IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Williams v. Fedalizo*,
2023 BCSC 102

Date: 20230123
Docket: M201965
Registry: New Westminster

Between:

Chelsea Williams

Plaintiff

And

Chadric Fedalizo, Toyota Credit Canada Inc. (Lessor), Carlos Fedalizo (Lessee)

Defendants

Before: The Honourable Justice Schultes

Corrected Judgment: The text of the judgment was corrected at paragraphs 391, 395, 415 and 468 on January 27, 2023

Reasons for Judgment

Counsel for the Plaintiff:	G.A. Smith
Counsel for the Defendants:	H.A. Walford J. Wiebe
Place and Date of Trial:	Port Coquitlam, B.C. October 12-15,18-20 & 22, 2021
Place and Date of Judgment:	New Westminster, B.C. January 23, 2023

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I. INTRODUCTION

[1] This trial dealt with liability for, and the consequences of, a collision between vehicles driven by the plaintiff Chelsea Williams and the defendant Chadric Fedalizo in Surrey in the early afternoon of May 6, 2016. It occurred as Ms. Williams was attempting to turn her vehicle left on the Fraser Highway on to 152 Street. It was struck by Mr. Fedalizo's vehicle, which had entered the intersection to proceed straight through on 152 in the opposite direction.

[2] Mr. Fedalizo's vehicle was leased by his father from Toyota, hence their roles as co-defendants.

[3] Liability was disputed on the question of which vehicle had the right of way at the time. Although their primary position is that Ms. Williams is entirely at fault, the defendants take the alternative position that liability could be apportioned between the parties, based on identifiable degrees of fault on the part of both drivers.

[4] The defendants accept that some of the injuries that Ms. Williams suffered in the collision have had ongoing effects. However, they dispute the extent of the injuries that she claims, in particular that she suffered a concussion, and the effects that she says her symptoms now have on her life. They also suggest that her situation is still capable of meaningful improvement, if she follows the recommendations made by some of her expert witnesses.

[5] I will refer to the accident that gives rise to this action as "the subject accident" to distinguish it from the accidents in 2013, 2015, and 2019 that Ms. Williams was also involved in, and that were also referred to in the evidence. In addition, the terms "concussion", "brain injury" and "mild traumatic brain injury" were used interchangeably in the evidence. Except for direct quotes in which one of the other terms was used, I will use "concussion."

II. LIABILITY

A. Circumstances of the Subject Accident

1. Ms. Williams

[6] She was on her way to the Guildford Mall on 152 Street, driving her Honda Civic. She was travelling east on the Fraser Highway and was intending to turn left to go north on 152. She believed that it was between 12:30 and 2:00 pm. The weather was clear.

[7] There is a dedicated left-turn lane on the Fraser Highway in her direction, as well as two through-lanes that continue east. In the opposite direction on Fraser Highway there is also a left turn lane and two through-lanes, as well as a dedicated lane for right-hand turns. It is a busy intersection, because both of the roads are arterial routes.

[8] Ms. Williams testified that she moved into the left-turn lane from the left-hand through lane. The light was green in her direction. There was a steady flow of traffic in the opposite direction, so she entered the intersection and stopped to wait for the light to change, so that she could complete her turn. When the light turned yellow, four more cars came through the intersection in the opposite direction. Other cars heading in that direction came to a stop. She believed that the cars that stopped were in the left turn lane and the left through-lane, although in cross-examination she said that because of the passage of time since the accident it was “confusing” which of the two through lanes one of the vehicles had stopped in. She remained certain that one or more vehicles had stopped in the left turn lane.

[9] She did a “scan” to make sure it was safe to go ahead with her turn. She saw the light turn red before she started turning. She had not gotten very far into that turn before she “quite quickly” heard a horn honking and a “bang”, after which she did not recall anything.

[10] She did not see Mr. Fedalizo’s vehicle before the accident, and was not aware of anything that would have prevented her from doing so.

[11] From her stationary position waiting to turn, she had accelerated to no more than 5-10 km/hr before she was struck. She agreed with the suggestion that once she began her turn she did not stop before each of the through-lanes to make sure that it was clear, but denied that she had proceeded “in one fluid motion” from the left turn lane into her turn, without stopping.

[12] Her next realization was that her vehicle had been turned completely around, presumably by the impact, and that she was now facing west on the Fraser Highway, near the crosswalk on 152 and a light post. (I took her to be describing a post at the northwest corner of the intersection.) The vehicle that had struck hers was in the middle of the intersection, facing in the same direction, turned slightly to its left.

2. Mr. Fedalizo

[13] He pinpointed the time of the collision more precisely, as 1:42 pm. It was just before the beginning of rush hour, so traffic was “getting slightly busy”. He was on his way to New Westminster from his home in Cloverdale when it occurred, driving a Subaru Cross Trek. He was intending to continue on the Fraser Highway, past the intersection with 152. He was travelling in the left of the two-through lanes, as he had been for his entire time on the Fraser Highway. His speed was 60 km/hr, which is the speed limit in the area.

[14] His version of events was that the light was green in his direction as he approached the intersection with 152, but that when he was three car lengths from the stop sign, it turned yellow. In his direction the road slopes slightly downhill towards the intersection. Because of this slope (and, I took it, his proximity to the stop line) he thought it would not be safe to try to stop, so he continued into the intersection. He maintained that the light was still yellow when he did so.

[15] He said that there was a vehicle, which we now know to be Ms. Williams’s, in the oncoming left turn lane, and it began to make its turn on the yellow light. He tried to dodge it, but it struck his vehicle on his left side. There was a “big impact”, which resulted in their vehicles “sliding for a bit” before they came to rest.

[16] In cross-examination Mr. Fedalizo agreed that there were two vehicles ahead of him in the right lane, travelling in the same direction, and that those vehicles were able to make safe, controlled stops when the light turned yellow, without entering the intersection. He attributed this to the fact that they had been travelling at a slower speed than he was, which he said was probably due to congestion in their lane. In contrast, the left lane ahead of him was clear and he could travel at the speed limit. After initially accepting the range that he had provided at his examination for discovery of 35-50 km/hr for those vehicles, he then described them travelling at the low end of that range, and said that he "doubt[ed]" that their speed could have been as high as 50 km/hr. He was unable to say whether there had been any cars in the right lane that had proceeded through the intersection on the yellow light (as Ms. Williams had described), ahead of the ones that were able to stop.

[17] He said that he had observed Ms. Williams's vehicle entering the left turn lane in her direction when he was five car lengths away from the intersection. However, when he was asked to identify his position on an aerial map of the intersection, he identified it as being about four cars back from the stop line. Regardless of that distinction, he accepted the suggestion that at that point her vehicle was approximately twice as far back from the intersection as his was. He described her vehicle as travelling at "a relatively fast speed" in the left turn lane.

[18] When he was confronted with the unlikelihood of Ms. Williams's vehicle being able to cover roughly twice the distance to the intersection as his vehicle, while travelling at a considerably slower speed, he explained that she had been travelling "very fast" into the left turn lane – "full speed or even faster".

