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1. *Dhillon v. Song, [2016] B.C.J. No. 564*

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Dhillon v. Song, [2016] B.C.J. No. 564

British Columbia and Yukon Judgments

British Columbia Supreme Court

New Westminster, British Columbia

C.J. Bruce J.

Heard: February 9-12, 15-19, and 22-25, 2016.

Judgment: March 21, 2016.

Docket: M128776

Registry: New Westminster

[2016] B.C.J. No. 564 | *2016 BCSC 486*

Between Jaswant Singh Dhillon, Rajwant Kaur Dhillon, Parwinder Kaur Gill and Gurkaran Singh Dhillon a Minor by his Litigation Guardian Gursewak Singh Gill, Plaintiffs, and Jun Song, Jun Ling Zhao, Yu Zuo Song and Harpreet Kaur Dhillon, Defendants

(205 paras.)

Case Summary

Damages — Physical and psychological injuries — Head injuries — Headaches — Considerations impacting on award — Degree of impairment — Credibility — Action by 35-year-old plaintiff passenger for damages for personal injuries arising from motor vehicle accident in 2008 allowed in part — Plaintiff required immediate craniotomy and emergency caesarean delivery — Sustained closed head injury and permanent scarring — Suffered mild intermittent post-traumatic headaches — No permanent cognitive deficits — No compensable wage loss as any impediment to her return to work was due to low back pain unrelated to accident — Earning capacity not impaired by continuing symptoms — Awarded $115,000 in non-pecuniary damages, $155 in special damages and $3,770 for costs of future care.

Damages — Types of damages — General damages — For personal injuries — Cost of future care — Special damages — Expenses and expenditures — Non-pecuniary loss — Pain and suffering — Action by 35-year-old plaintiff passenger for damages for personal injuries arising from motor vehicle accident in 2008 allowed in part — Plaintiff required immediate craniotomy and emergency caesarean delivery — Sustained closed head injury and permanent scarring — Suffered mild intermittent post-traumatic headaches — No permanent cognitive deficits — No compensable wage loss as any impediment to her return to work was due to low back pain unrelated to accident — Earning capacity not impaired by continuing symptoms — Awarded $115,000 in non-pecuniary damages, $155 in special damages and $3,770 for costs of future care.

Tort law — Negligence — Causation — Causal connection — Action by 35-year-old plaintiff passenger for damages for personal injuries arising from motor vehicle accident in 2008 allowed in part — Plaintiff required immediate craniotomy and emergency caesarean delivery — Sustained closed head injury and permanent scarring — Suffered mild intermittent post-traumatic headaches — No permanent cognitive deficits — No compensable wage loss as any impediment to her return to work was due to low back pain unrelated to accident — Earning capacity not impaired by continuing symptoms — Awarded $115,000 in non-pecuniary damages, $155 in special damages and $3,770 for costs of future care.

Action by the 35-year-old plaintiff passenger for damages for personal injuries arising from a motor vehicle accident in 2008. Liability for the T-bone collision was admitted. At the time of the accident, the plaintiff was eight months pregnant and was on maternity leave from her job as a dietary aide. The plaintiff suffered a blood clot in her brain, requiring an immediate craniotomy. She remained unconscious for several days. An emergency caesarean delivery was performed. The baby was born healthy. At trial, the plaintiff claimed she continued to suffer headaches, confusion, memory loss, soft tissue injuries to her neck, shoulders and low back, and right leg swelling and discomfort. She had scarring from the craniotomy and the caesarean delivery. The plaintiff did not fill her pain prescriptions and misled her family doctor. Her evidence regarding how long she was bedridden and her pain symptoms was inconsistent. In 2011, a functional capacity evaluation determined the plaintiff was able to return to work on a graduated basis. The plaintiff gave birth to her second child in 2011. She returned to part-time work in 2012. She stopped working in July 2013, claiming she was terminated when she refused to work full-time. Her employer testified that the plaintiff was terminated for continually calling in at the last minute to say she could not come in for her shift.

HELD: Action allowed in part.

The intermittent mild post-traumatic headaches the plaintiff continued to experience did not disable her from working. Some of her headaches were unrelated to the accident but were caused by her chronic sinusitis. The plaintiff had not suffered permanent cognitive deficits due to the brain injury. She had not established her low back pain or leg issues were caused by the accident. The plaintiff was awarded $115,000 in non-pecuniary damages. She had not suffered any past wage loss as she chose not to work due to her second pregnancy and thereafter any impediment to her return to work was due to low back pain unrelated to the accident. The plaintiff's earning capacity had not been impaired by her continuing symptoms. She was awarded $3,770 for future prescription costs. Her physiotherapy and chiropractic expenses were not compensable as they related to her low back pain. She was awarded $155 in special damages.

Counsel

Counsel for the Plaintiffs: Kevin D. ***Cowan***, Gulbahar S. Kang.

Counsel for the Defendants: Ewen C. Carruthers.

Reasons for Judgment

C.J. BRUCE J.

INTRODUCTION

1 This is an action for damages arising out of a motor vehicle accident that occurred on December 13, 2008. There were four plaintiffs, all of whom were passengers in one of two vehicles involved in the accident. The plaintiffs are all members of a family: Jaswant Dhillon and Rajwant Dhillon are the grandparents of the infant Gurkaran Dhillon, and Parwinder Gill is the infant's aunt and the daughter of Mr. and Mrs. Dhillon. The driver of the family's vehicle is the defendant Harpreet Dhillon, who is the infant plaintiff's mother and Ms. Gill's sister-in-law. The driver of the other

vehicle involved in the accident is the defendant, Jun Song. The two remaining defendants are the owners of the vehicle (Jun Zhao and Yu Song). By agreement of counsel, the claim of Gurkaran Dhillon, the infant plaintiff, is adjourned generally and I am not seized of this matter.

2 The defendants have admitted liability, jointly and severally, and Mr. and Mrs. Dhillon (Ms. Gill's parents) have settled their claims against the defendants. As a consequence, only the damage claim of Ms. Gill is in dispute.

3 There is no dispute about the circumstances of the collision. Ms. Dhillon was driving a Dodge Neon sedan on the evening of December 13, 2008. The collision occurred when Mr. Song, who was operating a Toyota minivan, turned left in front of the Neon and the two vehicles collided.

4 Ms. Gill was eight months pregnant at the time of the collision and she was seated in the rear seat of the Neon. At the time, Ms. Gill was on a maternity leave from her job as a dietary aide and a cook's helper at the Willingdon Care Centre in Burnaby. Although Ms. Gill was conscious immediately after the collision, shortly after arriving at Surrey Memorial Hospital she lost consciousness and was diagnosed with a subdural hematoma on the right side of her brain. This blood clot required an immediate craniotomy to relieve the pressure on her brain. Further, the hospital staff determined that the unborn child was in distress and immediately performed a caesarean delivery prior to the craniotomy. The child was born in a healthy state and remained at Surrey Memorial Hospital while Ms. Gill was transferred to Royal Columbian Hospital in New Westminster where she remained unconscious for several days after the craniotomy. The craniotomy successfully removed the blood clot and Ms. Gill was discharged from hospital on December 23, 2008.

5 Ms. Gill claims that she continues to suffer from the injuries occasioned by the accident including post-traumatic headaches, confusion, memory loss, difficulty with busy environments, soft tissue injuries to the neck, shoulders and low back, and right lower leg swelling and discomfort. Ms. Gill also has scarring from the craniotomy and from the caesarean delivery.

6 As a result of the injuries caused by the accident, Ms. Gill claims damages for pain and suffering; past wage loss and past diminished capacity to earn income; future loss of income earning capacity; the cost of future care; and special damages. The defendants agree that Ms. Gill is entitled to compensation for pain and suffering; however, they argue that she is not entitled to any compensation under the other heads of damage. Further, the defendants argue that the injuries Ms. Gill may have suffered to her low back and right knee and leg are unrelated to the accident.

CREDIBILITY

7 During the trial, it became apparent that Ms. Gill was not a reliable historian about events in her life. She repeatedly responded that she did not recall the dates, details and timing of events in direct and cross-examination. Moreover, Ms. Gill had almost no recollection of statements that she had made to any of the medical professionals that she met with or was treated by in the years since the accident. Even recent statements, including those made under oath in the trial, were beyond her ability to recall. Commonly Ms. Gill either adopted the notes made by the medical professionals or agreed that she "might have said" a particular statement noted. In addition, Ms. Gill has given inconsistent medical histories to the various medical professionals with whom she has had contact since the accident and, further, has given obviously incorrect information about her life to them. As a consequence, little of the history of Ms. Gill's complaints since the accident can be relied upon unless there is some corroboration of her evidence from other sources.

8 In addition, Ms. Gill's evidence has to be viewed with caution because it is apparent that she misled her family physician (Dr. Jawanda), as well as other medical professionals, about her use of prescribed medications for her headaches and her back pain and in regard to the treatment she received or sought. She also misled the court about the reason she left her employment at the Willingdon Care Centre in July 2013. It is of further concern that Ms. Gill's reports of pain in her low back and with respect to her headaches have been quite inconsistent over time. The pain symptoms appear to worsen as the years go by without any apparent explanation. For example, in

February 2015, she reported to Dr. Singh that her headaches were mild and intermittent and in March 2015, she reported worsening headaches and an increased use of prescription medication to Dr. Teal. Her reports of back pain have also been inconsistent in the same time frame; she reported being unable to stand or walk for more than two or three minutes to the occupational therapist (Ms. Sebastian) on April 20, 2011, while on April 16, 2011, she reported to her physiotherapist (Mr. Grewal) that she had low back pain with long periods of sitting and standing with forward neck flexion.

9 Ms. Gill's sister, Kulwinder Gill and her sister-in-law, Gurjot Gill, corroborated her evidence in some respects. I found Gurjot tended to exaggerate her observations of Ms. Gill's symptoms, and her recollection of the events, particularly when describing the sessions with Ms. Sebastian, was vague. I found Kulwinder's evidence to be vague and overgeneralized and thus mostly unhelpful. Kulwinder also appeared to have memory deficits when giving her evidence, particularly in cross-examination.

10 I did not find any credibility issues arising from the testimony of the experts called by both parties.

11 Ms. Sebastian, the occupational therapist assigned to Ms. Gill's case by ICBC, was also a credible witness; she provided her evidence in a straightforward, forthright manner. Ms. Sebastian did not testify as an expert; however, she was clearly not an advocate for either party. It was apparent that she disagreed with the views of the ICBC rehabilitation officer who retained her to act as Ms. Gill's occupational therapist and she advocated for her client with regard to insurance benefits. Ms. Sebastian also readily qualified her notes of the events in a manner favourable to Ms. Gill based on her independent recollection of Ms. Gill's state of health after the accident.

12 I also found Ms. Riar, who was Ms. Gill's supervisor at the Willingdon Care Centre, to be a credible witness. She was called as a witness for the plaintiff, and as such, any inconsistencies between her evidence and that of Ms. Gill must be resolved in her favour. The plaintiff cannot seek to discredit her own witness.

MATERIAL FACTS

A. Early History

13 Ms. Gill is 35 years old; she was born in India on September 17, 1980. Growing up she lived with her parents who owned a large farm. Ms. Gill was a hardworking daughter; she was energetic and helped her mother with household chores both before she left for school and after she returned home each day. She was a happy and healthy teen.

14 Ms. Gill was also a competent student. She graduated from high school and attended university, earning a Bachelor of Arts Degree in 2002 and Master's Degrees in History and Punjabi in 2004 and 2006. Her grades were in the 45 to 50% range but nevertheless passing marks. Ms. Gill's long-term goal was to become a teacher.

15 Ms. Gill's older sister, Kulwinder Gill, who trained as a registered nurse in India, immigrated to Canada in 1998. She trained as a care aide and obtained work at the Willingdon Care Centre. Kulwinder also learned English and testified at the trial without the assistance of an interpreter. Her husband, Gursewak Gill, has a construction business. In May 2006, Kulwinder sponsored her parents and Ms. Gill and they were all permitted to immigrate to Canada.

16 The entire family lived in a house in Surrey. Ms. Gill resided in the basement suite with her parents and Kulwinder and her family lived upstairs. Ms. Gill did not speak English, but Kulwinder obtained work for her at the Willingdon Care Centre as a cook's helper and a dietary aide. Although Ms. Gill still had plans to further her education and become a teacher in Canada, Kulwinder expected her to work and support herself before engaging in additional studies. Kulwinder testified that she counselled Ms. Gill to change her plans and consider becoming a care aide because she believed her sister was physically able to manage this type of heavy work. Ms. Gill testified that if she could not pursue a career teaching, she would have completed the care aide program.

17 Ms. Gill did not take ESL courses to improve her English or take any steps to further her education, either in the teaching field or as a care aide, prior to the accident in December 2008. There is also no evidence that she did any research regarding the qualifications and education required for a teacher or a care aide. Gurjot testified that she knew nothing of any employment or education plans Ms. Gill might have had.

18 Ms. Gill began working at the Willingdon Care Centre in July 2006. She worked full time between the positions of dietary aide and cook's helper. The cook's helper prepared the food for the cook and ensured the dishes and pots were cleaned and put away. The dietary aide prepared food trays, stacked them in large trollies and delivered them to the care aides who served the food to the residents.

19 Ms. Riar supervised Ms. Gill's work. Ms. Gill and Ms. Riar worked for M & K Food Services, which contracted with the Willingdon Care Centre to provide the meals for residents. Ms. Riar was the supervisor for three facilities. She testified that cook's helpers and dietary aides are in great demand in her business; they are hard to find.

20 In regard to the dietary aide and cook's helper positions, Ms. Riar testified that Willingdon has a relatively large kitchen with two food preparation stations at just below waist level. On each shift there is a cook and two helpers in the kitchen. She believed the work environment was not overly noisy or hectic except when meals were being served. There was also time for breaks between meals. The dietary aide is responsible for loading a large trolley with meal trays and two aides wheel it out to the care aides who serve the food to residents. A smaller trolley is used in the dining room for transporting food from the kitchen. There is an industrial dishwasher for plates and other items, but the pots are washed by hand in a deep sink. The lifting requirements, according to Ms. Riar's testimony, were limited for the cook's helper. The cook normally put away all her supplies and only occasionally asked the helpers to put away smaller items. The helpers were not required to lift full pots of soup or porridge but may have to slide them on the stove occasionally.

21 The job description for dietary aide was identified by Ms. Riar. She confirmed that the job required significant amounts of lifting, bending, stooping and stretching. However, she said the description contained every duty that could conceivably be performed and in practice some of the duties are rarely, if ever, required. She also testified that the dietary aides and cook's helpers are instructed to fill the bus pans and to carry only as much weight as they can manage safely, but acknowledged that the employees have to be efficient and during meal times it is very busy. As a consequence, the employees cannot make endless trips with lightly loaded bus pans back to the kitchen.

