff's pension is not a "benefit" in the sense that term is used in *Cunningham v. Wheeler* and its companion authorities.

[251] While Abrioux J. did not have the benefit of the reasoning in *IBM Canada Limited*, his conclusion is consistent with Cromwell J.'s analysis.

[252] Clearly, none of the jurisprudence about collateral benefits addresses a benefit that had not in fact been received because the issue is whether such benefit should be deducted from a damage claim so as to prevent double recovery. In no case were these principles applied to compensate for a notional loss. In each case, the court must determine whether the plaintiff has received a collateral benefit or compensating advantage that should or should not be deducted, applying the principles set out in *Cunningham v. Wheeler* and *IBM Canada Limited*.

[253] Mr. Chappell has not received a collateral benefit that constitutes an excess form of recovery and is therefore not entitled to damages for his notional pension loss.

**Loss of housekeeping capacity & home maintenance, repair and renovation costs**

[254] A claim for loss of housekeeping capacity is for the loss of the value of work that a plaintiff would have performed, but which because of his injuries, he can no longer perform. The basis for such a claim is the loss of the ability to work in a manner that would have been valuable to himself and to others. Because it is the loss of a capacity (an asset) that is compensated, such an award does not depend on whether replacement housekeeping costs are actually incurred. An award may be quantified by assessing the cost to replace the plaintiff's services, but damages are typically modest, and care must be taken not to compensate for more than can reasonably be said to have been lost: *Kroeker v. Jansen* (1995), 4 BCLR (3d) 178, leave to appeal to SCC refused (1995), 11 BCLR (3d) xxviii; *McTavish v. MacGillivray et al.*, 2000 BCCA 164. The same principle applies to past and future claims of this nature.

[255] In *Kroeker*, Gibbs J.A. provided this caution at para. 29:

> There is much merit in the contention that the court ought to be cautious in approving what appears to be an addition to the heads of compensable injury lest it unleash a flood of excessive claims. But as the law has developed it would not be appropriate to deny to plaintiffs in this province a common law remedy available to plaintiffs in other provinces and in other common law jurisdictions. It will be the duty of trial judges and this Court to restrain awards for this type of claim to an amount of compensation commensurate with the loss. With respect to other heads of loss which are predicated upon the uncertain happening of future events measures have been devised to prevent the awards from being excessive. It would be reasonable to expect that a similar regime of reasonableness will develop in respect of the kind of claim at issue in this case.

[256] Mr. Chappell claims a loss of past and future housekeeping capacity in the amount of $100,000 on the basis that he is no longer capable of managing the outside yard work and some of the interior work. He also claims $50,000 to compensate him for his loss of capacity to perform his own home maintenance,

repair and renovation work. This was not framed as a claim for loss of housekeeping capacity but it appears to be based on similar principles, and it also appears to be a claim for a future loss only. The defendant did not challenge the legal basis for this latter claim, just the amount, and seemed to include it as a future care cost.

[257] In my view, the claim for home maintenance, repair and renovations falls within the claim for the loss of housekeeping capacity, as such damages are intended to compensate for the loss of the value of work that would have been done by the plaintiff himself. This is to be contrasted with a future care cost, which is intended to compensate the plaintiff for the value of services rendered to him.

[258] Home maintenance, repair and renovation costs have been included in claims for past loss of housekeeping capacity: see *Reynolds v. M. Sanghera & Sons Trucking Ltd.,* 2015 BCCA 232, where the court accepted that under *McTavish,* a plaintiff can be compensated for the value of home repairs, maintenance and improvements he would have performed but for the accident. They have also been included in claims for future loss of housekeeping capacity, but these claims have generally been very modest: see for example, *Beagle v. Cornelson*, 2012 BCSC 1934 ($5,000); *Mojahedi v. Friesen*, 2016 BCSC 1225 ($4,000).

[259] Therefore, I have considered these claims together under this head of damage.

[260] It is clear that Mr. Chappell has lost much of his capacity to do the outside yard work, home maintenance, repair and renovation work. He said that he used to do all of the yard and garden work, and his wife did the inside housekeeping, although he would often help her with things like window washing and vacuuming. Mrs. Chappell confirmed that her husband took responsibility for the outside work and she the inside, but they shared these responsibilities on occasion. Both testified about his many repair and renovation projects and his limitations in all these things since the accident, and I accept that evidence.

[261] Dr. Polyrhonopoulos opined that Mr. Chappell is likely to remain limited in household activities and Dr. Samler was of the view that his ongoing shoulder problems will affect his ability to perform regular household duties. I am satisfied that this would be so with problems in either one or both shoulders, in combination with his other accident-related injuries.

[262] Mr. Chappell quantifies these claims based on the recommendations of Ms. Black, who provided costs for gardening and yard care, heavier and seasonal housecleaning functions, home renovations and maintenance. These recommendations were made in the context of a report for future care costs. While an award for loss of housekeeping capacity may be assessed on the basis of the costs for replacement services, it is important to note that such an award is quite different from one for future care costs: see *O'Connell v. Yung*, 2012 BCCA 57 at paras. 64-67, and as noted above, the court must be cautious in making an award that is commensurate with the loss of capacity.

[263] Some of the replacement services recommended by Ms. Black are not supported by the evidence, such as heavier and seasonal housework (neither Mr. Chappell nor his wife testified about what kind of seasonal work he did) and some are quantified for very lengthy time period (to age 75). Moreover, Ms. Black thought that Mr. Chappell was able to contribute to regular weekly housecleaning, and I find this is so albeit with the limitations described above.