[19] According to him, her vehicle slowed down at the intersection, but never came to a stop before it began its turn. He was not prepared to accept the estimate that he had given at his examination for discovery of her speed being 10-15 km/hr once she entered the intersection. He insisted that it was "at least" 15 km/hr. Her vehicle then accelerated into its turn.

[20] He testified that he began to apply his brakes when he was three car lengths from the stop line. He agreed with the suggestion that he "braked hard", and that he continued to do so until the point of impact.

[21] He denied the suggestion, which arises from the testimony of the witness Isabella Zawadzka, that he had actually been travelling in the right-hand through lane when he approached the intersection, but had switched into the left through lane to enter it once the vehicles in front of him in the right lane slowed to a stop.

[22] Mr. Fedalizo was 19 years old when the accident occurred, and had obtained his Class 5 drivers licence six months earlier. He bristled somewhat at the suggestion that he was an inexperienced driver at that time, describing himself as "a very good driver", and "very experienced".

3. Ms. Zawadzka

[23] Like Mr. Fedalizo, she was travelling west on the Fraser Highway, heading to her workplace in Surrey from Langley. She described there being a lot of traffic in the area of the intersection with 152 Street. She was travelling in the right-hand through lane.

[24] She said that when the light turned yellow she stopped her vehicle. She is very aware of the changing of lights and was looking at the numbers on the pedestrian crossing signal in her direction counting down as an indication that the green light was about to change. She does not "drive fast", she added. As a result of this approach she was able to bring her vehicle to a proper safe stop without suddenly hitting her brakes.

[25] As she was stopping, she looked in her rear-view mirror and saw a "large white vehicle" in her lane pass her in the left lane and enter the intersection. This vehicle accelerated past her in order to do so. It was moving "very fast…very quick", although she could not estimate a specific speed. She was calling this driver a "crazy person" in her own mind because of his actions. She had begun to reduce her own speed to about 40 km/hr by that point, in anticipation of stopping for the light.

[26] The collision with what turned out to be Ms. Williams's vehicle then occurred. Ms. Zawadzka was "pretty sure" that Ms. Williams's vehicle began its turn at the point that Ms. Zawadzka slowed her vehicle to a stop. As I understood her evidence, that was when the large white vehicle passed her quickly and entered the intersection "at full speed".

[27] It was her "opinion" that the light was red when the white vehicle entered the intersection, because of the amount of time that would have been needed for it to pass her and enter the intersection, after she had already stopped for the yellow light. She candidly conceded that she could not "confirm" that assertion however.

[28] She rejected the suggestion that the white vehicle was already in the left lane when she stopped. She was adamant that the vehicle was "exactly behind" her before it pulled out to pass. She did not notice any other vehicles in the left lane ahead of that one.

B. Governing Principles

[29] Three provisions of the *Motor Vehicle Act* affect the determination of liability here:

> 128 (1) When a yellow light alone is exhibited at an intersection by a traffic control signal, following the exhibition of a green light,
>
> (a)the driver of a vehicle approaching the intersection and facing the yellow light must cause it to stop before entering the marked crosswalk on the near side of the intersection, or if there is no marked crosswalk, before entering the intersection, unless the stop cannot be made in safety…
>
> 129 (1)…[W]hen a red light alone is exhibited at an intersection by a traffic control signal, the driver of a vehicle approaching the intersection and facing the red light must cause it to stop before entering the marked crosswalk on the near side of the intersection...
>
> 174 When a vehicle is in an intersection and its driver intends to turn left, the driver must yield the right of way to traffic approaching from the opposite direction that is in the intersection or so close as to constitute an immediate hazard, but having yielded and given a signal as required by sections 171 and 172, the driver may turn the vehicle to the left, and traffic approaching the intersection from the opposite direction must yield the right of way to the vehicle making the left turn.
>
> [Emphasis added]

[30] The cases on this subject frequently refer to the vehicle that has the right of way as being in the “dominant” position, and the vehicle that is required to yield as being in the “servient” one.

[31] Although it is not an exhaustive definition, it has been held that a vehicle is an immediate hazard “if its driver must take a sudden or violent action to avoid the threat of collision if a servient vehicle is about to make a left turn”: *Raie v. Thorpe* (1963), 43 W.W.R. 405, (B.C.C.A.), at para.18. This question must be assessed at the point that the servient vehicle is about to make its turn: *Raie*, at para. 25.

[32] If the driver of the dominant vehicle commits a breach of their common law duty of care or their statutory duties, the correct approach is to apportion liability for the accident between that driver and the servient driver who did not yield the right of way. The dominant driver does not lose their right of way for also having committed a breach: *Nerval v. Khehra*, 2012 BCCA 436, at para 38.

C. Positions

1. Plaintiff

[33] Ms. Williams’s counsel submits that the evidence demonstrates that the light had turned red before she proceeded with her left turn, which means that Mr. Fedalizo was in breach of s.129 of the *Act* by entering the intersection. He emphasizes that there is no reason not to accept Ms. Williams’s testimony on this point. Ms. Zawadzka’s conclusion that the light was red is supported by her own ability to come to a safe stop, despite having been ahead of Mr. Fedalizo, counsel argues, while Mr. Fedalizo’s account of how he came to enter the intersection is inherently unreliable.

[34] As an alternative position, her counsel submits that the evidence establishes that at the point that the light turned yellow, Mr. Fedalizo could have stopped safely, so that proceeding into the intersection represented a breach of s.128(a). A key point underlying this theory of liability is once again Ms. Zawadzka’s ability to stop safely, like the second vehicle that Mr. Fedalizo agreed was also closer to the

intersection than his. Notably, on his evidence these two other vehicles must have been even closer than the three car lengths away that Mr. Fedalizo placed himself. His claim that they had been travelling more slowly in their lane due to congestion does not hang together, Ms. Williams's counsel argues, because he said he was unaware of any other vehicles travelling ahead of them, and the speed of 35 km/h that he attributed to those vehicles is inconsistent with the wider range of 35-50 km/h that he gave for them at his examination for discovery.

2. Defendants

[35] Their counsel submit that Mr. Fedalizo was so close to the intersection that he constituted an immediate hazard to Ms. Williams, which meant that he had the right of way and she should not have engaged in her turn. Using an expression that is often found in vehicle accident cases, they say that Mr. Fedalizo was "there to be seen" by Ms. Williams, and she had no explanation for her failure to do so. Their position is that he exercised the standard of care of a reasonable driver in the circumstances, by deciding to proceed through when the light turned yellow, and that there was no evidence that he could have stopped safely once it was apparent that Ms. Williams was making her turn. As a result, she should be found completely liable for the accident.

[36] As an alternative, they submit that even if I conclude that Mr. Fedalizo was not exercising the required standard of care when he proceeded through the intersection, he still presented an immediate hazard and Ms. Williams should have yielded the right of way to him. To give effect to that finding, liability should be apportioned between them, either 60% against her and 40% against him, or equally.

[37] To illustrate these points, the defendants' counsel refer to some similar cases.