22 In addition to Ms. Riar's evidence concerning Ms. Gill's employment, there were two other reports describing the work duties. Ms. Sebastian prepared a worksite visit report on January 27, 2011, and described the two positions based on her observations, and after discussions with Ms. Gill and Ms. Riar, as follows:

> ***Cook's Helper*** - The main job duties of the cook's helper position include preparing and portioning out a variety of the day's menu items as determined by the Cook (eg salads, desserts, juices etc.). These tasks may involve lifting and transferring or carrying (up to 10 lbs) from all levels as ingredients are selected from the pantry and/or cooler shelves and taken to the food prep counter areas (approximately waist high) as well as constant bilateral hand tasking as the food is prepared. The cook's helper also must push the "Suzy Q" cart (which holds the hot food) out to the dining room and stand there for approximately 15 minutes to dish out the hot food on to plates which are then served to the residents (cook's helper does not serve the plates to residents, only prepares them). The cook's helper then clears the dishes from the tables using bus pans and takes them via the cart back to the kitchen where the dietary aide is responsible for washing them. ... The cook's helper must also wash the large pots and pans that are used for preparing meals in the large industrial sinks in the kitchen (some forward bending involved to reach into the sinks). The cook's helper is also responsible for cleaning out and wiping down the "Suzy Q" cart after serving the hot food.
>
> ***Dietary Aide*** - The position of dietary aide initially involves loading food trays with appropriate food items (approximately waist height) according to the dietary card on the trays for each resident, placing the trays on a "delivery cart" (floor to overhead positions) and then pushing the cart into the designated dining room.

> Once the carts are delivered, the dietary aide will serve coffee and tea for a short time period. It is then the dietary aide's responsibility to load the dishes (from the bus pans that the cook's helper has returned to the kitchen) into the automatic dishwasher for washing. He/she then unloads the clean dishes and puts them away.

23 Ms. Noel, a functional capacity evaluator with OrionHealth Rehabilitation & Assessment Centres, also prepared a job description for cook's helper and dietary aide with reference to Ms. Sebastian's description in the worksite report, the NOC job categories, and her own experience. Her report dated February 23, 2011, says as follows:

> The NOC (#6641) identifies the physical activity factors for Cook's Helper and Dietary Aide to include the following: working in multiple body postures (i.e. standing, crouching, stooping); upper limb coordination, and Medium strength demands. Ms. Gill's description of her work and findings from the work site visit report on file (dated January 27, 2011) are consistent with the NOC requirements with the exception of strength demands, where it is reported that the job demands are at a Light strength level.
>
> ...
>
> Although it was not identified in the work site visit report, based on my previous experience with assisting food service workers to return to work, Ms. Gill's position will likely require extensive amounts of neck flexion. Depending on the height of the work surface, there will be at least moderate neck flexion required during tasks such as food preparation, plating food, and hand washing dishes (as the industrial sink is likely below waist level).

24 On February 10, 2008, Ms. Riar authored a progress report commenting on Ms. Gill's performance. In all areas Ms. Gill more than met her employer's expectations. She was described as requiring minimal supervision and working accurately and thoughtfully. Ms. Gill always made time for extra duties and worked consistently and independently. She was conscientious in maintaining a clean, orderly and safe work area and remained calm under pressure. Ms. Riar testified that once the job duties were clear to Ms. Gill, she was very good at her work.

25 Ms. Gill described her work as very fast paced. The kitchen staff had to consistently meet the needs of all the patients at the centre during mealtimes. Thus the ability to work efficiently under pressure and to focus on one's tasks was essential. The work performed by Ms. Gill also required lifting and bending, as well as carrying heavy pots and utensils. Both the cook's helper and the dietary aide were described as physically demanding jobs. Although Ms. Gill picked up a little English while she worked outside her home, she testified that she was not proficient in the language and primarily spoke Punjabi within the family.

26 Ms. Gill enjoyed her work at the Willingdon Care Centre and easily managed the heavy work and relatively long hours. Even when she was pregnant, the work was manageable. Ms. Gill testified that she did not feel exhausted at the end of the day and she did not feel pain or stiffness in her back or shoulders after working each day or at the end of the week. Ms. Riar confirmed that she noticed no problems in her work while Ms. Gill was pregnant.

27 Ms. Gill earned $18,028 from her work at the Willingdon Care Centre in 2007. In 2008, she earned $22,349 and approximately $2,000 working for her brother-in-law's construction company. She performed bookkeeping services in the company's home office. Kulwinder testified that her sister was good at this type of work; she was efficient and organized.

28 In 2007, Ms. Gill became involved with Hira Gill, who is a cousin of Gursewak Gill. They married in March 2007 in India. After spending two or three months with her new husband, Ms. Gill returned to Canada intending to sponsor Hira as a new immigrant. Hira came to Canada as a visitor in early 2008 and Ms. Gill became pregnant with her first child. At this time, Ms. Gill was residing with her parents in the Surrey basement suite and her mother had agreed to provide childcare when she returned to work after her maternity leave. While on maternity leave, Ms. Gill planned to take an ESL course to upgrade her English proficiency and possibly take a training course to become a care aide. Due to the injuries sustained by her mother in the accident on December 13, 2008, she was unable to care for the new baby. In addition, Ms. Gill's injuries prevented her from engaging in any educational

programs. There is no evidence that Ms. Gill investigated the cost, duration or requirements for ESL and care aide training prior to the accident.

29 Ms. Gill commenced her maternity leave at the end of November 2008. She was eligible for a one-year maternity leave and EI benefits. In total her maternity EI benefits were $15,550. Before the accident intervened, it was Ms. Gill's plan to return to work full time at the Willingdon Care Centre after the one-year maternity leave.

30 At the time of the accident, Hira Gill was in India awaiting permission to immigrate to Canada. Because of the accident, he obtained permission to re-enter Canada on a temporary compassionate visa.

B. December 13, 2008 to January 2010

31 When Ms. Gill woke up in the hospital she felt empty and lifeless. She had no memory of the accident and was told that her daughter had been delivered by caesarean. At first she felt nothing because she was heavily sedated with pain medications; however, soon she felt pain all over her body and particularly in the area of the stitches on her head. When Ms. Gill learned that she had missed the birth of her daughter, she felt dry and empty inside and was extremely unhappy. Ms. Gill remained at Royal Columbian Hospital for ten days and her daughter stayed at Surrey Memorial. She expressed breast milk to feed the baby, but she did not see her or feed her.

32 Kulwinder testified that when Ms. Gill regained consciousness, she did not recognize her and had no memory of the accident. When Kulwinder told Ms. Gill about the baby, she appeared to be in shock and became extremely upset and then depressed. The entire family was very concerned about the possible complications arising out of the subdural hematoma and subsequent craniotomy. Because both her parents had been seriously injured in the collision, they were unable to care for Ms. Gill. As a consequence, Kulwinder took Ms. Gill to her home to convalesce after she was released from the hospital.

33 By this time, Kulwinder and her husband had moved to a different residence in Surrey. Ms. Gill stayed at her sister's home for several months until she travelled to India in July 2009. Both Kulwinder and Gurjot took time off work to care for Ms. Gill and the baby. In addition, a professional care aide retained by ICBC came to help Ms. Gill until April 2009. She came in the morning for four hours each day. Ms. Sebastian had to advocate for the continuation of the care aide services because she was primarily looking after Ms. Gill's baby so that Ms. Gill could rest. The ICBC rehabilitation officer in charge of the file was not inclined to continue these services because the care did not benefit Ms. Gill directly. He ultimately agreed to continue the services until mid-April 2009.

34 It is difficult to discern for how long Ms. Gill was bedridden after the accident. Kulwinder and Gurjot gave rather inconsistent time estimates and Ms. Gill's evidence was vague and her memory suspect. For some period of time she confined herself to the bedroom and required help walking to the bathroom. She breastfed her baby but was not able to change diapers or bathe the child. She experienced severe headaches and felt dizzy when standing. Her neck, shoulders and back were stiff and sore. Kulwinder assisted her sister by cooking her meals and helping her to the bathroom. Her sisters also cared for the baby. When Ms. Gill complained of sore muscles, Kulwinder massaged her back and shoulders. Kulwinder slept with her sister at night to keep her safe and help her to the bathroom. During this period, Ms. Gill was very sensitive to noise and would cry if Kulwinder's children or her own baby were too noisy. She continued to take pain medications and gradually increased the time spent out of bed. By the end of January 2009, Ms. Gill could spend two to three hours out of bed but she was not comfortable talking to anyone. Carrying on a conversation was difficult for Ms. Gill because she continued to have problems with her memory. Gurjot testified that Ms. Gill was a friendly, happy person before the accident, but during this early recovery period she was weak and did not want to talk to anyone.

35 Gurjot also testified about the cultural embarrassment Ms. Gill experienced due to the shaving of her head. Sikh women do not cut their hair and the shock of her shaved head was a significant embarrassment to Ms. Gill. Gurjot also testified that by January 2009, Ms. Gill could get to the bathroom on her own but did not do household activities such as cooking until about June 2009. For the first few months she did not read or watch television due to

the headaches. Gurjot provided Ms. Gill with a heating pad to relax her back and shoulder muscles because she was stiff all over her body.

36 On January 9, 2009, Ms. Gill saw her general practitioner, Dr. Jawanda, for an assessment of her C-section and the stitches from the craniotomy. Dr. Jawanda noted that she was healing quite well from the C-section and the right-sided hematoma surgery. Ms. Gill did not discuss her headaches or back pain on this visit. There was a follow-up pending with Dr. Lee who had performed the craniotomy.

37 On January 28, 2009, Ms. Gill saw Dr. Lee and he noted that overall she was doing well but continued to have headache pain and her family advised that she was forgetful. Her personality was described by the family members as normal.

38 Ms. Gill's first meeting with Ms. Sebastian was on January 14, 2009. Although Ms. Sebastian was able to communicate directly with Ms. Gill for the most part, she also had the assistance of Gurjot Gill if there was anything that needed to be clarified with Ms. Gill in Punjabi. Most of the other health professionals who met with Ms. Gill also said they were able to communicate with her directly in English. As a consequence, I prefer Ms. Sebastian's evidence on this point over Ms. Gill's testimony that suggested she did not speak to the occupational therapist directly. Kulwinder's evidence about Ms. Sebastian's visits is also suspect because it is apparent that Gurjot was the interpreter for most of the sessions rather than Kulwinder.

39 During the first meeting with Ms. Sebastian, Ms. Gill reported that she continued to have fairly significant throbbing pain at the surgical site and into her right eye and generally did not feel well. She was dizzy getting out of bed. However, Ms. Sebastian recorded that Ms. Gill could perform the activities of daily living independently and was not bedridden. Ms. Sebastian observed Ms. Gill walking in the home, and during their session she was seated in the living room. She could not care for the baby due to the constant headaches and the homemaking chores and meal preparation were done by her sisters. She also reported pain in her lower calves but Gurjot noted no cognitive changes or emotional problems. Ms. Gill continued to be very tired even after long periods of sleep. For pain Ms. Gill was taking Tylenol rather than a prescription medication. Ms. Sebastian counselled Ms. Gill to try walking more around the house to ease the muscle pain in her calves. Overall, given the serious nature of the injuries suffered by Ms. Gill in the accident, she was recovering well in Ms. Sebastian's view.

40 On February 2, 2009, Ms. Sebastian visited Ms. Gill again and Gurjot was present to help with translation. According to Ms. Sebastian, Ms. Gill reported continuing headache pain but it was reduced in severity. When asked to rate her headache pain Ms. Gill said they were now a 3.5 out of 10. Dizziness when getting out of bed had resolved and there was no mention of back pain. There was also no report of cognitive deficits or emotional difficulties by Gurjot or Ms. Gill. The pain in her lower legs had decreased since the last visit and she was getting up more. Fatigue was still a problem with the headaches and Ms. Gill said she continued to require the care aide's services for childcare.

41 On February 4, 2009, Ms. Sebastian provided ICBC with a progress report on Ms. Gill's case and itemized the following symptoms:

1. Headaches: Ms. Gill reports on-going headaches which originate from the surgery site and go anteriorly into her right eye. She states she feels throbbing and pressure in her head. Initially Ms. Gill reported that her headaches were constant and extremely intense (about 8/10 on a pain scale), however, at my follow-up session she reported the intensity of the headaches to have diminished substantially (now approximately 3.5/10 on a pain scale).
2. Right and Left Lower Extremities: Initially Ms. Gill reported pain in both her left and right calf muscles. However, this is also decreased significantly since my first visit.
3. Dizziness: Ms. Gill initially reported occasional dizziness particularly when getting up out of bed. This symptom reportedly seems to have resolved itself at this point in time.

4. Fatigue: Ms. Gill reports no problems with sleeping but that she feels extremely fatigued even after getting significant sleep.

42 In regard to functional capacity, Ms. Sebastian reported the following as of February 4, 2009:

> Ms. Gill reports she is independent in all aspects of self-care [washing, dressing and eating] and child care [with the aid of the care worker] at this point in time though continues to struggle in her ADL's due to her fatigue. She is currently receiving 4 hours of attendant care daily to assist her in this regard. She is able to sit and stand without difficulty and walks slowly for short distances only (mostly within the house) at this point in time. With respect to homemaking tasks she states her family is available to assist in this regard. She is not driving at this point in time.

43 On February 24, 2009, Ms. Sebastian met with Ms. Gill again. Ms. Gill was experiencing significant improvement in her fatigue levels and the headaches, which still were not resolved. She also reported to Ms. Sebastian pain in her lower legs that came intermittently. They talked about the care aide and Ms. Gill said it would probably be fine to end her services at the end of February 2009 because her husband was in Canada for another three months. She was also attempting more activity around the home including cooking and some childcare. There were still no cognitive issues reported by Ms. Gill or her sister-in-law.

44 By March 2009, Kulwinder testified that Ms. Gill had begun to walk independently but did not go outside and was not able to care for the baby beyond breastfeeding. She did not do any chores around the home and Kulwinder and her sister-in-law continued to help her with daily living activities. On March 25, 2009, Ms. Gill attended at Dr. Basra's chiropractic clinic for treatment relating to her cervical spine. Ms. Gill reported pain in her neck and shoulders and headaches. All movements were painful which she rated at 6 to 8 on a pain scale. Dr. Basra testified that on examination her cervical spine was in spasm on palpation and she had significant restriction in her range of motion. He treated Ms. Gill with muscle manipulation and she did not return for additional treatments until August 7, 2012.

45 On April 17, 2009, there was another follow-up visit with Dr. Lee who reported that while Ms. Gill was doing well, she still had some pain in her head and was still a bit forgetful. Her balance was satisfactory and there was no pronator drift. All of the CT scan reports showed full recovery without evidence of continuing injury to the brain.

46 On April 14, 2009, Ms. Sebastian met with Ms. Gill for the last time (until mid-2010) with the assistance of Gurjot. At this time, Ms. Gill reported that she still had the occasional headache once per week or once every two weeks. There was also occasional pain at the incision site. While she had no further leg pain and was independently doing personal care, she was still receiving help from her sisters for homemaking chores and childcare. The care aide was also coming two hours per day. Gurjot agreed that by this time Ms. Gill was managing all her activities of daily living related to personal care but she and Kulwinder still did all the housework and helped with childcare. Ms. Gill was quite content to give up the care aide because the family was there to help. I found Gurjot's evidence that Ms. Gill had daily headaches at this time to be quite suspect given the information provided to Ms. Sebastian that the headaches were now only intermittent.