[264] Ms. Black estimated annual costs for yard care services at $4,200 to $4,800, home maintenance services at $1,940 to $2,435, and renovation services at $6,000 to $7,500 (based on 150 hours per year). She recommended yard care to age 75, home maintenance to age 70 and a reduced amount to age 75, and renovation services for three years. My view is that these estimates are high, there may be some duplication among these services, and they do not take into account the measureable risk that Mr. Chappell's non-accident related conditions would have prevented him from doing some or much of this work in any event.

[265] In these circumstances, I consider an award of $50,000 to provide fair compensation for the past and future loss of housekeeping capacity, which includes the future loss of capacity to do home maintenance, repairs and renovations.

**Future care costs**

[266] Future care costs are intended to compensate a plaintiff for expenses that are reasonably necessary for his future medical care. These expenses must be reasonable and they must be medically justified: *Milina v. Bartsch* (1985), 49 BCLR (2d) 33 (SC) at 84, aff'd 49 BCLR (2d) 99 (CA).

[267] To be reasonably necessary, items and services must be ones that the plaintiff is likely to use: *Izony v. Weidlich*, 2006 BCSC 1315; *Maltese v. Pratap*, 2014 BCSC 18. To be medically justifiable, courts will accept opinions from a variety of health care professionals, and while physicians are not required to testify about the necessity of all items claimed, there must be an evidentiary link between a physician's assessment of pain, disability and recommended treatment and the care recommended by another professional: *Gregory v. Insurance Corporation of British Columbia*, (cited above) at paras. 38-39. Additionally, common sense should inform these claims: see *Penner v. Insurance Corporation of British Columbia*, 2011 BCCA 135; *Travis v. Kwon*, 2009 BCSC 63; *Kallstrom v. Yip*, 2016 BCSC 829 at para. 429.

[268] It is important to note that an award for the cost of future care is notional and imprecise in nature. The court is to consider what care is likely in the plaintiff's best interest and calculate its present cost, with appropriate adjustments for contingencies: *Kuskis v. Hon Tin*, 2008 BCSC 862 at para. 163.

[269] Cheryl Black recommended future care costs for a number of things, including flare-up treatments, psychological counselling, exercise instruction, medications, occupational therapy intervention and a pain program. With some modifications, I consider these recommendations to be both medically justified and reasonably necessary. I do not consider her recommendations for vocational counseling and post-surgical support and rehabilitation to be appropriate given my finding that

Mr. Chappell is not permanently disabled from returning to his employment and the fact that the further surgery he requires is not related to his accident-caused injuries.

**Flare-up treatments**

[270] The evidence shows that Mr. Chappell has had the most success with physiotherapy and I agree with Ms. Black that provision for eight treatments annually is reasonable. This is an annual cost of approximately $600.

[271] The medical evidence does not address how long such treatments may be needed. Dr. Adrian recommended that physiotherapy be continued until Mr. Chappell reaches a plateau. Given the poor prognosis for a full recovery from all of his accident-related injuries, I think an award to age 65 is justified, the present value of which is approximately $7,000.

**Psychological counselling**

[272] Mr. Chappell seeks future costs for counselling of $2,000. I think that is too low given the seriousness of his depression.

[273] Mr. Chappell's current counsellor charges $90 per hour. If Mr. Chappell returns to the lower mainland I expect he will incur higher fees than this. Ms. Black advised that $200 is the fee recommended by the B.C. Psychological Association.

[274] I would base this award on monthly counselling sessions for two to three years and I consider $6,000 to be required.

**Exercise instruction**

[275] Mr. Chappell seeks an award of $12,000 for exercise instruction. All of the medical evidence supports ongoing exercise. Ms. Black's recommendation, based on six sessions with a kinesiologist and an annual pass to a gym or exercise facility, is entirely reasonable. Since some of Mr. Chappell's physical problems are not related to the accident, I consider a reasonable award to be $10,000.

**Medications**

[276] Mr. Chappell claims $50,000 for medications. In my view, this does not sufficiently take into account the fact that his extended medical benefits cover 80% of this cost to age 60 while he remains employed by the Corporation of Delta. Given this, as well the need for medications related to non-accident injuries, this amount must be reduced further and I consider an award of $25,000 to be reasonable.

**Occupational therapy**

[277] Ms. Black recommended the services of an occupational therapist for three months to assist Mr. Chappell with compensatory strategies to optimize his function at home and in the community. I think that Mr. Chappell could get significant benefit from this and Ms. Black's cost estimate of $4,946 is reasonable. I would round this up and award $5,000.

**Pain program**

[278] Access to a pain program is clearly needed. Ms. Black estimated this cost at $14,500, which is entirely reasonable. I would not add anything for travel costs in order to take into account the non-accident related injuries.

**Summary of future care costs**

[279] Accordingly, Mr. Chappell is entitled to future care costs as follows:

| | |
|---|---|
| Flare-up treatments | $7,000 |
| Psychological counselling | $6,000 |
| Exercise instruction | $10,000 |
| Medications | $25,000 |
| Occupational therapy | $5,000 |
| Pain program | $14,500 |
| Total | $67,500 |

**Special damages**

[280] Special damages have been agreed at $20,000. This amount does not include $3,500 for travel expenses associated with medical legal assessments, which the parties agree should be included in costs.

**Summary of damages**

[281] Mr. Chappell is entitled to the following damages:

| | |
|---|---|
| Non-pecuniary damages | $150,000 |
| Past wage loss | |
| Delta | $353,424 (gross) |
| Construction | $80,000 (gross) |
| Future loss of capacity | |
| Delta | $317,589 |
| Construction | $118,503 |
| Loss of housekeeping capacity | $50,000 |
| Future care costs | $67,500 |
| Special damages | $20,000 |
| Total (less tax on past wage loss) | $1,157,016 |

[282] The parties have leave to make submissions on costs.

"Fisher, J."