[38] In *Boyd v. Baldwin,* 2015 BCSC 887, the plaintiff was a passenger in a vehicle driven by one of the defendants. That driver had turned left when the light was "early into its yellow phase". His view of oncoming traffic was obstructed by a large vehicle facing him in the opposite direction, which was also waiting to turn left. This left-turning vehicle containing the plaintiff was struck by a vehicle proceeding

through the intersection in the opposite direction, which was driven by the other defendant. That vehicle was travelling at or below the speed limit, and the trial judge found that its driver could not have brought it to a safe stop before the intersection. Crucially, the judge also found that the driver of that vehicle was entitled to assume that the driver of the plaintiff's vehicle would yield the right of way. The judge referred to the point made in *Pacheco (Guardian ad litem of) v. Robinson* (1993), 75 B.C.L.R. (2d) 273 (C.A.), at para.11, that drivers are entitled to proceed on the basis that other drivers will obey the rules of the road. Thus, liability was apportioned entirely to the driver of the plaintiff's vehicle.

[39] Similarly, the defendants' counsel submit that Mr. Fedalizo was entitled to assume that Ms. Williams would not turn left in front of him once his vehicle presented an immediate hazard.

[40] As an example of a left-turn case in which liability was apportioned, counsel cite *Kabir v. Simpson*, 2016 BCSC 1594. There, the trial judge found that the plaintiff had turned left on a yellow light at a point when the oncoming defendant's vehicle was so close as to constitute an immediate hazard, thus giving the latter the right of way. The judge found that the plaintiff had done so "without checking the light or checking for oncoming northbound traffic, and did not see the defendant [,] who was by then in the intersection" (para.90). Despite this finding, liability was apportioned equally between the parties, because the defendant had also breached her duty of care by failing to stop before entering the intersection. The judge found that the defendant would have been able to stop, since she had time to honk her horn and apply her brakes before the collision.

D. Discussion

[41] First of all, I conclude that Mr. Fedalizo's version of events should be rejected. He abandoned the ranges of speed for Ms. Williams's vehicle and the ones travelling in his direction in the right lane that he had provided at his examination for discovery, in favour of the end of each range that best supported his position – faster for Ms. Williams and slower for the vehicles in the lane next to him. This suggests a

strategic approach to giving his evidence. He struggled to explain how Ms. Williams's vehicle could have covered roughly twice the distance to the point of impact as his vehicle in the same time period, when he was travelling 60 km/hr before braking, and it seems unrealistic that she would travel "full speed or even faster" in a left turn lane. It was also not clear how the collision could have occurred if he began braking when he was three car lengths from the intersection and had braked hard, as he agreed. He could not point to any actual basis for the "congestion" that had caused the vehicles in the right lane to travel more slowly, and he made the perplexing assertion that he was an experienced driver at the time, which suggests some defensiveness on his part.

[42] Most importantly, even if they were travelling more slowly than he was, the undisputed ability of Ms. Zawadzka and the driver of the vehicle ahead of her, who were closer to the intersection, to stop safely on the yellow light, undermines his claim that it would have been unsafe for him to try to stop.

[43] Taken as a whole, his evidence came across as an effort to reason backwards from a desired outcome, rather than a straightforward narrative of events that he had actually experienced.

[44] In contrast, there was nothing inherently implausible in Ms. Williams's description of how the collision occurred. In particular, it was to her credit that she acknowledged that she was unable to be certain about two important points – which through lane the other oncoming vehicles had stopped in and where Mr. Fedalizo's vehicle actually came from before it struck hers – rather than trying fill in those gaps to present a comprehensive narrative in her own favour. I found the latter point particularly meaningful, because by conceding that she does not know where he came from, she was leaving herself open to the suggestion that she should have been able to see him. I think it is unlikely that she would have done that if she had been taking a strategic approach to giving her evidence.

[45] On that crucial question of why she failed to see Mr. Fedalizo's vehicle before she began her turn, I am satisfied that Ms. Zawadzka's evidence provides a

convincing explanation. I found Ms. Zawadzka to be a careful and fair witness, and her ready concession that she infers that Mr. Fedalizo ran the red light, rather than actually having seen it, demonstrated those attributes. Although she had clearly concluded that Mr. Fedalizo's actions were unsafe and had caused the accident, her description of those actions provided a solid foundation for her point of view. There is no basis on which to find that she misperceived the movement of his vehicle, and her account of how it came up behind her as she was slowing to a stop and rapidly passed her had the natural, unforced quality and contained the kind of idiosyncratic detail that one would expect to find in a recollection of actual events.

[46] It is true that she did not describe another vehicle stopping ahead of her in the right lane, as Mr. Fedalizo did, but even if her vehicle was the first one to stop at the light, her ability to do so safely still demonstrates convincingly what a reasonably prudent driver was capable of in those circumstances, in contrast to Mr. Fedalizo's actions.

[47] In the final analysis, the sequence of events that Ms. Zawadzka's evidence supports – her slowing to a stop appropriately on a yellow light and Mr. Fedalizo passing her very quickly, but still not in time to make that light – makes sense of Ms. Williams's description of being struck, seemingly out of nowhere, while she was in the process of clearing the intersection, after the light turned red. I am satisfied that Mr. Fedalizo was not visible to her when she undertook her scan of oncoming traffic because he was still in the process of changing lanes to pass Ms. Zawadzka, on an increasingly stale yellow light.

[48] Thus, I find that Ms. Williams had the right of way when she began her turn, there being no vehicles reasonably visible to her that constituted an immediate hazard, and that the cause of the accident was Mr. Fedalizo accelerating into the intersection against what had by then become a red light. As a result, he is completely liable for the accident.

III. DAMAGES

A. Ms. Williams's Background

1. Overview

[49] She was 34 years old when this trial began. Her training and work background are in early childhood education and her current job is as a pregnancy support worker for a community services agency. She is in a committed relationship, and she and her partner have a child together, who was born shortly before the trial.

2. Previous Accidents

[50] In June 2013, her vehicle was rear-ended. As a result, she suffered from neck, shoulder, and back pain. She thought that this accident might have "heightened" her emotions, but that particular symptom did not persist. She received physiotherapy for a short period afterwards. The only ongoing problem from that accident at the time of the subject accident was pain in her right shoulder, which would sometimes also travel down her arm and back.

[51] Then in October 2015 her vehicle was struck by an oncoming vehicle while she was attempting to make a left turn onto her street. She suffered from some bruising and stiffness, but no ongoing physical effects. This accident also left her feeling "quite panicky" and ashamed for having caused it. She said that she was able to "move on" quite quickly from its effects however.

3. Employment and Career Plans

[52] She received her diploma in early childhood education from Douglas College in 2008. After completing the program, she began working in a daycare in Surrey, which she combined with a job at the YMCA that involved similar duties. In the ensuing years she also worked in childcare programs at SFU (which involved some supervision of other staff) and at a women's shelter.

[53] She also did one-on-one behavioural interventions with children who were on the autism spectrum. She worked in her first such position between 2012 and 2015, with a teenage client. She agreed in cross-examination that she had failed to report

her income for this work on the income tax returns for the years 2012-2014, although she said that she had not done so purposely.