47 On April 21, 2009, Ms. Sebastian reported to ICBC that there was significant improvement in Ms. Gill's functional abilities and symptoms as of her visit on April 14, 2009. Ms. Gill was currently managing independently in self care, childcare and homemaking tasks. (During testimony Ms. Sebastian agreed that this was not entirely accurate in light of her sisters' help and the services of the care aide). Ms. Sebastian reported that Ms. Gill's headaches reoccurred approximately every two weeks and there was minor pain in the incision sites occasionally. (Again not entirely accurate). There was also no pain in her lower legs as earlier reported. At this time Ms. Gill was not on any medications and Ms. Sebastian concluded that her services were no longer necessary.

48 Ms. Sebastian agreed that at this time Ms. Gill was not fully recovered from her injuries and was clearly not ready to return to work. She had not yet resumed her pre-accident activities at home and continued to require the assistance of her family members to care for her baby and for household tasks. She was, however, improving and

the services of an occupational therapist were not required at that time. The file was not closed but simply put on hold awaiting further instructions from ICBC.

49 Ms. Gill continued to receive maternity benefits throughout this period but not partial disability benefits from ICBC. Ms. Gill's husband was in Canada on a visitor's visa and there is some evidence he was working part time as a roofer. Thus I accept that at this time Ms. Gill was not well off financially.

50 On June 3, 2009, Ms. Gill reported reoccurring headaches to Dr. Jawanda and she prescribed Naproxen for pain at bedtime. Ms. Gill filled this prescription on the same day. On June 8, 2009, Ms. Gill consulted with Dr. Jawanda about her husband's positive HIV status and was advised to use condoms. Dr. Jawanda testified that Ms. Gill was dealing with this issue well and did not appear to be anxious about the matter. In a subsequent visit, Ms. Gill learned that she was not HIV-positive. Although the defendants argued the HIV situation was causing Ms. Gill's ongoing headaches or at least contributing to the headaches, I find there is no evidence to support such an inference.

51 On June 11, 2009, Ms. Gill had another follow-up visit with Dr. Lee and she reported headaches "at times". Although she also reported forgetfulness, Dr. Lee did not have concerns about any reoccurrence of the hematoma and anticipated that there would be further improvement. On June 30, 2009, Ms. Gill again reported persistent headaches to Dr. Jawanda. Later visits in July 2009 were unrelated to the accident.

52 On July 24, 2009, Ms. Gill travelled to India with her husband to spend time with his family and to introduce them to the new baby. She remained in India until November 23, 2009. She came back with her husband who now had permanent residency status and he began working full time. On their return, Ms. Gill and her husband lived with Kulwinder for a short time before moving to their own basement suite. Ms. Gill testified that the flights were very difficult for her because sitting for long periods brought on lower back pain. To relieve the pain she stood in the aisles for portions of the flight. She did not refer to any headache pain during the flight or during the visit in India. Nor did she complain of low back pain while in India.

53 On December 2, 2009, shortly after returning to Canada, Ms. Gill complained to Dr. Jawanda that she was still having quite a few headaches and had been experiencing these since the accident. She described a feeling of heaviness. Dr. Jawanda diagnosed muscle tension headaches and prescribed Elavil 10 mgs per day. Ms. Gill filled this prescription the same day and received 30 tablets in a 10 mg dosage. Dr. Jawanda also provided Ms. Gill with a note concerning her headaches to enable her to apply for EI sickness benefits, which were subsequently denied because she had already received the maximum amount in maternity benefits.

54 On December 24, 2009, Ms. Gill returned to Dr. Jawanda's office complaining of continuing headaches of the same type. She prescribed an increase in the Elavil to 20 mgs. Ms. Gill did not fill this prescription. Ms. Gill testified that she likely still had some Elavil from early December 2009.

55 Ms. Gill and Kulwinder testified that there had been stiffness and pain in the lower back since the early days after the accident. Gurjot could not confirm this evidence as she was only aware of stiffness throughout Ms. Gill's body. There is no evidence that a specific complaint of low back pain was mentioned to any health professional up to the end of 2009. While pain in both calves was reported to Ms. Sebastian, it does not appear that Gurjot, Kulwinder or Ms. Gill mentioned back pain to Ms. Sebastian between January and April 2009.

C. January 2010 to December 31, 2011

56 The first complaint of back pain recorded in clinical records is Dr. Jawanda's note from a visit on January 25, 2010. At that time Ms. Gill complained of upper and lower back pain. This complaint occurred shortly after Ms. Gill moved into her own basement suite and began doing housework and taking care of the baby without assistance from members of her family. Although this fact logically supports Dr. Caillier's conclusion that Ms. Gill's deconditioned state, brought on by inactivity due to the accident injuries, gave rise to mechanical low back pain once she returned to household tasks, Ms. Gill and Kulwinder testified that the low back pain was a specific

complaint in the early days following the accident. Ms. Gill advised Dr. Caillier that the low back pain began 15 to 20 days after the accident when she tried to get out of bed. On the other hand, Ms. Gill was not able to identify when the low back pain began when she was examined by Dr. Teal. As outlined earlier, Ms. Gill's recollection of events is quite suspect and cannot be relied upon without corroboration and there is little independent evidence to confirm either the onset of the pain in early January 2010 coincident with a return to household chores or the existence of low back pain shortly after the accident. I note that Dr. Jawanda's clinical notes do not identify an incident leading to the low back pain and Ms. Gill did not testify that the low back pain came on while she attempted household chores or childcare.

57 When she examined Ms. Gill on January 25, 2010, Dr. Jawanda found no abnormalities or reduced range of motion and diagnosed musculoskeletal injuries due to muscle tenderness on palpation. Dr. Jawanda recommended that Ms. Gill continue with her physiotherapy because she was under the impression that physiotherapy was ongoing at this time. However, Ms. Gill was not involved in any type of treatment at that time. Ms. Gill again complained of pain in her lower and upper back on March 9, 2010, and was told to continue with physiotherapy. Ms. Gill failed to advise Dr. Jawanda that she was not engaging in any physiotherapy at that time.

58 Ms. Gill had stopped taking Elavil, and she returned to Dr. Jawanda's office complaining of headaches on April 29, 2010. She was told to restart Elavil at 10 mgs. However, Ms. Gill did not fill any prescription for Elavil at this time and the last Elavil she purchased was on December 2, 2009.

59 In late May 2010, ICBC was considering whether to pay disability benefits to Ms. Gill. Ms. Gill's legal counsel had requested disability benefits be considered for her, and Dr. Jawanda had provided a medical note from December 2009 that indicated she could not work for another six to eight weeks due to headaches (notably not for low back pain). Some benefits were paid out but ICBC wanted Ms. Sebastian to re-assess whether Ms. Gill was still disabled and unable to work, and whether she required any further rehabilitation before deciding whether such benefits could be paid to her. On June 7, 2010, Ms. Sebastian telephoned Gurjot and advised her that the file was being re-opened and set up a meeting for June 14, 2010.

60 On the same day, June 7, 2010, Ms. Gill returned to Dr. Jawanda complaining of back pain and on examination she was found to be tender in the paralumbar area with a slightly decreased range of motion. She prescribed Flexeril and Naproxen and recommended physiotherapy. On the same day Ms. Gill filled both prescriptions. She also had her first physiotherapy session with Mr. Grewal at Singh Physiotherapy on June 7, 2010. His office is adjacent to Dr. Jawanda's in the same building. Ms. Gill's primary complaint was low back pain. Mr. Grewal was unable to do a complete examination for nerve damage and range of motion because Ms. Gill reported the pain was not bearable. However, range of motion as tested was substantially restricted and there was no detectable nerve involvement. She reported pain on palpation and he observed her bent posture and abnormal gait when she walked. Mr. Grewal diagnosed a lumbar muscle spasm. Ms. Gill continued to attend for physiotherapy sessions on a weekly basis until July 7, 2010. At the conclusion of these sessions Ms. Gill appeared to be managing better and saw some improvement in her back pain and flexibility. Mr. Grewal noted on July 7, 2010, that she was lumbar pain free. Home exercise was recommended along with massage therapy. By July 5, 2010, Ms. Gill was able to lift ten pounds from floor to waist five times and to carry ten pounds for ten metres, having lifted floor to waist. Ms. Gill testified that she would have liked to have continued with the physiotherapy; however, she could not afford to pay for the sessions.

61 On June 14, 2010, Ms. Gill met with Ms. Sebastian, and Kulwinder was present to help interpret. Ms. Gill reported intermittent headaches that could last up to a week. The headaches were characterized by pain behind the eyes and across the forehead and the temples. It felt like "heaviness in her head." The back pain was in the lumbar region and radiated into the upper back and shoulders. This is the first occasion that Ms. Gill reported memory problems when she was experiencing a headache. She also reported slower processing of information for the first time. Ms. Gill reported that Dr. Jawanda had prescribed muscle relaxants and painkillers. As she testified, Ms. Gill told Ms. Sebastian that she managed the cooking and cleaning and childcare by taking breaks; however, bathing the child was difficult due to low back pain. Her husband helped with the heavy tasks and with childcare when he

was not at work. Her mother-in-law was also now available to help out with the child as she was visiting from India for several months. Ms. Gill advised Ms. Sebastian that she was not ready to go back to work.

62 On July 17, 2010, Ms. Gill again reported headaches and Dr. Jawanda increased the dosage of Elavil to 20 mgs and Naproxen twice daily. Ms. Gill did not fill these prescriptions. She testified that she was not taking Naproxen every day. It is unlikely that Ms. Gill had Elavil left from December 2, 2009 unless she was not taking it contrary to Dr. Jawanda's advice. Ms. Gill testified that in these early days her husband was not working full time and the family could not afford to pay for her prescriptions. ICBC would sometimes reimburse her for prescriptions but payment was very slow. This is inconsistent with her evidence that her husband had full-time work when they returned from India in late November 2009. She had also received some disability benefits from ICBC and was purchasing other types of medication at this time quite consistently. There was no reference to low back pain during this visit, which supports a conclusion that the physiotherapy sessions had been successful.

63 In early July 2010, Ms. Sebastian contacted the Willingdon Care Centre to inquire about a job for Ms. Gill and they agreed she could come back as a supernumerary working as a dietary aide if she was able to do so. However, she had to be capable of all the required duties and they would support a graduated return to work. In a report dated July 8, 2010, Ms. Sebastian advised ICBC of her recommendations as follows:

1. ... It is recommended that Ms. Gill begin participation in an active rehabilitation program (or continue if this is the nature of her program at Singh Physiotherapy) in an effort to address her current complaints of back pain and condition herself toward increased functioning in her ADL's as well as a successful return to work. A 1:1 exercise therapy program supervised by a registered kinesiologist 3 times per week for the next 8-12 weeks which would include strengthening, range of motion and conditioning exercises as well as the incorporation of work simulation tasks when appropriate would certainly assist her in achieving this goal. ...
2. ... Given Ms. Gill's on-going complaints of significant and sometimes long lasting headaches, a follow-up with the neurosurgeon may be warranted. ...
3. ... OT services are recommended to monitor Ms. Gill's progress and facilitate the progression of the gradual return to work trial when deemed appropriate to do so by her family physician. ...

64 Between July 2010 and late March 2011, Ms. Gill participated in a variety of exercises in a supervised program designed to recondition her body and hopefully reduce her back pain. The exercise program included workouts at the gym under the supervision of a kinesiologist at the Newton Wave Pool. During the exercise program, Ms. Gill reported that her back pain was significantly reduced and less frequent. She continued to suffer from headaches but the exercises made her feel stronger and she noticed improvement in the back pain. The kinesiologist reported that Ms. Gill was compliant with the exercises and showed good effort.

65 On September 27, 2010, Ms. Gill reported to Dr. Jawanda that her back was better now that she was involved in the supervised exercise program and she did not report low back pain again to Dr. Jawanda until April 18, 2011.

66 It was in this time period that Dr. Jawanda referred Ms. Gill to Dr. Singh, who is a neurologist, for her reoccurring headaches. Dr. Singh saw Ms. Gill on November 15, 2010 and diagnosed her with a closed head injury and continuing post-traumatic headaches. However, because she reported mostly mild headache pain at that time Dr. Singh did not believe a prophylaxis was necessary to inhibit the headaches. She was advised to take Tylenol or Advil for pain relief and he suggested physiotherapy. At this time Ms. Gill advised Dr. Singh that she took Tylenol or Advil for headaches and had not tried any other medication except Elavil for about a month and did not find it helpful. Ms. Gill testified that this was true and acknowledged that she had not filled the prescriptions for other headache pain medication that Dr. Jawanda provided her, such as Naproxen.

67 Ms. Gill also continued to see Dr. Jawanda for ongoing headaches on September 27 and 30, 2010 and on November 22, 2010. She advised Dr. Jawanda that Tylenol was not helpful and Naproxen was mildly helpful.

However, Ms. Gill had not filled a prescription for Naproxen since June 7, 2010. Dr. Jawanda prescribed Zoloft 25 mgs in early January 2011. Ms. Gill did not fill the Zoloft prescription until March 2, 2011.

68 When Ms. Gill returned to Dr. Jawanda's office in early February 2011, she reported that the Zoloft was helping reduce the headache pain and the dosage was increased to 50 mgs. This was obviously untrue because Ms. Gill had not yet filled the prescription. There were visits with Dr. Jawanda in February, March and early April 2011 that appeared to be about unrelated medical issues.

69 Throughout this period (Fall 2010 to February 2011), Ms. Gill was also meeting with Ms. Sebastian who recorded that the headaches continued to be problematic, particularly after gym workouts, but the back pain was continuously improving with exercise. Sometimes she would miss gym workouts due to headaches. By March 2011, Ms. Gill reported to Ms. Sebastian readiness to begin a graduated return to work program at the Willingdon Care Centre.

70 On January 17, 2011, Ms. Sebastian had visited the worksite with Ms. Gill and prepared a review of the job demands of the cook's helper and dietary aide. She concluded, based on Ms. Gill's self-report and with input from the kinesiologist, that Ms. Gill could meet the job demands at a light strength level with an increased ability for dynamic and static standing and postural tolerances including bending and forward reaching. Ms. Sebastian recommended a gradual return to work, keeping in mind that headaches may continue to be a limiting factor even if she could perform the physical aspects of the job. The employer still took the position that only during the graduated return to work would Ms. Gill have modified duties. Thereafter she would have to be fit for all of the required duties.

71 As of early February 2011, Ms. Gill was lifting 20 pounds from floor to waist at the gym under the supervision of the kinesiologist, Mr. Bhambra. She reported to Mr. Bhambra that she was also going to the gym twice per week in addition to the weekly supervised session. It was determined that a functional capacity evaluation should be obtained before the return to work. At this time Ms. Gill told Ms. Sebastian that she was open to the graduated return to work even though her headaches continued to be problematic.

72 At the request of ICBC, Ms. Noel, who is an occupational therapist with OrionHealth, conducted a functional capacity evaluation of Ms. Gill on February 14, 2011. She noted good effort on the part of Ms. Gill. Despite finding Ms. Gill did not meet some aspects of the two jobs evaluated, Ms. Noel concluded that she was currently able to work part time (one-half to three-quarters) in the cook's helper and dietary aide positions with the potential to progress to full-time work. Ms. Noel also noted the difficulties presented by ongoing headaches and recommended adjustments to the return to work plan to address these problems:

> Although Ms. Gill demonstrated endurance for part time work, due to her on-going headache complaints and some observable signs of fatigue, I recommend that she start her GRTW at reduced hours (i.e. 2 hour shifts) and alternating days to start, with weekly progressions in hours and days worked. As Ms. Gill's overall performance speed was slow, it is recommended that she start her GRTW with job tasks that do not require time pressures. As indicated in the work site visit report, the employer requires her to be an extra worker during the GRTW; therefore she can start the GRTW with assisting with job tasks such as food preparation, serving coffee and tea to the residents and clearing the dishes from the tables which would be less time pressured.
>
> It is also recommended that the job tasks requiring moderate neck flexion are slowly introduced during her GRTW (for example, if dishwashing is regularly a 20-30 minute job task, she would start with 5 minute periods and progressively increase by 5-10 minutes per week). In addition, Ms. Gill would benefit from a work site assessment as to whether there are any possible ergonomic modifications that can be implemented to improve her neck positioning and postural tolerances (i.e. raising table surface used for food preparation, use of long handled scrubber for washing pots, use of a sit stand stool to reduce standing demands).

73 Ms. Noel also concluded that Ms. Gill had not demonstrated in her functional capacity assessment, any

symptom management strategies. Further education on this topic was recommended, which would include training about such strategies as micro-breaks, pacing, and stretching.

74 A graduated return to work program ("GRTW") was arranged for April 12 to May 20, 2011. Ms. Gill attended for her first shift on April 12, 2011 as a cook's helper. Ms. Sebastian noted that Ms. Gill did not have a headache that morning but she commented that her back felt sore and "locked up" when she woke up that morning. Ms. Gill was to shadow another employee assigned to the job. Ms. Sebastian was present for the first one-and-a-half hours of the shift and did not observe any pain behaviours by Ms. Gill. On April 14, 2011, Ms. Gill telephoned Ms. Sebastian and reported that she had such pain in her lower back that she could not walk or stand for more than two to three minutes. Ms. Gill did not attend for work that day and thereafter Ms. Sebastian's attempts to contact her were unsuccessful. On April 18, 2011, Ms. Gill went to work and advised her employer that she was not well. That afternoon she telephoned Ms. Sebastian and advised that her increased back pain led her to attend for physiotherapy on April 16 and 18, 2011. She also attended Dr. Jawanda's office on April 18, 2011 complaining of back pain. Dr. Jawanda testified that Ms. Gill attended her office that day with complaints of lumbar pain and it was tender upon examination. There were no complaints of headache pain.

75 The clinical records from Singh Physiotherapy indicate that Ms. Gill attended on April 16, 2011 complaining of lower back pain with sitting and standing for long periods and with bending forward activities. This appears to be a different history from that provided to Ms. Sebastian. Her range of motion was full apart from pain at the very end of backward and forward flexion. Mr. Grewal noted that Ms. Gill had weak abdominal muscles but there was no nerve involvement in the hips and spine. He diagnosed low back pain secondary to decreased abdominal strength. In cross-examination, Mr. Grewal agreed that Ms. Gill's back pain was minimal and consisted of a dull ache and some stiffness. Ms. Gill advised Mr. Grewal that she was not taking any medication for back pain. He also agreed that Ms. Gill's posture and gait were normal and that the sensory tests were normal. It appears irreconcilable that Ms. Gill had weak abdominal muscles a short time after her supervised exercise program ended. She may have continued to exercise at the gym on her own but there is no evidence to support this assumption and Dr. Caillier noted in her report dated March 10, 2014, that Ms. Gill did not feel comfortable in the gym environment and was only doing stretching exercises at home.

76 Ms. Gill returned for treatment on April 18, 2011. However, after advising the physiotherapist that she was pregnant, he counselled against further treatment and recommended that she undergo massage therapy through a specialist therapist. This was a recommendation from Dr. Jawanda. There is no evidence that Ms. Gill subsequently attended for massage therapy.

77 Ms. Gill attended for work on April 20, 2011, but experienced increased back pain at the end of the shift and did not return to work thereafter. On April 27, 2011, Ms. Gill reported lower back pain radiating into the hip region to Dr. Jawanda. Although this suggests sciatic nerve involvement, Mr. Grewal's tests indicated there was no sensory impingement. Dr. Jawanda prescribed extra strength Tylenol and further physiotherapy, which is inconsistent with Mr. Grewal's evidence that massage therapy was recommended. I note that there were several visits to Dr. Jawanda's office between September 2010 and April 2011, with no complaints of lower back pain.

78 On May 3, 2011, Ms. Sebastian contacted Dr. Jawanda who continued to support Ms. Gill's return to work provided she did not do any heavy lifting. Dr. Jawanda indicated that Ms. Gill was coming in soon and they would discuss the return to work. Dr. Jawanda did not recall this conversation and has no record of it.

79 Although Ms. Gill attended Dr. Jawanda's office on May 11, 2011, there is no indication in her clinical records that they discussed a return to work or back pain. Instead, Ms. Gill reported increased headaches and was prescribed Zoloft. However, Ms. Gill did not fill the prescription for Zoloft at that time or at any time before the end of 2011. Her last Zoloft prescription was filled on March 2, 2011. On May 18, 2011, Ms. Sebastian spoke to Ms. Gill and was advised that her headaches and low back pain continued to prevent her return to work. Although she advised Ms. Sebastian that she was now taking a new medication, this was obviously a misrepresentation of the facts.

80 Dr. Jawanda saw Ms. Gill on May 24, June 13, July 25, August 10, August 31, September 17, and October 18, 2011, but there were no complaints of low back pain during these visits. The primary complaint remained headaches. On October 4, 2011, Ms. Sebastian closed her file because she had not heard from Ms. Gill since May 18, 2011.

81 Ms. Gill gave birth to her second child on or about December 23, 2011. It was a normal birth without complications.

D. January 2012 to present

82 In the early months of 2012, Ms. Gill attended Dr. Jawanda's office with complaints of ongoing headaches. She was prescribed Naproxen and Elavil; however, Ms. Gill did not fill the prescription for Elavil. She purchased the Naproxen sometime after her appointment on February 8, 2012.

83 Notwithstanding some attendances for headaches, Ms. Gill's primary complaint commencing in early 2012 was tibia and fibula pain and swelling in her right leg. An X-ray taken on March 16, 2012 showed a slight thinning of the lateral main knee joint, but otherwise there were no abnormalities of the tibia or fibula or ankle. On June 26, 2012, a bone scan revealed soft tissue inflammation and active osseous remodelling within the right mid tibia medially. Although the X-ray evidenced bone healing after a recent trauma, Dr. Caillier and Dr. Jawanda agreed that "recent" meant within the past six to eight months and thus not likely related to the accident. The remodelling could also be due to an infection and, as a consequence, Dr. Jawanda ordered a CT scan.

84 The CT scan dated July 24, 2012 was inconclusive as to the cause of the new bone formation but there was a suggestion of either infection or neoplasm. A chest radiograph and an abdominal ultra sound were recommended. A follow-up CT scan on December 19, 2012 revealed a healed stress fracture in the medial tibial cortex, leaving chronic mature periosteal reaction over the surface of the tibia. There was no evidence of infection, tumour or osteoid osteoma.

85 Dr. Jawanda was unable to diagnose the cause of the stress fracture and referred Ms. Gill to Dr. Matthew, who is an orthopaedic surgeon. Dr. Matthew ordered an MRI and, in a consultation report dated January 9, 2013, he diagnosed an old stress fracture but was otherwise unhelpful in isolating the cause. Because the right leg was no longer giving Ms. Gill too much pain, and there were no mechanical symptoms, Dr. Matthew recommended some physiotherapy to strengthen the area and prescribed Diclofenac topical gel. It does not appear that Ms. Gill filled this prescription in Canada and she left for India a short time later. Dr. Jawanda testified that currently she is still unsure of the cause or precise nature of the tibia injury.

86 Throughout the summer and fall of 2012, Ms. Gill regularly saw Dr. Jawanda with complaints of pain in her right leg. There were also periodic visits due to headaches and low back pain. Dr. Jawanda continued to prescribe Naproxen and Elavil for the headaches but Ms. Gill did not fill these prescriptions. Although Ms. Gill testified that she did not use Elavil continuously and may have had some left from the last prescription she filled, there was no Elavil prescription filled after December 2, 2009. In cross-examination, Ms. Gill acknowledged that she misled Dr. Jawanda in regard to her use of these prescription medications for headache pain. She also testified that at this time the family could not afford to fill all of her prescriptions; however, in January 2013, Ms. Gill had sufficient funds for a trip to India. Her husband was also working full time and she began working part time at the Willingdon Care Centre in May 2012.

87 Later in 2012, Ms. Gill experienced flu symptoms, sore throat and sinusitis. Dr. Jawanda agreed that at times Ms. Gill's headaches are related to sinus infections but these headaches are located more in the sinus areas and are different from the "hat band" headaches that Ms. Gill has reported since the accident.

88 On March 21, 2012, ICBC asked Ms. Sebastian to re-open her file on Ms. Gill to attempt another graduated return to work program at the Willingdon Care Centre. Ms. Gill advised Ms. Sebastian that it was her intention to

return to work, but her mother-in-law was arriving from India in late April 2012 and thus she felt a May start date would be better for her family because of childcare concerns. In her assessment visit on April 5, 2012, Ms. Gill said that her back pain was the same but increased with activity. Headaches were described as returning every few days and she took Tylenol for pain and a prescription drug in the evening. Ms. Gill had not kept up with her exercises at the gym and was not otherwise regularly active.

89 When Ms. Sebastian contacted the Willingdon Care Centre, she was advised that only a part-time position was available for Ms. Gill in May 2012. Ms. Gill felt that part-time work was manageable if scheduled on alternate days. She wanted to work weekends on the early shift from 6:30 a.m. to 2:00 p.m. Ultimately it was Ms. Gill who negotiated her own return to work without any accommodations apart from shorter shifts to begin.

90 Ms. Gill went back to work on May 13, 2012, working four shifts of four hours' duration in a two-week period. Occasionally she worked five shifts in a two-week period. This schedule continued until November 24, 2012. Thereafter she consistently worked five shifts in a two-week period until January 2013 when Ms. Gill travelled to India. Ms. Gill reported back pain to Ms. Sebastian at the end of May 2012, but said she was managing at work. In August 2012, Ms. Gill saw Dr. Basra for chiropractic treatments on three occasions. Her complaints were cervical, mid-back and lumbar pain that was aggravated by prolonged sitting and forward flexion. At the end of the treatments there was not much improvement in the low back but the cervical pain had decreased.

91 Ms. Gill took a trip to India in early January 2013 and returned to work on April 16, 2013; she worked six shifts in a two-week period. Thereafter Ms. Gill worked ten shifts in some two-week periods to cover people off sick, but at other times she worked six to seven shifts in a two-week period. July 20, 2013 was Ms. Gill's last day at work. She testified that her employer required a full-time cook's helper and dietary aide and could no longer use her services part time. When she refused to accept full-time work, Ms. Gill was forced to resign. The record of employment indicates termination due to a refusal to work shifts. Ms. Gill testified that due to her headaches and her low back pain she was not able to work full time. However, Ms. Riar testified that Ms. Gill was performing her work without any signs of difficulty even when she worked close to full-time hours. Contrary to Ms. Gill's evidence, Ms. Riar testified that she was forced to terminate Ms. Gill's employment because she continually called in at the last minute to say she could not take a shift. The schedule was set about ten days in advance and the staff had an opportunity to choose the shifts they wanted to work. Ms. Gill would choose her shifts and then change her mind when it was too late to replace her. Ms. Riar denied that she had demanded Ms. Gill work full time.

92 There were a number of visits with Dr. Jawanda in the spring and fall of 2013; however, most of the complaints related to headaches and sinusitis. It was only in mid-September 2013, that Ms. Gill raised lumbar pain with Dr. Jawanda. She prescribed Elavil and Naproxen for headaches. Ms. Gill filled a prescription for Naproxen on September 10, 2013 and Elavil on August 1, 2013, which must have been prescribed in early July 2013.

93 In September 2013, Ms. Gill attended for chiropractic treatments on four occasions, complaining of right-sided SI joint pain rather than acute low back pain. In October 2013, she had three physiotherapy sessions with Mr. Grewal and her complaints were lumbar back pain and stiffness. He found a restricted range of motion and tenderness in the lumbar region with passive leg raising. The treatments improved her pain and she was given some exercises to do at home. In October 2013, Dr. Jawanda recommended exercise and stretching for the back pain and ordered an X-ray that showed no disc narrowing or other abnormalities.

94 Ms. Gill did not return to work after July 2013 even on a part-time basis. She continued to report headaches to Dr. Jawanda into the early months of 2014 and was prescribed Elavil again at bedtime. Although Elavil was prescribed on May 9, 2014, Ms. Gill did not fill this prescription until October 7, 2014. Thereafter she regularly filled prescriptions for Elavil (called Amitriptyline) throughout the balance of 2014 in 25 mg doses and this continued until June 2015. Toradol was also prescribed for headache pain in March 2015, but this prescription was not filled. In April 2015, Flexeril was prescribed for headache pain and Ms. Gill filled this prescription in May 2015. On June 22, 2015, Ms. Gill reported lumbar pain and was advised by Dr. Jawanda to take Naproxen and Flexeril. Ms. Gill reported to Dr. Jawanda, recurring headache pain on September 16, 2015 and required additional Elavil as she had run out. This prescription was not filled. It was not until January 11, 2016 that Ms. Gill filled a prescription for Elavil.

Thus it appears Ms. Gill attended Dr. Jawanda's office throughout the fall of 2015 with complaints of headache pain but did not fill the Elavil prescription until the New Year.

95 Ms. Gill did not attend for any further chiropractic or physiotherapy treatments and it does not appear that after she left work in July 2013 she engaged in a regular exercise program. However, Dr. Jawanda referred her to Dr. Singh again in November 2014 due to the ongoing headaches. Dr. Jawanda testified that headaches were always Ms. Gill's primary complaint and the low back pain did not stand out for her as a significant ongoing problem.

96 Dr. Singh's consultation report dated November 25, 2014, indicates that Ms. Gill continued to suffer from headache pain that was made worse by a sensation of dizziness that was not previously reported. She also related a feeling of numbness in her head associated with frontal pain, which she later reported to Dr. Caillier. On this occasion, Ms. Gill associated the headaches with anxiety rather than with exertion and sensitivity to sound and light as she had previously reported to Dr. Jawanda. Although Ms. Gill advised Dr. Singh that she was taking Elavil to prevent headaches, she also took 20 mg of Elavil at night for insomnia, which may explain why her Elavil prescriptions were regularly filled in 2014 unlike in previous years. Rather than post-traumatic headaches as diagnosed by Dr. Singh in November 2010, his impression was that the headaches were from stress, which was suggested by the description of forehead pain and tingling. Because he also felt there was a migraine component to the headaches, Dr. Singh prescribed magnesium and riboflavin.