[54] At the time of the subject accident, she was still providing behavioural intervention for a child, through the Reach Child & Youth Development Society. It was a seven-hour per week position, which she carried out over several days each week, in addition to her full-time job. It began in 2015. It overlapped with her previous behavioural intervention position, which she left because she did not want to be working three jobs at the same time. The funding for her work with the child at Reach was scheduled to end in November 2016, but her expectation before the subject accident was that she would be referred by Reach to work with another child after that.

[55] In direct examination she referred to another part-time job, selling merchandise for a company that promoted events in nightclubs, for four to six months in 2014. It consisted of shifts on weekend evenings. However, after it was put to her in cross-examination that she had not reported her income from it, she said that the majority of the work was as a volunteer, and that she was provided with free admission to events, rather than being paid.

[56] She obtained her first position with her current employer, Options Community Services, in 2013. It involved providing childcare and support for teenage mothers who were attending high school. The position ended in 2015 due to a decline in enrollment in the program.

[57] At the time of the subject accident, her position with Options was in a pregnancy and post-natal outreach program for expectant mothers who are in challenging life circumstances. She started working in that position in 2015 and was still in it as of the trial dates. She provides individual support for her clients and also conducts group sessions, all with the goal of helping the clients have healthy pregnancies and plan for the births of their children. She finds the work enjoyable and fulfilling. The position requires 28 hours of work per week. .

[58] Before the subject accident her long-term career plan was to become a community care licensing officer. That job involves childcare facilities to ensure that the facilities are complying with government health and safety requirements. Ms. Williams envisioned it as a way to advance her career while still being able to work with families and children.

[59] The training program to become a licensing officer is provided by the Justice Institute of British Columbia. The courses are online, and can be completed through 15 months of full-time study, or on a part-time basis over a maximum of four years. Ms. Williams's plan was to pursue the part-time option while maintaining her existing job. She began taking courses in 2015, and has taken two of them so far, completing the second one in December of that year. She achieved good marks in both. At the time of the subject accident, she was intending to save up enough to take two more courses in the fall of 2016.

[60] She confirmed in cross-examination that she had not yet conducted any searches for available positions in that field, and agreed that based on the recommendations of the Justice Institute, she would likely have to obtain another year of supervisory experience in order to qualify for such a position.

4. Physical and Social Activity

[61] Since high school she has maintained an interest in gym exercise. She testified that in the year before the subject accident she was going to the gym three times per week on average, for one to one-and-a-half hours each time, engaging in both cardio-vascular exercise and weight training. She and a close friend would also do outdoor workouts. She was an avid hiker in the spring and summer months, and would jog for parts of the hikes to increase the amount of exercise involved. She went for walks when the season was not conducive to actual hiking. Her previous position with Options tracked the school year, so she had her summers off, and during them she would hike the Grouse Grind once per week. Overall, she said that before this accident she was focused on exercise and on improving her health.

[62] To contradict this portrait of her fitness level before the subject accident, the defendants' counsel referred Ms. Williams to a December 2016 medical-legal report that was prepared by Dr. Darby, her family doctor. It had been prepared in relation to her June 2013 accident. It referred to Ms. Williams's "sadness and low mood" during a visit on February 18, 2015. Ms. Williams had emphasized to Dr. Darby during that visit that she had been in very good shape before the 2013 accident, "unlike at the present time". Her sadness and anxiety were "especially triggered" by being unable to attend the gym for a period of time because of her injuries, Dr. Darby wrote, and workouts were her most effective means of controlling her anxiety.

[63] In cross-examination, Ms. Williams was unwilling to fully acknowledge the accuracy of these statements. There may have been some times when her ability to exercise was impeded by the 2013 accident symptoms, she said, but she recalled attending a gym in 2014 and "some of" 2015, and having a regular routine in that regard. She pointed out that this visit to Dr. Darby was during the same period that she was suffering with an unhappy intimate relationship (I took her to mean that problems in that relationship could have accounted for her mood during the visit).

[64] She described herself as being very active in the social dimension of her life before the subject accident as well - engaging in numerous dinners, parties and other events, with a wide circle of friends.

[65] This view of her pre-accident physical and social activities was generally supported by two friends who appeared as witnesses: Shea Carson and Meghan Morrice.

[66] Ms. Carson, who described Ms. Williams as one of her best friends, referred in particular to Ms. Williams's high energy level, her outgoing, bubbly personality, her good sense of humour and her tendency to be the "life of the party". According to Ms. Carson, that high energy level was not affected by Ms. Williams working multiple jobs or attending school. She also noted the care that Ms. Williams took with her appearance.

[67] Ms. Morrice also described herself as a best friend of Ms. Williams's, dating back to 2011-12. She referred to Ms. Williams's energetic participation in social activities with a large circle of friends, such as going to clubs. In the early years of their friendship they shared an intense gym exercise regime (working out daily or every other day). However, there was a period after the 2013 accident in which Ms. Williams was not able to work out, Ms. Morrice said. When Ms. Williams got back into those workouts she did not use the heavier weights that she had previously used, to ensure that she did not hurt herself, and in general did not return to her pre-2013 exercise levels. Ms. Morrice said that she and Ms. Williams were very physically active in other respects however, such as hiking and walking their dogs, and that those kinds of activities were not hindered by the 2013 accident.

5. Mood Disorders

[68] Ms. Williams also acknowledged some struggles with anxiety in the years before the subject accident.

[69] The problem first surfaced in 2011, after the end of a relationship with an intimate partner, which had involved unfaithfulness on his part. She experienced difficulty sleeping and had "racing thoughts" about the relationship. She did not think that she ever stopped exercising as a result however. Her family doctor prescribed lorazepam (often described by the trade name Ativan) for her symptoms, which she found helpful. She continued taking it "off and on" until September 2015.

[70] Her next intimate relationship also ended unhappily, once again with unfaithfulness by that partner. In February 2015, she became overcome with emotion about the situation while she was at work. Because she made a comment to a co-worker that could be interpreted as contemplating self-harm, she was required by workplace policy to go to the hospital.

[71] As a result of this attendance at the hospital her medication for sleep difficulties due to anxiety was changed from lorazepam to quetiapine (often referred to by the trade name of Seroquel), because there is a danger of addiction to

lorazepam from long-term use. The main benefits of quetiapine are with respect to sleep, she advised, but it also functions as a mood stabilizer.

[72] In addition, she was prescribed trazodone, an antidepressant that is also used to treat sleep difficulties, as part of this process, but she did not take it very frequently until after the subject accident.

[73] She also described having been prescribed the antidepressant Cipralex for low mood during the second of these unhappy intimate relationships, but she did not take it in the manner prescribed, which she believed may have contributed to her anxiety.

[74] In March 2015, I infer as a result of her hospital attendance, she began to receive counselling from Sharan Sandhu, a registered social worker, through Surrey Mental Health. These sessions continued up to and following the subject accident. They focused on changing her negative thinking patterns and challenging her anxious thoughts. This was mainly in the context of her unsuccessful intimate relationships.