97 Ms. Gill again attended for a consult with Dr. Singh on December 23, 2014, and she advised that the headache intensity and frequency had improved by 10%. Dr. Singh increased her dose of Elavil to 37.5 mgs. Her last consultation with Dr. Singh was on February 3, 2015, and at that time she reported that her headaches were now mild, if they reoccurred, and she had not needed to increase her Elavil consumption beyond 25 mgs.

EXPERT REPORTS

A. The Plaintiff's Experts

98 Dr. Jawanda is Ms. Gill's treating physician and has been so since September 2008. In her expert report dated January 20, 2011, Dr. Jawanda provided a diagnosis of chronic muscle tension headaches and a musculoskeletal injury to her low back arising from the accident. By January 2011, Dr. Jawanda concluded there was no longer evidence of any upper or lower back problems; however, her prognosis regarding the ongoing headaches was guarded:

> My impression is that Ms. Gill suffered from extensive injuries and has done remarkably well. Most importantly, she delivered a healthy baby via an emergency C-section. Also her head injury was dealt with in a timely fashion. The right-sided subdural hematoma was drained and evacuated so that she does not have any neurological deficits. Her residual problem from this motor vehicle accident is the fact that she does have these ongoing headaches. We have tried a variety of medications such as Elavil, most recently Zoloft, and the p.r.n. use of naproxen. That seems to work the best as a p.r.n. use of naproxen. My impression is that she has done remarkably well. She will probably continue to have these headaches and my prognosis for the headaches is guarded at this time. Only time will tell over the next couple of years how she will fare.

99 In cross-examination, Dr. Jawanda testified that she was unaware that Ms. Gill was not regularly filling the prescriptions she provided for the headaches and thus Ms. Gill was likely misleading her in regard to the consumption and effectiveness of these medications. However, Dr. Jawanda's report indicates that she was aware Ms. Gill was not always taking the prescribed Elavil. Dr. Jawanda agreed that her opinion about the severity and ongoing nature of the headaches may have to be rethought in light of Ms. Gill's sporadic use of prescribed medications. She continued to opine that the headaches reported to her by Ms. Gill were a post-traumatic symptom of the head injury she received in the accident.

100 Dr. Singh provided an expert report dated April 5, 2015, based on his four consultations with Ms. Gill since

November 2010. As a neurologist, he opined as to the cause of her headaches:

> Based on the information we have, that is my evaluation reports, Ms. Gill, prior to the motor vehicle accident of December 13, 2008, was in good health, fully functional. She was not known to have any medical conditions, was not on any regular medications. [She was taking prescription medications for a thyroid condition but this had no bearing on the injuries claimed to be caused by the accident.] December 13, 2008, she was involved in a motor vehicle accident and is amnesic as to what happened over the next three days and came to her senses at Royal Columbian Hospital. She did have a subdural hematoma, which was drained by Dr. Lee. We do not have those records, though.
>
> Based on available information, the motor vehicle accident is the direct cause of head injury, which led to subdural hematoma and the ongoing headaches.

101 It was Dr. Singh's opinion that Ms. Gill suffered a severe traumatic brain injury and likely has underlying cognitive deficits, which would have to be tested by a Neuropsychiatric evaluation. He recommended cognitive and physical rehabilitation. Dr. Singh did not believe any subsequent bleed was likely given Ms. Gill's young age, but he had a guarded prognosis for her ongoing headaches:

> Ms. Gill, to this date, continues to have headaches, which are posttraumatic. The headache prognosis is usually variable but I do believe she very likely has overlapping depression contributing to the headaches and, therefore, a Psychiatry evaluation would be of value. ...
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> ...
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> ... Specifically, there is a real possibility that the injuries will limit the patient's opportunities with respect to employment.
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> ... The cognitive impairment is likely subtle and it can affect her future employability; however, I would suggest that Ms. Gill be evaluated by a vocational and physical rehabilitation to assess her employability.

102 Dr. Singh testified that he disputes Dr. Teal's opinion that the headaches are entirely related to sinusitis. While at times Ms. Gill may suffer from a sinus headache, her description of the headaches in the "hat band" area and accompanying symptoms of heaviness and tingling suggest they are post-traumatic headaches. I note that Ms. Gill does not appear to have suffered from sinusitis until late 2012, which is long after the headaches began. Dr. Singh opined that the slight thickening of the mucus in one or two of Ms. Gill's sinus cavities on X-ray is common in the general population and does not indicate ongoing sinusitis. On the other hand, Dr. Singh did not provide an explanation for his later consultation reports from November 2014 and February 2015, wherein he diagnosed tension headaches triggered by stress rather than a continuation of Ms. Gill's post-traumatic headaches.

103 Dr. Caillier is a specialist in Physical Medicine and Rehabilitation and she provided two expert reports dated March 10, 2014 and July 29, 2015. When Dr. Caillier first saw Ms. Gill in January 2014, her complaints related to low back pain, right knee and lower leg pain and headaches. There were times when her thinking was not clear and this was associated with headaches and a freezing sensation in her head when she did paperwork or rushed around with activities. She also reported sound sensitivity with headaches. The headaches could be gone for a week but also could last two to three days.

104 Dr. Caillier opined that Ms. Gill suffered a traumatic brain injury as a result of the accident that was at least moderate in nature. She also recovered quite well from the injury with her only cognitive deficit being a reduced thinking capacity with headaches. She opined that the cognitive effects in the form of memory and decreased ability to concentrate are likely secondary to the headaches and that it is possible the headaches cause the visual difficulties Ms. Gill has when reading and watching television. The existence of one brain injury makes her susceptible and vulnerable to a subsequent brain injury even if it is mild. Dr. Caillier also opined that the headaches were post-traumatic and secondary to the brain injury and given their chronicity would likely continue into the future. The headaches described by Ms. Gill were likely to cause fatigue and reduce her cognitive functioning, memory and

attention. When she has a severe headache, Ms. Gill will have a reduced ability to participate in home, work and recreational activities.

105 In regard to the lower back pain, Dr. Caillier found this was related in a secondary way to the accident:

> It is my opinion that as a result of the motor vehicle accident of December 13, 2008, Ms. Gill became physically deconditioned. With this, there was a loss of strength, endurance, and flexibility through the low back, core, pelvis and hip regions.
>
> It is my opinion that she remains physically deconditioned. There is weakness of her core and hip musculature. This is likely increasing her susceptibility and vulnerability to worsening of her lower back pain when she is involved in activities of a repetitive nature, such as repetitive bending, heavier lifting and carrying, heavy impact activities, as well as sustained posturing.

106 Dr. Caillier noted that the back pain improved while Ms. Gill was involved in the exercise rehabilitation program; however, she no longer went to the gym or otherwise engaged in strength and endurance exercises. The stretching and movement exercise that Ms. Gill did at home each day was not sufficient to improve her physical conditioning for work or daily chores at home. Dr. Caillier supported her opinion with the lack of any history of back complaints prior to the accident and evidence that she was able to work in a physically demanding job without complaints prior to her maternity leave in late 2008. Dr. Caillier testified that the delay in the onset of low back pain coincided with Ms. Gill's resumption of homemaking chores when she moved to her own apartment in early 2010.

107 In terms of a prognosis, Dr. Caillier opined that the back pain would continue into the foreseeable future in view of its already chronic nature. Further, Dr. Caillier opined that Ms. Gill was now susceptible to a worsening of her lower back condition if she sustained a subsequent injury.

108 It was also Dr. Caillier's opinion that the lower back condition limited Ms. Gill's ability to engage in activities that required sustained posturing, repetitive bending, heavier lifting and carrying, heavier pushing and pulling, as well as heavy impact activities. Further, if Ms. Gill participated in a reconditioning supervised exercise program, Dr. Caillier believed that these limitations would decrease provided she continued on with the strengthening and endurance exercise program. She could also return to part-time work if she became reconditioned through an exercise program. However, due to the lack of success in the last attempt to return to work, and the lengthy time off work entirely, Dr. Caillier's opinion was that a return to full-time work is unlikely.

109 In addition, Dr. Caillier opined that the accident caused an injury to Ms. Gill's right leg:

> Ms. Gill sustained an injury to her right lower leg region as a result of the accident. There was bruising. There was swelling. The right lower leg is less painful but continues to have right knee pain. The knee pain appears to involve the medial aspect of her knee or the inside of the knee. Her knee examination today is benign.
>
> It is my opinion that the discolouration involving the anterior lower leg region on the right is likely permanent and related to the MVA assuming that this area was injured in the accident.

110 Dr. Caillier deferred to an orthopaedic surgeon the question of whether the fracture and remodelling in the right lower leg was related to the accident. In any event, Dr. Caillier did not believe the pain in this region was likely to restrict her activities provided Ms. Gill completed a supervised exercise program and strengthened her quadriceps muscles.

111 Lastly, Dr. Caillier referred to the permanent scarring from the C-section and the craniotomy. The deformity of the skull was tender and this would likely be chronic.

112 In a report dated July 29, 2015, Dr. Caillier provided an updated opinion on Ms. Gill's ability to return to full-time work. In providing her opinion, Dr. Caillier relied on Mr. Hosking's functional capacity evaluation from May 12,

2015; she did not examine Ms. Gill. Dr. Caillier's opinion is as follows:

> If there is significant improvement in her physical conditioning translating to improved management of her symptoms and lessening of the flares of pain when engaged in sustained posturing or heavier-based activities, in my opinion, it is possible that she will be able to return to work within a full-time capacity but at the very least she will be able to return to work within a part-time capacity within her previous occupation.
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> It remains my opinion that she is capable of working in some capacity and working within a sedentary to light capacity is also an option for her but, again, language barriers would be an issue. I am in agreement with Mr. Hosking that she would have to likely work with an occupational therapist or that of a vocational rehabilitation consultant in order to assist with this.

113 Dr. Caillier testified that although Ms. Gill had already participated in a supervised exercise program, she required a program that was specifically designed for back to work conditioning and one that addressed Ms. Gill's particular physical deficits. Dr. Caillier was also concerned that a successful and sustained return to full-time or part-time work for Ms. Gill depended upon the extent to which her headaches could be managed. She also agreed with Mr. Hosking that eye strain may be playing a role in the headaches Ms. Gill experiences when she reads or watches television.

114 Dr. Schmidt is a neuropsychologist who evaluated Ms. Gill with respect to her current psychological and neuropsychological status subsequent to the accident. In his report dated November 16, 2015, Dr. Schmidt summarized his interviews and testing process with Ms. Gill. Ms. Gill reported primarily pain symptoms since the accident and denied any change in her psychological functioning. However, she reported developing problems with anxiety typified by shortness of breath around the time she returned to work in 2012 and now this occurred daily. She also reported difficulties focusing and sustaining her attention and this was associated with headache pain which was present two-thirds of the time. Getting to sleep was problematic due to anxiety and I note that Ms. Gill had been taking 20 mgs of Elavil for sleep.

115 Based on the tests administered by Dr. Schmidt, which were quite limited due to language and cultural barriers, it appeared that the only cognitive deficit that could be detected related to the ability to process and analyze visuoperceptual information. This area of functioning refers to the person's ability to perceive and interpret information that is visually presented. It includes the ability to recognize objects and faces, to determine their positions and movement in space, to perceive visual patterns and to analyze visual information. Ms. Gill also showed subtle but consistent weaknesses in executive functioning, which was not further described. Notably he did not find any memory deficits based on the tests administered to Ms. Gill.

116 While it was Dr. Schmidt's opinion that Ms. Gill suffered a neuropsychologically significant traumatic brain injury in the form of these subtle deficits in executive function and visual perception, he did not believe that these deficits were affecting her daily life or precluding her from returning to the type of work she was doing before the accident. If she decided to retrain in a field that required pattern construction (such as a seamstress) there may be difficulties. However, if she continued in relatively unskilled, low cognitive demand jobs, he did not expect the weaknesses would have any impact on her performance. Lastly, Dr. Schmidt recommended that Ms. Gill seek treatment for her depression and anxiety from a Punjabi-speaking psychologist.

117 Mr. Hosking is a physiotherapist who is trained as an expert in functional capacity evaluations. He assessed Ms. Gill's functional capacity as of May 5, 2015 and the report of the results of the assessment is dated May 12, 2015. Mr. Hosking was of the opinion that while Ms. Gill demonstrated the capacity for medium strength occupations based on tests for lifting, carrying and pushing/pulling, she had a tendency to fatigue with the physical activity requiring prolonged standing and stooped standing positions. Because standing is a critical work demand in her jobs as a cook's helper and dietary aide, Mr. Hosking concluded that she did not meet the requirements for these jobs. In addition, he found that Ms. Gill demonstrated reduced capacity for sustained reaching overhead due to reports of bilateral neck pain and exacerbation of headache pain. In regard to low back pain, Ms. Gill advised that this was well controlled with an external support belt.

118 Mr. Hosking concluded that a significant underlying cause of Ms. Gill's inability to meet all of the job requirements for cook's helper and dietary aide was her lack of conditioning and, in particular, poor lumbar-pelvic and hip muscle strength. The fact that the belt controlled her low back pain gave support to Mr. Hosking's conclusion that Ms. Gill had weak core muscle strength.

119 The lack of conditioning and the unknown factor of possible eye strain (related to the development of headache pain) presented barriers to Ms. Gill's successful return to full-time and part-time work in her previous occupations. At p. 5 of his report, Mr. Hosking says:

> Ms. Gill presents with sufficient physical strength to meet the physical load demands of her pre-MVC occupation on an intermittent or occasional basis. She is very deconditioned, however, evidenced by poor posture, poor aerobic capacity and signs of poor lumbo-pelvic muscle stability. These physical deficits are reflected in her poor durability for repeated and prolonged activity. ... From a physical perspective, and based on the observed performance in this FCE, the probability of her returning to gainful employment is high. However, her ongoing reported headaches and associated symptoms such as "eye strain" likely present a barrier to her complete and full participation in full time work. ... The presence of headaches does introduce an element of uncertainty to the extent to which she may expect to function normally in the workplace.

120 It is quite troubling that Ms. Gill was unable to provide Mr. Hosking with an accurate history of her treatment since the accident. She overestimated the number of physiotherapy sessions since the accident and did not recall a seven-month exercise rehabilitation program in 2010 and 2011 under the supervision of a kinesiologist. She also misled Mr. Hosking in regard to the reason for leaving her job in 2013, and Ms. Gill demonstrated less than full effort in the grip tests administered by Mr. Hosking. Further, while heart rate data suggested that Ms. Gill could lift greater than 30-pound weights, her core muscle weakness precluded the safe lifting of heavier objects particularly when reaching overhead. There was also demonstrated right knee swelling at the end of the test day.

121 From my reading of Mr. Hosking's report and based on his testimony, if Ms. Gill was not in such a deconditioned state of health and wore her lumbar support belt, the only barrier to her full-time return to work as a dietary aide and a cook's helper would be the possibility of headache pain.

122 Ms. Craig, who is also a physiotherapist and an expert in the cost of future care, evaluated all of the medical and rehabilitation recommendations to prepare a cost of care report for Ms. Gill. Her report dated September 3, 2015, provided a summary of the costs associated with each recommendation. These included the cost of future evaluations and physical assessments, projected therapeutic modalities, medications, health and strength maintenance, vocational assessment and household assistance. The average one-time costs total $4,550.20 and the average ongoing yearly costs total $1,901.19.

B. The Defendants' Expert Reports

123 Dr. Sovio was qualified as an expert in orthopaedic surgery. He examined Ms. Gill on August 27, 2013 and provided an opinion regarding her lower back complaints. In his report dated August 28, 2013, Dr. Sovio recorded Ms. Gill's current complaints as recurring headaches, neck tightness and shoulder pain with work and a strain in the right wrist. She complained of low back pain and stiffness and limitation in her flexion and extension. She also had complaints of pain in the right knee and tibia but no limitation in regard to range of motion in the knee. On examination, Dr. Sovio found no abnormalities in neck alignment and no limitation in her range of motion and no pain on palpation of the neck muscles, just some tightness with side bending. There were also no abnormalities associated with her shoulders or her arms. In regard to the spine, the range of motion in the lumbar spine was relatively normal (clarified in cross-examination as within normal limits), but she complained of pain in this region. The right knee examination was normal apart from pain in the tibia on palpation.

124 After reviewing Ms. Gill's medical history, Dr. Sovio came to the following conclusions:

> On physical examination the patient did not have any abnormality of the cervical spine or the upper extremities. Nothing to suggest disc issues or nerve root problems.
>
> As far as her low back was concerned the patient complained of some pain in the low back but certainly no evidence of nerve root tension signs, no neurologic abnormality was noted in her lower extremities.
>
> I do not feel that there has been any significant injury to the low back. Perhaps some musculoligamentous type discomfort but nothing to suggest any significant abnormality which would be cause for alarm.
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> ...
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> The patient's knee complaints did not arise until quite some time after the motor vehicle accident and likely are not directly related to the motor vehicle accident.
>
> In 2012 the patient was diagnosed by MRI of having a stress fracture. Certainly periosteal reaction would not last 4 years so I do not feel that this is related to the motor vehicle accident. ...
>
> ...
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> From the physical standpoint I do not feel that this lady requires any further investigation. The patient is working as a dietary aide 2 days a week, I believe. I do not feel that there is any indication from the physical standpoint that she is limited in her ability to function in her work or recreational activities for that matter.

125 By a report dated January 15, 2016, Dr. Sovio responded to Dr. Caillier's report regarding the low back complaints:

> ... Dr. Caillier was given the history that the patient's low back pain started 15 to 20 days post motor vehicle accident. This, however, seems to be a bit contentious since there is no indication in the family physician's records following the motor vehicle accident of any back pain for more than a year.
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> Similarly in the reports provided by Symmetry Injury Rehabilitation the first mention of back pain is in the July 8, 2010 report and it states that back pain was not an issue when the patient was initially assessed and followed by occupational therapy and during the reassessment the patient was unable to recall when she began to experience these symptoms.
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> Based on the fact that the patient appears to have developed back pain more than a year after the motor vehicle accident it would certainly not be related to that.

126 Dr. Sovio considered that the back pain may be related to the first pregnancy or to her deconditioned state; however, he did not feel the back pain could be related to the accident. He also opined that this type of mechanical back pain normally responds to exercise and core strengthening. Dr. Sovio testified that he found no objective signs of injury to the low back and Ms. Gill's subjective pain symptoms alone rendered it very likely that she should have a full recovery.

127 In cross-examination, Dr. Sovio commented that while he did not know Ms. Gill also worked as a cook's helper, it was his opinion that she was not disabled by her back pain from any work as a cook's helper as described by counsel for Ms. Gill. He opined that she was physically able to work five days a week and that her back should not be an issue. Dr. Sovio did not factor into his assessment Ms. Gill's headaches.

128 Dr. Sovio agreed that if Ms. Gill spent two months in bed after the accident, it is likely that her muscles would become deconditioned and her recovery process slowed. He did not agree that this fact would render her full recovery from back pain less likely.

129 Dr. Levin is a psychiatrist and he provided an opinion dated June 4, 2014, regarding Ms. Gill's psychological and emotional functioning and her cognitive function. He interviewed Ms. Gill with the assistance of an interpreter

on May 22, 2014. In cross-examination, he indicated that specifics of the functional difficulties Ms. Gill experienced during times when headaches rendered her somewhat forgetful were difficult to obtain through the interpreter.

130 Dr. Levin did not observe any ongoing psychiatric or neuropsychiatric disturbances in Ms. Gill's clinical presentation that would impair her occupational, social or interpersonal functioning. He opined that she did not suffer any type of post-traumatic depression or any other neuropsychiatric disorder. Ms. Gill's clinical presentation did not reveal any personality changes, irritability or disruption of interpersonal skills. Ms. Gill reported that she was able to care for her children and had a good relationship with her husband and other family members. Ms. Gill did not present with any symptoms of depression, anxiety or any other major mental illness that would require therapy. She did not present with any behavioural abnormalities, maladaptive coping strategies or cognitive distortions that required any type of rehabilitation or therapy.

131 By a report dated November 30, 2015, Dr. Levin commented on Dr. Schmidt's opinion. In this regard, Dr. Levin opined that the subtle weaknesses identified in cognitive function are also present in the general population and are not clinically relevant. Further, Dr. Levin believed that the subsequent expression of anxiety and intermittent difficulties with focus (during periods of headache) were more likely not the type of cognitive impairments seen in patients who have experienced traumatic brain injuries. It is more likely that such cognitive difficulties would be constant if related to a brain injury. Dr. Levin opined that these transient symptoms had emotional origins and were not organically related to the brain injury.

132 Dr. Levin regarded Dr. Schmidt's test results as unreliable due to the language and cultural limitations of the testing that the psychologist acknowledged, and because the test results contradicted the information provided to him by Ms. Gill. In particular, Dr. Levin noted that she described no type of executive dysfunction or inability to make decisions or any visual deficits. While working at her job in 2012 and 2013, she did not have any accidents related to visual perception errors. Lastly, he concluded there was no clinical evidence to support the test findings due to Ms. Gill's unimpaired social, interpersonal, and occupational functioning since the accident.

133 In cross-examination, Dr. Levin testified that Ms. Gill's apparent mistakes in the dates of important events were not clinically significant to him. He believed that errors of this nature are made by a large percentage of the population and cannot be correlated with a traumatic brain injury and cognitive deficits. These are also short-term memory issues which are not normally associated with a past injury to the brain. I note that Dr. Schmidt's test results did not indicate any memory deficits. Dr. Levin also testified that the accident did not represent a traumatic event to Ms. Gill, as she could not recall it and what happened was not constantly or even intermittently replayed in her mind. Although it was a sad event, along with waking up to find she had given birth, the aftermath of the accident did not bring back traumatic memories or feelings for Ms. Gill.

134 Dr. Teal is a neurologist and he provided an expert opinion regarding Ms. Gill's injuries in a report dated March 20, 2015. Dr. Teal examined and interviewed Ms. Gill through the services of an interpreter on March 20, 2015; however, he commented that she was able to communicate fairly effectively herself. He opined that as a result of the accident, Ms. Gill suffered a head injury in the form of a right-sided subdural hematoma and an immediate post-traumatic seizure (within 24 hours). Further, as a result of the trauma (whether due to the force of the collision that propelled her head forward and back or as a result of striking her head), the hematoma resulting from the disruption of veins between the dura matter and the brain required a craniotomy to relieve the pressure on the brain itself. This is a potentially life-threatening injury.

135 Further, it was Dr. Teal's opinion that immediately after the accident Ms. Gill suffered acute post-traumatic headaches, which are a combination of post-surgical headaches related to the scalp incision and the resolving effects of the hematoma. However, he opined that these headaches resolved by April 21, 2009, in large part based on Ms. Gill's report to Ms. Sebastian on April 14, 2009 that the headaches occurred once every two weeks and were not disabling. The current headaches are not accident-related:

> It is my opinion Ms. Gill's initial headache pattern was typical of posttraumatic headaches that gradually but progressively improve following a subdural hematoma and surgical management.

> It is my opinion that Ms. Gill probably experienced an excellent recovery from her posttraumatic headaches. Over time, however, she developed different patterns of headaches which had mixed features. Her primary headache pattern is consistent with tension-type headaches. She was also assessed by her family physician on October 23, 2012, as having headache reoccurrence triggered by cold weather.
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> On December 17, 2012, she was evaluated by Dr. Jawanda, her family physician, as having sinus tenderness and sinus symptoms. She was treated with antibiotics and had sinus x-rays. ...
>
> On May 30, 2013, Dr. Jawanda documented headache in the "hatband area" and diagnosed tension headache.
>
> On June 11, 2013, Dr. Jawanda diagnosed chronic sinus infection with symptoms which he [sic] treated with antibiotics.
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> At the time of my evaluation, it is my opinion the majority of Ms. Gill's headaches were tension-type headaches that are unrelated to the head injury and do not represent posttraumatic headaches. Based on Dr. Jawanda's records, it also appears that some of her headaches in the years following the motor vehicle accident were related to sinus infections and chronic sinus disease.
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> It is my opinion it would be unusual for posttraumatic headaches to resolve and then later recur. It is most likely the majority of her current headaches are tension-type headaches, unrelated to the motor vehicle accident. It is possible that the head injury made her more vulnerable to recurrent headaches.

136 Further, it was Dr. Teal's opinion that Ms. Gill had an excellent recovery from any cognitive effects of the hematoma and had no residual disability:

> ... Ms. Gill does report some very mild subjective cognitive symptoms of being occasionally forgetful. It is possible there are very mild residual cognitive sequelae arising from her head injury, however, it is my opinion any residual symptoms are unlikely to be limiting or result in significant restrictions on domestic, recreational, or occupational activities.

137 While there is a small chance of developing delayed post-traumatic epilepsy, most people develop this within two to five years of the injury and thus Dr. Teal opined that Ms. Gill was beyond the period of highest risk.

138 In regard to the low back pain, Dr. Teal opined that at the time of his examination, the low back pain was mechanical in nature and soft tissue in etiology. She had mild tenderness and mild restricted range of motion but there was no nerve root or neurological involvement upon examination. He did not express an opinion on the cause of the low back pain but indicated that Ms. Gill was unable to say when the back pain first arose and the earliest clinical note of low back pain is from January 2010. He disagreed with Dr. Caillier's conclusion that the accident indirectly caused the low back injury due to Ms. Gill's deconditioned state brought about by the accident.

139 In regard to treatment recommendations, Dr. Teal opined as follows:

> Ms. Gill may benefit from further management of her tension-type headaches. She is currently on amitriptyline, a tricyclic medication that is often used to treat tension-type headaches. I would recommend a gradual progressive increase in the dose of amitriptyline as tolerated. Ms. Gill may also use simple over-the-counter analgesics such as acetaminophen (Tylenol) or ibuprofen (Advil) providing she does not use them on a daily basis.
>
> Treatment of anxiety and stress management would likely also be helpful.
>
> It is my opinion the severity of Ms. Gill's headaches should not prohibit her from daily activities, domestic activities, or returning to work in a previous capacity as a cook's assistant.
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> With respect to back pain management, Ms. Gill may benefit from a conditioning and exercise program with efforts made to increase her stamina and endurance as well as her core strength. Ms. Gill will not require surgery for her back pain.

DISCUSSION

Causation

140 The plaintiff must prove on a balance of probabilities that the defendants' negligence caused or materially contributed to an injury. The defendants' negligence need not be the sole cause of the injury so long as it is part of the cause beyond the range of *de minimus*. Causation need not be determined by scientific precision: *Athey v. Leonati*, *[1996] 3 S.C.R. 458* at paras. 13-17.

141 The primary test for causation is the "but for" test. But for the defendant's negligence, would the plaintiff have suffered the injury? This test recognizes that compensation for negligent conduct should only occur where a substantial connection between the injury and the defendant's conduct is present: *Resurfice Corp. v. Hanke*, *2007 SCC 7* at paras. 21-23. Causation must be established on a balance of probabilities before damages are assessed. As McLachlin C.J.C. stated in *Blackwater v. Plint*, *2005 SCC 58* at para. 78:

> ... 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*.

142 Turning to the facts of this case, there is no doubt that as a result of the accident Ms. Gill suffered a serious closed head injury that led to her collapse at the hospital, a craniotomy, three or four days in a coma, loss of memory of the accident and events immediately before and after it, as well as the necessity for a caesarean delivery of her first child. It was a truly horrible experience that could have led to her death had the surgeon not been able to remove the subdural hematoma in a timely fashion. Whether or not the movement of the brain due to displacement by the hematoma caused damage to her brain, there is no question that this was a serious injury that required a lengthy recovery period.

143 Ms. Gill spent over ten days in the hospital recuperating from the craniotomy and C-section surgeries. She was unable to function beyond bed rest and was continually medicated for pain. The evidence is consistent that she was in substantial pain throughout this time and did almost nothing but sleep. During this period she was also faced with the loss of the birth experience and deprived of the opportunity to bond with her first child until she was discharged. This was a devastating experience for Ms. Gill.

144 Ms. Gill was unable to manage on her own when she was discharged from hospital and stayed with her sister, Kulwinder from December 2008 until July 2009 when she travelled to India with her husband and daughter. For the most part up until the end of April 2009, Ms. Gill remained housebound. While there are some inconsistencies in the evidence surrounding her mobility during this period, it is apparent that she was not active apart from walking short distances within the home, and both Kulwinder and Gurjot were helping with childcare and doing all of the household chores, even though Ms. Gill could care for herself (washing, dressing and eating meals) independently. I accept Ms. Gill's testimony that she was stiff and sore all over her body at this time. There can be no doubt that recovering from a craniotomy and a C-section is going to involve pain and stiffness from head to foot.

145 I find the evidence establishes continuity in the headaches throughout January to April 2009, primarily based upon Ms. Sebastian's notes and Dr. Lee's consultation reports, albeit reduced in severity and frequency by mid-April 2009. It does not appear that Ms. Gill was taking anything but Advil or Tylenol for her headaches at this time. Further, there is evidence of a continuity of headache symptoms in early June 2009 when Ms. Gill first reported headache pain to Dr. Jawanda. She was prescribed Naproxen and filled this prescription on the same day.

146 Thereafter the evidence of increased headache pain is quite suspect because Ms. Gill did not fill subsequent prescriptions for various headache medications and she misled Ms. Sebastian and Dr. Jawanda as to her use of

these medications and their effectiveness. In November 2010, she advised Dr. Singh that she had only used over-the-counter pain medications apart from one month of Elavil up until that time. This was not the same as the reports Ms. Gill made to her family doctor and Ms. Sebastian over the same period.