[75] She was unable to recall telling the psychiatrist she saw at the hospital on February 23, 2015 that she had “a longstanding history of difficulty coping”, but she agreed that it was an accurate description “at that time”. She said that this difficulty arose mainly during “bad relationships” (indeed, the psychiatrist noted its presence “particularly when it comes to management of the self in the context of relationships”). Similarly, the tendency toward self-blame and viewing herself as weak that she expressed to the psychiatrist was only in the context of that unsuccessful relationship. In fact she had been feeling good about herself before it began.

[76] The psychiatrist she saw for follow-up on September 1, 2015 encouraged her “to adopt more of a structure into her day as she is currently not working”, and “to engage in healthy living activity, such as going to the gym as well as socialization [,] because she is quite isolated at this time.” Ms. Williams explained that her position in

the program for teenage mothers had concluded by that time. Although she acknowledged that “it was difficult to be completely accurate after so long”, she did not recall being “very isolated” at that point. She thought that she might have been referring to the part of the day when she was used to being at work, and all of her friends were still at work. She did not address the further suggestion by the defendants’ counsel that the psychiatrist’s encouragement to go to the gym meant that she was not doing so at that point, about eight months before the subject accident.

[77] Her counsellor Ms. Sandhu recorded that she suffered a panic attack before a session on February 26, 2016. She conceded that being late for things made her anxious, but she was unable to “agree fully” with the suggestion that it did not take much to increase that anxiety to a panic attack. She was prepared to agree that she was “having a hard time” at that point though.

[78] As a further indication of her mental state just before the subject accident, she told Ms. Sandhu on March 3, 2016, that she was struggling with increased anxiety and low mood. She had been “emotionally triggered” by two of her friends having gone on a vacation without including her. In her evidence, she explained that she had been triggered by this situation because it involved the friends lying to her, which brought her back to the same issue that had been present in her negative intimate relationships.

[79] On June 9, she told Ms. Sandhu about the subject accident and her concussion symptoms. She testified that she was still not feeling well but was concerned about being off of work for too long.

[80] Notably from the defendants’ perspective, she related her anxiety during the June 17 session with Ms. Sandhu to her partner’s impending move to this province from Alberta, rather than to any work-related issues. She conceded that the relationship was her main stressor during that period.

[81] She acknowledged that in the December 2016 medical-legal report Dr. Darby had recommended cognitive behavioural therapy if her anxiety symptoms persisted. She rejected the suggestion that she had anxiety from the 2013 accident that was increased by her relationship difficulties, and that it was this anxiety that Dr. Darby was referring to when she wrote the report, despite it being written after the subject accident. She agreed that she had some anxiety before the subject accident, but it was not something she experienced every day and in every aspect of her life, unlike her current situation.

[82] Her friend Ms. Morrice also described Ms. Williams having some struggles with anxiety and depression before the subject accident. For example, she recalled Ms. Williams mentioning that her "heart was racing". Despite recalling these issues, Ms. Morrice emphasized that Ms. Williams's struggles were manageable before the subject accident, and did not prevent Ms. Williams from working and "hanging out with her friends". Referring specifically to the depression, Ms. Morrice said that it "never hindered [Ms. Williams] from being the person she was."

6. Non-Prescription Drug Use

[83] Ms. Williams testified that she occasionally self-medicated her anxiety with marihuana and cocaine. She began using marihuana recreationally in 2009 with friends, but then used it to address her anxiety after the 2011 breakup. It distracted her from that anxiety and calmed her down "a little bit". Her use of cocaine was also initially recreational, with the two intimate partners I have mentioned, and later with friends. The benefit that she perceived in addressing her anxiety was that it made her feel "more comfortable in [her] own skin". She used both drugs in 2015-2016, with marihuana being the more frequent one, but her ultimate intention was to stop using them, she said. She did not consider herself to have an addiction to either. She initially testified that she believed she eventually stopped using cocaine sometime in 2016. She later added that the exact date was difficult to pinpoint, but that it was approximately three years before the trial. She continued to use marihuana until she became pregnant, which was late in 2020.

[84] She agreed that her statements to the psychiatrist in February 2015 that she had a history of cocaine abuse, “although not as much recently”, and that she used marihuana daily, were accurate at that time. She also confirmed a report to another psychiatrist in November 2015 that she was using a gram of cocaine every one to two weekends. She accepted the suggestion that she had been warned of the interactions between cocaine and her prescription medication, and chose not to take the medication if she was using cocaine.

[85] In her March 3, 2016 session with Ms. Sandhu, she said that she felt she needed marihuana in order to be able to sleep. She confirmed in her evidence that this marihuana use was in addition to the prescription medication she was taking for sleep, but said that she did not recall exactly what her sleep situation was at that time.

[86] In Ms. Sandhu’s record of their session on March 9, 2016, she described her anxiety as being particularly high that week, which she attributed to having used more cocaine than she planned the previous weekend. When these statements were put to her, she said she did not recall that exact conversation. She thought that she recalled the underlying incident, but was “not fully clear”.

7. Overall Pre-Accident Situation

[87] Ms. Williams acknowledged that she still had some issues to deal with arising from her unsuccessful relationships, but maintained that in general she was “functioning quite well in [her] life” before the subject accident, and was “able to manage what was going on”. In particular, she had begun her current pregnancy support position with Options, which allowed her to apply a lot of her childcare education, and she was excited about advancing her career through further education.

B. Claimed Effects of the Collision

1. Indications of a Concussion

[88] Ms. Williams was not able to say whether she had lost consciousness after the impact, or how long the gap had been between the impact and the point that she was aware of her situation. Her last clear recollection was hearing a bang. Her next one was sitting in her vehicle, facing in the opposite direction, and starting to cry. She then realized that her airbag had deployed.

[89] A woman helped her out of the car and brought her to the curb. She described herself as being “pretty shocked”, as well as scared and emotional. She remembered Ms. Zawadzka approaching her while she was sitting on the curb to say that she had seen the accident and would be a witness. Firefighters arrived from a nearby station, and eventually an ambulance. Ms. Williams’s memory was “foggy” about the extent of the ambulance’s involvement. She phoned her brother, who picked her up and drove her to a doctor’s office. The doctor recommended that she go to the hospital, in case she had suffered a concussion in the collision. Her brother then drove her to the hospital, where she had a CT scan[1].

[90] Mr. Fedalizo said that after the impact Ms. Williams pulled her vehicle over to the side of the road. When she reversed in order to do so, the front bumper of her vehicle fell off. He saw Ms. Williams inside her vehicle, crying and speaking on the phone, as well as speaking to some pedestrians. He said that she got out of her vehicle “just fine”, and he did not see any sign that she was injured.

[91] Ms. Williams was not able to say if she had backed her vehicle up after the collision occurred, because she did not recall anything between the impact and her next memory of the burn on her wrist and the deployment of the airbag.