147 I also agree with the defendants' submission that Ms. Gill's later reports of headache pain do not match her objective behaviour. Indeed, the headaches were controlled sufficiently to permit her to travel to India in July 2009, and although she testified about low back pain during the flight, Ms. Gill did not refer to headaches during this trip.

148 The medical evidence and the continuity of symptoms clearly establish that Ms. Gill suffered from post-traumatic headaches and that these continue to be present in her life. However, I must conclude that these headaches have subsided in frequency and severity to the point where they are mild when they reoccur, which is what Ms. Gill reported to Dr. Singh in February 2015. It is highly unlikely that mild, intermittent post-traumatic headaches continue to be disabling in regard to work, personal care, recreational activities and household chores. There is evidence that since 2014, Ms. Gill has regularly filled prescriptions for Elavil (Amitriptyline); however, she was specifically prescribed 20 mgs per day for insomnia. Thus I cannot conclude that the post-traumatic component of her headaches has worsened to the point where she now requires a prophylaxis to inhibit them.

149 There is also cogent evidence that superimposed upon the post-traumatic headaches are sinus headaches and tension-type headaches brought on by stress and anxiety that are also intermittent in nature. These headaches are unrelated to the accident, given the lack of evidence that Ms. Gill suffered any significant emotional or psychological trauma as a result of the head injury that persisted beyond a few months post-accident. Ms. Gill also developed a chronic condition of sinusitis in early 2013. Dr. Singh diagnosed chronic tension headaches in November 2014, which he testified stemmed from a different description of the location of the headaches (bi-frontal vs. bi-temporal) and their underlying trigger (i.e. stress vs. trauma). Dr. Teal's evidence also supports a conclusion that Ms. Gill's headaches are in part (if not wholly) due to tension and sinusitis. As a consequence, even the mild headaches that Ms. Gill continues to suffer from are not entirely accident-related.

150 Although I am not satisfied that Ms. Gill suffered any permanent cognitive deficits due to the brain injury, I accept that when she experienced a significant headache, some confusion, dizziness, lack of focus and forgetfulness occurred. These symptoms appear to be consistently documented in the consultation reports of Dr. Lee. Further, Ms. Gill has consistently limited any cognitive deficits to periods in which she is suffering from a headache. As the headaches subsided, these symptoms would naturally also lessen. Further, I accept that Ms. Gill suffered from fatigue due to the severe headaches, but this also subsided as recorded in Ms. Sebastian's notes from April 2009.

151 Ms. Gill demonstrated a very poor memory of events during her testimony. She also provided incorrect histories to various medical professionals regarding significant events. However, I am unable to relate these memory lapses to the accident. Dr. Schmidt's test results do not support any deficits in memory and there is no other evidence that would suggest Ms. Gill's poor memory is related to the injuries she suffered in the accident.

152 There is no evidence that Ms. Gill claimed to suffer any emotional or psychological injury due to the accident. Dr. Levin's opinion in that regard is not contradicted by any of the plaintiff's expert opinions.

153 In regard to ongoing cognitive deficits, Dr. Schmidt's opinion is quite limited in value due to the language and cultural differences in Ms. Gill's background. He acknowledged that the tests were developed with North American subjects in mind and are based on an assumption that the test subject is fluent in English. However limited the results of testing were, Dr. Schmidt found only subtle visual perception deficits that he testified would not have an impact on Ms. Gill's ability to manage daily life activities or her work as a cook's helper and dietary aide. Moreover, without a benchmark standard with regard to Ms. Gill's pre-accident visual acuity, the subtle deficits noted by Dr. Schmidt may pre-date the accident. Dr. Schmidt also noted subtle deficits in executive function; however, he did not elaborate on the nature of these deficits or how, if at all, they would likely affect her daily functioning. It is significant that Ms. Gill, Kulwinder and Gurjot reported no cognitive issues to Ms. Sebastian up to April 14, 2009.

154 Gurjot testified that she has noticed a significant change in Ms. Gill's personality since the accident. She is withdrawn and quiet and is no longer the outgoing, communicative person she was before the collision. However, Ms. Riar testified that Ms. Gill was always a very quiet person at work who did not gossip or waste time chatting with her co-workers. Although she noticed a reduced tolerance for noise because of the headaches, Kulwinder's evidence did not support a significant change in her sister's personality after the accident. I accept that in the months following the accident while Ms. Gill convalesced, she likely wanted to be left alone to rest and due to pain she was likely much less communicative with others. However, apart from this early period of recovery, I find Ms. Gill has failed to prove any real changes in her personality since the accident.

155 I am satisfied that Ms. Gill has suffered permanent scarring from the craniotomy and C-section surgeries. In addition, she suffered the cultural embarrassment occasioned by the shaving of her head. She also lost the pleasure of a natural childbirth and the joy of bonding with her new baby in the first days of life. Further, Ms. Gill was deprived of the ability to care for her new baby for several months after the accident and during her recovery period.

156 Turning to the low back complaints, there is a rather complicated history concerning this injury. As discussed earlier, the deconditioning occasioned by inactivity while recovering from surgery during the early months of 2009 is logically connected to the onset of low back pain when Ms. Gill moved to her own home and resumed the normal activities of daily life in January 2010. However, Dr. Caillier's diagnosis in this regard is inconsistent with the evidence of Ms. Gill and Kulwinder, who both testified that there was low back pain shortly after the accident and during the early days of Ms. Gill's convalescence. Ms. Gill advised Dr. Caillier that she felt low back pain 15 to 20 days after the accident when she tried to get out of bed. Somewhat inconsistently, Ms. Gill was uncertain when the low back pain began when she was interviewed by Dr. Teal about a year later.

157 It is also troubling that Ms. Gill testified that she had low back pain during the flight to India in July 2009, which occurred several months before she moved to her own residence. More troubling is that the only treatment Ms. Gill sought before she reported back pain to Dr. Jawanda was chiropractic manipulation due to cervical pain rather than low back pain. On January 25, 2010, when Ms. Gill first reported back pain to Dr. Jawanda, she provided no description of back pain due to household chores or childcare responsibilities. Dr. Jawanda recorded in her clinical notes no incident that triggered the low back pain. When Ms. Gill attended the Singh Physiotherapy Clinic on June 7, 2010, she complained of low back pain stemming from the December 2008 accident, not pain triggered by household chores, childcare responsibilities or recreational activities. Lastly, Ms. Gill testified that when she moved to her new residence in or about January 2010, her husband was doing the heavy household chores and bathing the baby. There is no evidence that Ms. Gill was actually performing any heavy work in her home to trigger a back injury due to deconditioning.

158 These contraindications of a relationship between the low back pain and deconditioning caused by the accident-related injuries are compounded by the lack of trustworthiness in Ms. Gill's evidence. It is difficult to attach any credibility to her subjective reports of pain in light of her behaviour. She clearly misled her physician and Ms. Sebastian about the medications she was taking for headaches and the effectiveness of these medications. She also misled her physician about the treatment she was having for back pain and appears to have ignored Dr. Jawanda's recommendation about physiotherapy. In this regard, a report of significant upper and lower back pain on January 25, 2010, did not lead to any treatments until June 7, 2010, when Ms. Gill first attended for physiotherapy. I must assume that the back pain was quite nominal if Ms. Gill chose to delay any treatment for over five months. Moreover, it does not appear that she was taking any prescription medications for pain during this period as the last prescription she filled for Elavil was on December 2, 2009.

159 It is suspicious that Ms. Gill reported extreme back pain to Dr. Jawanda on June 7, 2010 and on the same day Gurjot was advised that Ms. Sebastian was re-opening the rehabilitation services file on her sister. However, Mr. Grewal testified that when he examined Ms. Gill on June 7, 2010, he noted objective signs of muscle spasm in the low back, which corroborates Ms. Gill's subjective report of pain. Thereafter Ms. Gill attended several physiotherapy sessions for low back pain.

160 Considering the evidence as a whole, I find the first reliable indication of low back pain is the acute injury presented by Ms. Gill to Mr. Grewal on June 7, 2010. This is almost 18 months after the accident and six months after Ms. Gill resumed daily life activities without the assistance of her sisters. Dr. Caillier does not opine that the low back pain experienced by Ms. Gill was caused directly by the collision despite Ms. Gill's report that the pain began shortly after the accident. Her opinion is based on an indirect causal connection and the foundation for this opinion is an assumption that performing activities of daily life in a deconditioned state led to low back pain in or about January 2010, when it was first reported to Dr. Jawanda. I find there is no credible evidence to support this assumption.

161 The onus rests with Ms. Gill to establish a causal connection between the low back injury and the accident; she must prove on a balance of probabilities that the accident caused or contributed to the injury: *Athey* at para. 13. She has failed to do so. There is no credible evidence to support Dr. Caillier's hypothesis, particularly due to the inconsistent evidence of Ms. Gill and her sister regarding the onset of low back pain. There is also no reliable evidence of Ms. Gill's state of physical conditioning in January 2010, and some evidence that her husband was performing the heavier household chores at that time. The report of back pain in January 2010 was upper and lower back pain and it was apparently not serious enough to warrant pain medication or physiotherapy.

162 Thus for all these reasons, I find there is insufficient evidence to establish a direct or indirect relationship between the accident and any low back injury. The accident neither caused nor contributed to this injury through deconditioning or otherwise.

163 Lastly, I find the right knee and tibia injury is unrelated to the accident. Although Ms. Gill had pain in both legs during the first few months after the accident, this was described as pain in her calves, not pain and swelling in the right knee and tibia. This pain subsided in February 2009 and was completely resolved by April 14, 2009. The right knee and tibia pain appears to have first surfaced in February 2012, over three years after the accident. There is no clear diagnosis for the knee and tibia pain; however, all of the medical experts agree that if it was caused by an injury, such as a fracture, it is unrelated to the accident because the timing of that event is too remote. In other words, the injury could only have been caused by a far more recent event (between six and eight months prior to the bone scan and the MRI). Although Dr. Caillier opined that the knee and tibia injury was accident-related, her conclusion is based on an assumption that Ms. Gill struck this portion of her right leg during the collision. There is no evidence of any direct injury to her right leg at the time of the accident.

164 Accordingly, I find the plaintiff has failed to establish, on a balance of probabilities, that the injury to her right knee and tibia was caused or contributed to by the accident.

Damages for Pain and Suffering

165 Having made these findings concerning Ms. Gill's accident-related injuries, I turn to the quantum of damages appropriate in the circumstances. Ms. Gill claims $175,000 in general damages. In support of her position, Ms. Gill relies on *Felix v. Hearne*, *2011 BCSC 1236*; *Stapley v. Hejslet*, *2006 BCCA 34*; *Anderson v. Bicknell*, *[1998] B.C.J. No. 1847* (S.C.); *Curtis v. MacFarlane*, *2014 BCSC 1138*; and *Bricker v. Danyk*, *2015 BCSC 2404*. The defendants argue that damages for pain and suffering are in the range of $75,000. They rely on *Stapley*; and *Clark v. Hebb*, *2007 BCSC 883*.

166 The purpose of general damages for pain and suffering was recently summarized in *Bricker* at paras. 134-35:

> [134] Non-pecuniary damages are awarded to compensate an injured person for pain, suffering, loss of enjoyment of life and loss of amenities. The principles governing the assessment of such damages are well known and have been discussed in numerous cases: see *Stapley v.* [*Hejslet*], *2006 BCCA 34* at para. 46, leave to appeal ref'd *[2006] S.C.C.A. No. 100*.

> [135] Awards of non-pecuniary damages in other cases provide a useful guide to the court, however the specific circumstances of each individual plaintiff must be considered as any award of damages is intended to compensate that individual for the pain and suffering experienced by them: see *Trites v. Penner*, *2010 BCSC 882* at para. 189. Moreover, the compensation award must be fair and reasonable to both parties: see *Miller v. Lawlor, 2012 BCSC 387* at para. 109 citing *Andrews v. Grand & Toy Alberta Ltd., [1978] 2 S.C.R. 229*, *83 D.L.R. (3d) 452*.

167 A convenient discussion of the factors to be considered when calculating general damages is found in *Stapley* at para. 46:

> [46] The inexhaustive list of common factors cited in Boyd that influence an award of non-pecuniary damages includes:
>
> (a) age of the plaintiff;
>
> (b) nature of the injury;
>
> (c) severity and duration of pain;
>
> (d) disability;
>
> (e) emotional suffering; and
>
> (f) loss or impairment of life;
>
> I would add the following factors, although they may arguably be subsumed in the above list:
>
> (g) impairment of family, marital and social relationships;
>
> (h) impairment of physical and mental abilities;
>
> (i) loss of lifestyle; and
>
> (j) the plaintiff's stoicism (as a factor that should not, generally speaking, penalize the plaintiff: Giang v. Clayton, *[2005] B.C.J. No. 163* (QL), *2005 BCCA 54*).

168 Ms. Gill suffered a closed head injury and permanent scarring as a result of the accident. For years after the accident she has suffered from intermittent, post-traumatic headaches. Ms. Gill recovered very well from the closed head injury but there are lingering headaches, albeit mild and intermittent. Further, associated with severe headaches were some minor cognitive deficits. As a result of the surgeries caused by the accident-related injuries, she suffered pain and stiffness in her entire body for several months and was unable to care for herself or her newborn. She was seriously injured and the recovery period was slow and painful. Ms. Gill was deprived of a natural childbirth for her first child and was unable to bond with her daughter in the first critical days of her life. While Ms. Gill suffered a loss of memory due to the head injury, there is no lingering emotional trauma.

169 Having regard to the cases cited by both parties and the factors outlined in *Stapley*, I find an award of damages in the amount of $115,000 is appropriate in all of the circumstances.

Past Wage Loss

170 Ms. Gill claims past wage loss of $171,000 based on her plan to train as a care aide and argues that the accident-related injuries precluded her from performing this type of work. In the alternative, she argues these injuries precluded a return to full-time work as a cook's helper and dietary aide and claims damages in the amount of $121,075. The defendants argue there is no evidence of any past wage loss because Ms. Gill was not disabled from her pre-accident work at the conclusion of her maternity leave.

171 Ms. Gill was on maternity leave when the accident occurred and planned to take a one-year leave. She received maternity EI benefits in the amount of $15,550 in 2009. It was not Ms. Gill's intention to return to work before the end of her maternity leave and she does not claim lost wages for this period.

172 There is some evidence that during her maternity leave, Ms. Gill planned to improve her English skills and investigate the training required for the position of care aide with a view to completing this training in the future. However, Ms. Gill did not produce any evidence that she had taken positive steps towards these objectives, either before her maternity leave commenced or prior to the accident. She did not testify that she had researched the cost of these courses or that she met the prerequisites for the care aide training. I acknowledge that the plaintiff is not required to prove this loss of opportunity on a balance of probabilities. Instead, the loss of opportunity is given weight according to its relative likelihood and a hypothetical possibility will be taken into account as long as it is a real and substantial possibility and not mere speculation: *Athey* at para. 27.

173 I find it is unlikely that Ms. Gill would have sought training as a care aide. Her background education was in language and history. She had no medical training and her long-term goal was to become a teacher not a hospital worker. Moreover, there is no evidence that the injuries sustained in the accident would preclude Ms. Gill from training as a care aide. As I outlined earlier, the low back injury is not related to the accident and the post-traumatic headaches are minimal and intermittent. Ms. Gill's memory difficulties were limited to the times when she had a severe headache and by February 2015, she reported to Dr. Singh that any reoccurring headache was mild. As a consequence, I find there is no evidence of a loss of opportunity.

174 The main impediment to Ms. Gill's return to work as a dietary aide and a cook's helper has been her low back pain. The functional capacity evaluations prepared by Ms. Noel in 2011 and by Mr. Hosking in 2015 indicate that while Ms. Gill would be able to manage these jobs on a part-time basis, provided there were some accommodations in scheduling and workload, a return to full-time work is problematic due to her reports of intermittent low back pain and her generally deconditioned state of physical health. Because I have found no causal relationship between the low back injury and the accident, it cannot be said that Ms. Gill's loss of wages for this reason is compensable.

175 The functional capacity evaluations also refer to Ms. Gill's headaches as a possible impediment to part-time or full-time work as a cook's helper and dietary aide. Ms. Noel and Mr. Hosking's comments in this regard are based on Ms. Gill's subjective reports of headache pain. They are not qualified to provide an expert opinion on the cause or severity of the headache pain. The role that headache pain plays in Ms. Gill's inability to return to work is unclear.

176 When she returned to work briefly in April 2011, it was clearly low back pain that led Ms. Gill to abandon the graduated return to work plan. There were no complaints of headaches during the first GRTW. She subsequently sought physiotherapy treatments for low back pain. Thereafter Ms. Gill realized she was pregnant with her second child and she made no further attempts to return to work until after the child was born in late December 2011.

177 Ms. Gill's second return to work occurred in May 2012. She worked two days per week normally, but gradually there was an increase in the number of shifts until the summer of 2013 when Ms. Gill began working almost full-time hours. Ms. Gill testified that her headaches and low back pain prevented her from working full time. Although Ms. Gill testified that she was forced to leave her job in July 2013 due to Ms. Riar's insistence that she work full time, I am unable to accept this evidence as credible. Ms. Riar testified that she was forced to terminate Ms. Gill's employment because her last minute refusal of shifts made it very difficult to find a replacement for her. Ms. Riar denied that she demanded that Ms. Gill work full time. Moreover, Ms. Riar testified that Ms. Gill was handling the work without any apparent difficulties and she was quite satisfied with her performance. In my view, Ms. Riar's evidence, as a witness called by the plaintiff, cannot be reconciled with Ms. Gill's testimony regarding her departure from work at the Willingdon Care Centre.

178 Ms. Gill's complaints of back pain as a reason for leaving the job in July 2013 are not corroborated by any reports of back pain to Dr. Jawanda around this time; however, she attended for chiropractic treatments in August 2013 with complaints of cervical and low back pain. She also attended for physiotherapy treatments in October 2013. Nevertheless, I have concluded that Ms. Gill's complaints of low back pain are not related to the accident.

179 Ms. Gill's claim that headaches also precluded full-time work is only partly corroborated by her reports of headache pain during visits with Dr. Jawanda. Ms. Gill's primary complaint in 2012 was fibula and tibia pain in her

right leg. I have found this injury to be unrelated to the accident. Further, in the fall of 2012, Ms. Gill was prescribed medications for headache pain that she reported to Dr. Jawanda but she did not fill these prescriptions. In late 2012, and again in the fall of 2013, Dr. Jawanda treated Ms. Gill for sinus headaches due to chronic sinusitis. When Ms. Gill was referred to Dr. Singh for ongoing headaches, he diagnosed headaches that were triggered by stress rather than the post-traumatic headaches he diagnosed in November 2010. Lastly, Ms. Gill reported only back pain to Ms. Sebastian during her return to work in 2012 and 2013.

180 In light of the subjective nature of headache pain, the inconsistencies between the evidence of Ms. Riar and Ms. Gill regarding her work performance and the reason for her termination, the failure to fill prescriptions for headache medications during the return to work, and the lack of significant complaints of headache to Ms. Sebastian, I am unable to conclude that Ms. Gill's inability to work full time is causally connected to headache pain related to the accident. It is more probable that, if there was a problem with full-time work, it was caused by periodic low back pain which is unrelated to the accident.

181 As a consequence, I find that Ms. Gill is not entitled to any wage loss from the period April 2011 to August 2013. It is apparent that she chose not to work due to her second pregnancy from April 2011 to May 2012. Thereafter if there was an impediment to her return to full-time work, it was due to low back pain which is not related to the accident. While Ms. Gill may have suffered from headaches during this period, I must conclude that they were not severe enough to interfere with work.

182 After her maternity leave ended in late November 2009, Ms. Gill did not attempt any type of return to work. There were a number of visits to Dr. Jawanda's office for back pain in early 2010; however, there were no complaints of headaches until April 29, 2010. On this visit she was told to restart Elavil at 10 mgs. However, Ms. Gill did not fill any prescription for Elavil at this time and the last Elavil she purchased was on December 2, 2009. On July 17, 2010, Ms. Gill again reported headaches and Dr. Jawanda increased the dosage of Elavil to 20 mgs and Naproxen twice daily. Ms. Gill did not fill these prescriptions.

183 It was in this time period that Dr. Jawanda referred Ms. Gill to Dr. Singh for her reoccurring headaches. Dr. Singh saw Ms. Gill on November 15, 2010 and diagnosed her with a closed head injury and continuing post-traumatic headaches. However, because she reported mostly mild headache pain at that time, Dr. Singh did not believe a prophylaxis was necessary to inhibit the headaches. She was advised to take Tylenol or Advil for pain relief and he suggested physiotherapy.

184 Ms. Gill also continued to see Dr. Jawanda for ongoing headaches on September 27 and 30, 2010 and on November 22, 2010. She advised Dr. Jawanda that Tylenol was not helpful and Naproxen was mildly helpful. However, Ms. Gill had not filled a prescription for Naproxen since June 7, 2010. Dr. Jawanda prescribed Zoloft 25 mgs in early January 2011. Ms. Gill did not fill the Zoloft prescription until March 2, 2011.

185 When Ms. Gill returned to Dr. Jawanda's office in early February 2011, she reported that the Zoloft was helping reduce the headache pain and the dosage was increased to 50 mgs. This was obviously untrue because Ms. Gill had not yet filled the prescription.

186 The medical experts all agree that headache pain is a subjective symptom and they must rely on the patient to accurately describe the duration and severity of pain symptoms. It is difficult to accept Ms. Gill's subjective complaints of headache pain when her actions are inconsistent with her claims. Ms. Gill was not filling the prescriptions for prophylaxis medications given to her by Dr. Jawanda and she misled her doctor and Ms. Sebastian regarding the effectiveness of these medications. She also ignored Dr. Singh's recommendation for physiotherapy. In these circumstances, it is unlikely that the headaches were disabling and it is more probable than not that Ms. Gill was exaggerating the pain to Dr. Jawanda and Ms. Sebastian.

187 As a consequence, I find there is no compensable wage loss between the end of November 2009 and the first return to work attempt in April 2011. If Ms. Gill was experiencing post-traumatic headaches during this period, they were not disabling and would not have interfered with a return to work.

188 From July 20, 2013 to date, Ms. Gill has not worked part time or full time. There is essentially no evidence to explain her failure to return to work on a part-time basis. Mr. Hosking's functional capacity evaluation suggests Ms. Gill is capable of part-time work as a cook's helper and a dietary aide. Ms. Riar testified that she was prepared to offer a position to Ms. Gill, despite her termination in 2013, due to the scarcity of good workers in this field.

189 During 2014 and 2015, Ms. Gill continued to report headache pain to Dr. Jawanda and she was again referred to Dr. Singh for a neurological consultation. In these years Ms. Gill began regularly filling the prescriptions for Elavil that were prescribed for her headaches; however, she was also taking this medication for insomnia. Further, when she saw Dr. Singh in 2014 and 2015, he diagnosed the headaches as stress-related rather than post-traumatic. Moreover, by February 2015 she reported that the headaches were mild and only intermittent. In my view, if any part of the headaches is related to the accident, mild intermittent headaches are unlikely to have an adverse impact on Ms. Gill's ability to return to work.

190 For these reasons, I find that Ms. Gill's intermittent headaches, if accident-related, do not preclude a return to full-time work. She is thus not entitled to any past wage loss for the period July 20, 2013 to the date of trial.

Future Loss of Earning Capacity

191 Ms. Gill argues that the injuries caused by the accident have diminished her capacity to earn income in the future and that damages should be assessed in a global sense. She advocates the test established in *Kwei v. Boisclair* *(1991), 60 B.C.L.R. (2d) 393* (C.A.), which sets out four considerations at para. 25:

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.

192 Regarding the value attributed to a loss of future earning capacity, Ms. Gill argues that a partial disability must be given weight. In this regard, Ms. Gill cites *Pallos v. Insurance Corp. of British Columbia* *(1995), 100 B.C.L.R. (2d) 260* (C.A.). She argues that the calculation of damages is a matter of judgment rather than mathematics: *Rosvold v. Dunlop*, *2001 BCCA 1* at para. 18. Ms. Gill says her capacity to earn income as a capital asset has been diminished by the residual symptoms she suffers from the accident. Lastly, she argues that the standard of proof is simple probability because the assessment of damages is based on hypothetical events: *Reilly v. Lynn*, *2003 BCCA 49* at para. 101. The amount claimed is between $300,000 and $350,000.

193 The defendants argue that Ms. Gill has proven no loss of capacity to earn income in the future. If she is unable to return to work as a cook's helper and a dietary aide, it is for reasons that are unrelated to the accident. In support of their argument, the defendants cite *Kim v. Morier*, *2014 BCCA 63*; *MacDonald v. Kemp*, *2014 BCSC 1079*; *Perren v. Lalari*, *2010 BCCA 140*; and *Steward v. Berezan*, *2007 BCCA 150*.

194 I have found that Ms. Gill continues to suffer mild, intermittent headaches that are in part related to the accident. I have also found that her complaints of lower back pain and right leg pain are unrelated to the accident. When assessing whether the mild, intermittent headaches represent a loss of earning capacity to Ms. Gill, I must take into account all substantial possibilities and give them weight according to how likely they are to occur in light of all the evidence. The authorities support an award for future loss of earning capacity even if the plaintiff is able to work at her pre-accident employment because to do so she must work through the pain and suffering of an

accident-related injury. If there is a real and substantial possibility of a loss in future, an award should follow for loss of capacity to earn income.

195 In this case, I am not satisfied that Ms. Gill left her job in July 2013 due to headache pain. I accept Ms. Riar's evidence that Ms. Gill was performing the job duties without apparent difficulties and it was not a demand that she work full time that led to her termination. Further, I find there is no explanation for Ms. Gill's failure to return to any type of work since July 2013 that is related to injuries suffered in the accident. I have denied any claim for past wage loss. If she is unable to return to her work as a cook's helper and dietary aide, it is for reasons unrelated to the accident. In February 2015, Ms. Gill reported mild intermittent headaches to Dr. Singh. These headaches were diagnosed as stress-related; however, if the accident represents one of the underlying causes of Ms. Gill's headache pain, I find that her earning capacity has not been impaired by these continuing symptoms.

196 Ms. Gill has not been rendered less capable overall from earning income from all types of employment by mild, intermittent headaches. She is not less marketable or attractive as an employee to potential employers. Ms. Gill has not lost the ability to take advantage of all job opportunities which might otherwise have been open to her, had she not been injured, and she is not less valuable to herself as a person capable of earning income in a competitive labour market.

197 There is no cogent evidence that headaches caused Ms. Gill to abandon the return to work in April 2011 or that headaches precipitated her termination from the Willingdon Care Centre in July 2013. There is also no credible evidence that mild, intermittent headaches currently preclude Ms. Gill from working at her pre-accident employment. Based on the standard for hypothetical future events, I find it is highly unlikely that headache pain will preclude Ms. Gill from working in the future or render her less competitive in the workforce. It is not a substantial possibility and constitutes mere speculation to say that mild headaches, which are only intermittent, will impact her employment opportunities in the future.

198 Further, it is not a substantial possibility that any cognitive deficits related to the accident will diminish Ms. Gill's future capacity to earn income in her pre-accident occupation. Dr. Schmidt's evidence establishes that the subtle visual perception deficits measured in neurological tests will not have any impact on Ms. Gill's ability to perform jobs similar to the cook's helper and dietary aide. The forgetfulness and lack of focus Ms. Gill might experience when she has a severe headache is also unlikely to have an adverse impact on her employability or income earning capacity because the accident-related headaches are now only mild and intermittent.

199 The impact of continuing headaches on Ms. Gill's future income earning capacity is entirely based on her subjective report of ongoing pain. Because I have found her evidence to be generally lacking in credibility, I cannot accept her historical reports of pain to be reliable without corroboration. There is also no evidence as to why Ms. Gill has made no attempt to return to part-time work, which is supported by the functional capacity evaluations. These are insurmountable difficulties in the plaintiff's case for loss of future earning capacity.

200 I thus find no claim has been established for loss of future earning capacity.

Cost of Future Care

201 The only future cost related to the accident is prescriptions for Elavil. Ms. Craig calculated the cost of this medication based on one tablet per day. However, Ms. Gill's past reliance on Elavil for headaches is very inconsistent and she currently is prescribed 20 mgs per night for insomnia and the dose she purchases is 25 mgs. While it is possible that at some times her headaches may require a prophylaxis, I do not accept that it is regularly necessary to inhibit headaches related to the accident. Ms. Craig estimates the cost for Elavil to be $240 per year. Attributing one-half of this cost to headache prevention and management, and applying the present value tables at a rate of interest of 2%, I award $3,770 for cost of future care.

Special Damages

202 Ms. Gill claims $1,485.15 for the cost of chiropractic services, physiotherapy, medications and mileage for attendances at Dr. Jawanda's office from her home. The initial chiropractic treatment on March 29, 2009 for cervical pain is compensable because it appears to be part of her overall stiffness complaint during her initial recovery period ($35). Thereafter the treatments were for low back pain, which I have found are not related to the accident. The physiotherapy treatments from Singh Physiotherapy were all related to low back pain and are not compensable. There is an outstanding account with Mountainview Health and Wellness for $464.94; however, there is no evidence in regard to the purpose of this treatment. There is no evidence that Ms. Gill sought any type of therapy for her headaches. Thus this account is unlikely compensable. Similarly, there is no evidence that the physiotherapy treatments from Apex Physiotherapy in June and July 2015 are related to Ms. Gill's headaches. As a consequence, I find the cost is not recoverable as special damages.

203 Lastly, Ms. Gill is entitled to mileage for visits to her family doctor if the visits concerned accident-related injuries. The costs claimed appear reasonable. I thus award $120 for mileage.

204 In total, I award $155 for special damages.

Summary

205 Ms. Gill is awarded $115,000 for non-pecuniary loss, $3,770 for cost of future care, and $155 for special damages, together with prejudgment interest on the award for special damages. In addition, she is entitled to costs at Scale B. I retain jurisdiction to address any dispute regarding costs.

C.J. BRUCE J.

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