[92] Ms. Zawadzka was not asked whether Ms. Williams moved her vehicle after the impact. She said that she did not pay attention to whether Ms. Williams’s eyes

[1]Dr. Chawla, one of the experts called on Ms. Williams’s behalf, reviewed the records of this scan, which apparently did not show any abnormalities, but the records themselves did not form part of the trial evidence.

were open as she drove past her. Ms. Williams was responsive but in shock when she came back and spoke to her, so there was “not much response” from her. She did not notice whether Ms. Williams was interacting with the firefighters, or the other people there who were asking her questions.

2. Initial Physical Injuries and Effects

[93] The first injury that Ms. Williams noticed was a burn (from friction, I took it) to her right wrist as a result of the airbag deploying. This proved to be transitory, as did the swelling, bruising and stiffness that she also experienced in the period immediately following the accident. In cross-examination she clarified that the burn took about three weeks to resolve, and that these other injuries took about two weeks.

[94] Of the ongoing effects of the accident that she claims, the first ones that she noticed were sensitivity to light and sound, headaches, nausea, and a greater susceptibility to becoming irritated or angry. The theory of the plaintiff in this case is that she suffered a concussion in the collision, and Ms. Williams described these symptoms as stemming from that injury.

[95] When it was suggested to her that any dizziness following the accident had resolved by December of 2016, she said that she thought that it had, but actually when she suffers from prolonged headaches it still leaves her feeling dizzy. She had confirmed 2016 as the year that the dizziness resolved during her examination for discovery, but explained that while that may have been what she “felt” at that time, her headaches can in fact still result in dizziness.

[96] In order to make sense of Ms. Williams’s post-accident requests for medical attention, it is important to know that her brother’s doctor, Dr. Meek, had a walk-in clinic that was closer to her home. She testified that before the accident she would see him or another doctor at his clinic if she could not get in to see Dr. Darby in a timely way. She continued this practice after the accident because she did not want to drive the additional distance to see Dr. Darby, whom she still regarded as her family doctor.

3. Initial Concussion Support

[97] Starting in June 2016, the month after the accident, and continuing until August of that year, Ms. Williams was seen by an occupational therapist from Community Brain Injury Support Services at WorkSafe BC[2]. With respect to her concussion symptoms at that time, she explained that she was not as “in tune” with them as she would come to be later. She added that her goal at the time was to get back to work, and she was aware that what she said to the occupational therapist would impact that. I took her to mean that negative reports about her condition could delay her return. Although there were “some improvements in some cases” at the time, she was not expressing to the therapist that things were getting better with her condition. Rather, she was trying to be “positive and hopeful”.

4. Visual Issues and Noise Sensitivity

[98] She was particularly troubled by the visual issues. She testified that she did not fully understand these issues until she came under the care of Dr. Sass, an optometrist to whom she was referred by her counsel, and who provided expert reports on her behalf.

[99] Her initial experience was that she did not want to have lights on, because they would irritate her headaches and require her to squint. Fluorescent lights caused her the greatest problem, because of their brightness.

[100] She also found it more difficult to use computer screens - it was hard for her to read the words being displayed, and they caused headaches and a feeling of discomfort. She became aware of the computer issues shortly after her return to work at the prenatal support program after the subject accident. She was on a program of gradual return to work and said that she was conscious during that period of not using the computer or reading for too long. Her cellphone screen caused similar discomfort, requiring her to turn down its brightness level.

[2] The accident occurred while she was working (on the way to see a client). WorkSafe BC has a subrogated claim for wages and health expenses that it covered.

[101] In addition to squinting, she had to cover one eye in order to feel more comfortable reading for a lengthy period of time. She would find herself doing this while reading, rather than having consciously decided to do so. Another required adjustment, when she was reading hard copies of documents was to use her finger or a ruler, to avoid losing her place.

[102] A further symptom that she “might have been aware of” before she began seeing Dr. Sass was “mixing words up” (while reading, I took her to mean).

[103] As I have mentioned, she continued with her part-time behavioral intervention position with Reach until November 2016. After the subject accident, she had difficulties with light sensitivity (the room in which she worked with the child had fluorescent lighting), and with filling out the necessary forms. She was also sensitive to the loud noises made by the child.

[104] She agreed that the occupational therapist had recorded her as experiencing “mild” noise and light sensitivity, and that her accommodations at work consisted of reducing overhead fluorescent lighting and using task lighting instead. Those accommodations were helpful, she conceded.

[105] She also experienced visual symptoms outside of the workplace. Being in a stopped vehicle while another vehicle was moving beside her would startle her, and cause dizziness and discomfort. In malls or grocery stores she would feel overwhelmed and dizzy from the lighting and the length of the aisles. When she was in grocery stores she had to look at the floor most of the time to prevent these effects, and she avoided buying too many items in one visit in order to keep the visits short.

[106] Dr. Sass gave her exercises to do at home to try to reduce her visual symptoms, which involve reading or looking at diagrams while engaging in different types of physical activity. Her headaches, which I will discuss further, interfered with her ability to perform these exercises with the frequency that Dr. Sass had

recommended. In any event, as of the time that she testified she did not think that she was making any further progress with them.

[107] In cross-examination she confirmed that she did not report visual symptoms to any other care providers (other than the immediate post-accident ones that she described to the occupational therapist) until after she began to see Dr. Sass. She maintained that she did not connect her need to use a finger or a ruler while reading to visual concerns before she began to see him.

[108] She agreed that she had suffered some blurred vision after the accident but, like her other visual symptoms, she did not think that she "connected it with what to do next or what was going on with [her]". While the blurred vision usually clears up in 30 seconds to a minute, that can vary.

[109] She did not miss any work between 2016 and 2019 solely because of these visual issues, but she thought that they could have caused her to do so in combination with other problems. She then said that because of the importance of her job to her she would push herself to continue.

[110] A potential visual issue that she reported to Dr. Sass, but which appears not to have been recorded by any other care provider, was clumsiness. She clarified that the various ways in which she has injured herself through clumsiness have not required medical attention. She recalled discussing the issue with Dr. Darby, although she could not say in what year.

[111] She also confirmed that on October 16, 2018, two weeks before her first meeting with Dr. Sass she had been examined by another optometrist, Dr. Hanberg. He recorded that her light sensitivity had "mostly resolved". While there may have been some improvement in that condition, she agreed, that did not mean that she was better, and she would not have used the phrase "mostly resolved" to describe her situation. She pointed out that Dr. Hanberg's role at that point was to test her eyes, which she distinguished from Dr. Sass's role in exploring her broader visual symptoms. When it was put to her that at various points she had indicated to the

occupational therapist, Dr. Meek and this optometrist that her light sensitivity was resolving, she disagreed, pointing out once again that she did not have as much insight and knowledge about the issue as she would come to have later, and that at those early points she simply "wanted to be okay".

[112] Dr. Hanberg did not record any particular comments by her during her visit on December 17, 2018, which was described as being in relation to a retinal lesion, but she was not prepared to confirm that she had not raised any of her other visual issues at that time. She took the same position in relation to the absence of such comments in the notes of an April 16, 2019 visit, and once again drew a distinction between Dr. Hanberg, who "fixes [her] eyes" and Dr. Sass, whom she sees for the visual issues that figure in her injury claims.

[113] Finally, during a visit on October 28, 2019, Dr. Hanberg recorded "concussion, headaches and occasional light sensitivity" in relation to the subject accident, with a recently increased frequency that her "GP thinks may be due to new medication". She could not recall what they had discussed beyond what Dr. Hanberg had noted, so she was not prepared to concede that she had not disclosed any other visual symptoms.

[114] Ms. Morrice was able to comment on Ms. Williams's visual problems, which she said arose in the context of reading, using the computer or her cellphone, or attending movies. After they went to one particular movie together, Ms. Williams was "down for the count" for days, Ms. Morrice said, despite having sat at the back of the theatre.

5. Headaches

[115] Ms. Williams's initial experience following the accident was of intense headaches, which were triggered by light, reading, the movement of images on television, noise (especially by the child with whom she was working as a behavioural interventionist) and her own movements.

[116] After first describing their location as being in her temples and the front of her head, she then clarified that when they were intense they could cover her entire head.

[117] She obtained some temporary relief by using peppermint oil (through a humidifier, and applied to her temples and the back of her neck), listening to meditation music and recorded mediations, and seeking refuge in a quiet, dimly-lit room. She has also found that “old fashioned light bulbs” (by which I took her to mean incandescent bulbs) are easier to tolerate. It took her several months to progress beyond “lying in the dark and feeling depressed” to research these other remedies.

[118] Over the five years between the subject accident and her testimony, Ms. Williams has been able to categorize her headaches as dull, mild-to-moderate, and severe.

[119] The dull and mild-to-moderate ones have an impact on her work, she explained, interfering with her focus, making her easily frustrated and irritated and requiring breaks from using the computer. They also interfere with her ability to be fully attentive to the needs of her vulnerable clients and to prepare adequately for their sessions together. When they leave her unable to fulfil her expectations for those interactions, that leads to an increase in her anxiety.

[120] These headaches also have an impact on her household responsibilities, especially if she has had one throughout the day at work. Her fear of aggravating them restricts her ability to assist with housework, and her partner has taken on the tasks of cooking and cleaning to avoid that.

[121] She described the severe headaches as leaving her totally disabled, crying, holding her head and having to lie in the dark. Just before the trial started, she experienced such a headache when she, her partner and their child were on their way to a family dinner. It came on very quickly and she ended up wearing sunglasses and resting her head against the car window because the cold was

comforting. Her partner bought her some Extra Strength Tylenol from a gas station store and after taking it she was able to enjoy the dinner.

[122] In contrast, the occupational therapist who saw Ms. Williams in the months following the subject accident quoted her as describing “gradually resolving” symptoms, with mainly “residual, occasional” headaches by the time that she was discharged from the program in August 2016. Ms. Williams maintained that these symptoms had not actually resolved, although there had been some progress. She recalled still having headaches quite frequently.

[123] At another point in her report the therapist described the headaches as “largely resolving, with the exception of experiencing occasional milder headaches…” Ms. Williams could not recall making those specific statements. When she was asked if they were an accurate description of her condition at that time she said that she “could have been dealing with some improvement”, but that she did not think that she was ‘better completely”. She added that there were times during this period when she felt that the symptoms were resolving, and that she was “hopeful that it was the case”.

[124] In addition, the occupational therapist had recorded Ms. Williams describing experiencing a “strong” headache only after a “longer strenuous hike”. When it was suggested that she must have been feeling better or she would not have attempted such a hike, she recalled that it had actually just been a lengthy walk on a trail. The hike had taken place during a week-long camping trip, which she was otherwise able to enjoy however. She also resisted the suggestions that her willingness to embark on such a hike undermined her general position that she avoids activities that can provoke severe headaches, and that she would not have gone camping if she was lying in bed with headaches. She explained that it was a pre-booked trip and that she had “pushed” her activities without knowing what the outcome would be.

[125] It appeared that the first indication to a medical professional of more enduring headaches, of the kind that she described in her testimony, was during a visit to Dr. Meek in December 2018.

6. Anxiety

[126] In overview, Ms. Williams testified that at times her anxiety is unmanageable, causing symptoms such as fidgeting, pacing, changes in the rate of her breathing (both slower and faster than normal) and confusion. It can escalate to the level of her crying and panicking.

[127] Her anxiety specifically in relation to driving arose immediately after the subject accident. She said that when driving she becomes very fearful, with a racing heart and rapid breathing, and is hypervigilant about the actions of other drivers. If someone drives in a way that makes her uncomfortable, she comes close to having a panic attack. She initially described that it is “more common than not” that she will have to pull over at some point when she is driving due to such an attack, although she later modified that position to say that in the majority of trips she is “working through” anxiety or panicking, but not to the point of actually having to pull over.

[128] She avoids making left turns whenever possible, even if that requires a succession of right turns to reach her destination, as well as busy routes and longer commutes.

[129] She is also extremely nervous when riding as a passenger.

[130] Until this trial, when traffic conditions required her to use it, she had not driven through the intersection where this accident occurred, even though it is a main one in the area where she lives. Her partner was driving when they went through it, and she had to put her head down as they did so.

[131] Ms. Carson said that she has taken over all of the driving when going out with Ms. Williams, which they used to alternate between them, because she is aware that Ms. Williams does not enjoy it. She referred to a recent incident in which she was driving and they were almost hit by another car – Ms. Williams went from chatting beforehand to being completely silent.

[132] Ms. Morrice also described having assumed the responsibility for all of the driving when she and Ms. Williams were together after the subject accident. She has noticed Ms. Williams behaving in a very tense manner in the passenger seat. At times Ms. Williams would ask Ms. Morrice not to make a left turn. She is now able to tolerate left turns, Ms. Morrice said, but is still a lot more cautious about them than she was before the accident.

[133] Ms. Williams began participating in dialectical behaviour therapy ("DBT") in a group setting in 2017, and she finds some relief from her driving anxiety from reviewing the worksheets that she received from the program, which she carries with her in a binder. However, given the frequency with which she experiences this kind of anxiety, it is not feasible to be reviewing the worksheets constantly. (I understood her to be indicating that the DBT worksheets are also helpful for dealing with anxiety that arises in other situations as well.) She also tries to apply the mindfulness tips that Dr. Darby has provided to her for relief.

[134] Her direct evidence did not address the timing of the onset of her anxiety. When it was put to her that her initial post-accident doctor's appointments in May 2016 (she was coming back weekly to the doctor during that period to monitor her signs of a concussion) do not refer to increased anxiety, she maintained that it was present but "more so [that she was] feeling depressed".

[135] Similarly, she denied that the focus in her sessions with Ms. Sandhu on anxiety arising from her new relationship with her intimate partner meant that she was not suffering from anxiety due to other causes as well. The relationship was one of her stressors, but that certainly did not mean that her anxiety from the accident had resolved by then, she emphasized.

[136] She could not specifically recall having told Ms. Sandhu in October 2016 that she was "managing better" except for intense anxiety around the time of her menstrual period. She conceded that it might have been what she expressed in that session, although the anxiety had "never really gone away". Once again, she rejected the statement attributed to her in that session that "her main concern [was]

the relationship". It was "something that was going on", but not her main concern. Later in her evidence she added that she needed emotional support with things that were contributing to her anxiety (like the relationship, I took it), but not necessarily causing it.

[137] Her sessions with Ms. Sandhu of Surrey Mental Health after the subject accident have continued to focus on relationships and friendships, she said. She did not think she discussed the accident because she does not like "going there in [her] mind."

7. Obsessive-Compulsive Disorder ("OCD")

[138] Ms. Williams explained that this condition manifests itself in the requirement for an elaborate routine, often taking 30-40 minutes, before she is able to leave her house. It involves her repeatedly checking that her bedroom door is closed, that all of the electric appliances are unplugged, that her dog has not escaped and, finally, that the outside door is locked. Any doubt that she has completed a step requires her to repeat it, and after leaving the house she will often become so anxious that she has neglected to do something that she will have to return to check. She has resorted to recording videos of herself taking these various steps on her phone so that she can review them later, but I took from her evidence that this is not always effective in alleviating her anxiety. If she is the last person left in the office at work, she is compelled to go through the same repetitive process of unplugging and locking before she can leave. The net effect is exhaustion, because she is in a state of high anxiety throughout the process.

[139] Dr. Darby has more recently prescribed the drug Trintellix to her, which she initially said has cut down on the amount of time that this routine takes and the anxiety she feels concerning it (as well as providing some improvement in her ability to focus), but the overall problem has not resolved. Later in her cross-examination however, she said that she did not think the Trintellix "has helped that much" with the OCD.

[140] When she was asked by her counsel how comfortable she was pursuing treatment for OCD, she said that she finds it quite embarrassing and that she is more comfortable with Dr. Darby (as opposed to being referred for more specialized assistance, I took it). Her treating psychologist, Dr. Krull, assists her with this problem by giving her positive feedback and pointing out when she is doing well. She agreed that he had recommended that she continue receiving OCD support but that she had not done so. Surrey Mental Health advised her that they did not have any OCD support groups, only one-on-one counselling. It was not clear why she had not pursued such counselling.

[141] Ms. Carson said that she has observed Ms. Williams repeatedly checking if doors were locked and electric devices unplugged, despite having just carried out those actions, and becoming anxious later because of doubts that she had done so. A particular example she gave was Ms. Williams carrying her hair straightener around with her to ensure that it was unplugged.

[142] Ms. Morrice provided the same example involving the hair straightener, as well as describing Ms. Williams video-recording herself locking doors, so that she could watch the videos later when she became anxious about it. Ms. Morrice has seen the videos herself and said that Ms. Williams finds them embarrassing. Despite having them, she would still sometimes need to return to her house after ten minutes in order to re-check everything. On occasion, Ms. Morrice would specifically observe the various steps at the house, so she could reassure Ms. Williams later that she had carried them out.

8. Depression

[143] The depression she experiences is associated to negative thinking about herself, especially dwelling on her feeling that she is “a completely different person”, as a result of the subject accident, and what she has lost as a result of it. The reduction in her energy level and the need to isolate herself that come from the ongoing headaches also play a role in this depression.

[144] Another factor is the amount of weight she has gained since the accident, which makes her feel embarrassed about her appearance, especially in comparison to the high level of fitness that she was previously able to maintain. This has been accompanied by a decline in her level of grooming and self-care, which fuels further negative thoughts.

[145] Both Ms. Carson and Ms. Morrice commented on the effect on her mood of Ms. Williams's loss of her previous fitness level and neglect of her appearance.

9. Fatigue

[146] It was not entirely clear from Ms. Williams's evidence whether this was claimed to be a discrete effect of the accident, or a by-product of her ongoing pain and mood disorders. Aside from the effects of her headaches on her ability to perform household tasks, she said more generally that after the accident she noticed that she was less able to perform them, and less willing to leave her home and socialize, because of a feeling of exhaustion. She ended up coming home from work and "doing nothing", a practice that continued on weekends as well.

[147] She initially tried to "push through" this feeling, and was "not really connecting" how exhausted she was with her inability to socialize and engage in her usual range of pre-accident activities.

[148] As of the trial she said that she feels exhausted all the time, and is unable to be "energized" or "re-charged" (by resting, I took it). While she was pregnant, even resting for the entire three days before her work week did not increase her energy.

[149] Both Ms. Morrice and Ms. Carson testified to observing a very significant decline in Ms. Williams's pre-accident energy level. Ms. Morrice attributed this to the effects of Ms. Williams's anxiety and depression.

10. Cognitive Effects

[150] Ms. Williams said that she experiences a reduced ability to comprehend and retain information, a tendency to become confused easily, and problems with her

memory, such as forgetting what she is talking about in the middle of a conversation. She elaborated that she has to re-read material several times in order to understand it, and may have to look up the meaning of some words.

[151] As in the case of the other effects of the subject accident, the feeling of not being able to understand something increases her anxiety level. She gave an example of becoming extremely anxious about the advice she had given to a client, because she felt she had not been able to research it properly and convey it clearly.

[152] She was unable to say when she noticed these cognitive problems. She did not have "good insight" into them for some time. When she began to see Dr. Sass for her visual problems she started to connect the cognitive issues with them - noticing, for example mixing up words with similar beginnings, or mixing up the order of words within sentences.

[153] Addressing the occupational therapist's report in August 2016 that her "mental fatigue" was "largely resolving" except "by the end of a particularly long or challenging work day", Ms. Williams said that may have been what she was feeling "on that day".

11. Impact on Employment and Career Goals

[154] Ms. Williams testified that the most troubling effects of the accident to her on a day to day basis are the anxiety and OCD (with panic attacks generally happening every day), and the headaches, which she experiences "almost" daily, although they vary in intensity, as has been summarized.

[155] Ms. Carson, who works at Options in a different capacity, said that there have been times when she has visited Ms. Williams in her office and ended up advising her to go home, because her headache or her anxiety was so bad. Her view is that because the employer discourages it, Ms. Williams has not always taken the time that she should have taken to address her physical or mental health.

[156] Ms. Morrice described Ms. Williams as being depressed about not being able to “give as much” to her job as she had previously, because of the challenges from the accident that she was experiencing.

[157] In response to the note by the occupational therapist that Ms. Williams felt that her work tolerance was “improving each week”, she said that while there might have been some improvements by that point there were still some challenges as well. When it was put to her that Ms. Sandhu had recorded her comment during a session in August 2016 that “work was going well”, she responded that this did not mean that there were no challenges at work, and that she might not have talked about them with Ms. Sandhu.

[158] When the funding for her behavioural intervention position with Reach ended in November 2016, she avoided getting connected with another child to work with. Before the subject accident she had enjoyed the position, but she found it quite challenging after. She elaborated that interacting with the child made her extremely fatigued, and she began to dread upcoming sessions because of this effect. This in turn increased her depression, because before the accident she had felt that she was really making a difference in that child’s life. She did not pursue working with another child because she did not want to repeat this experience.

[159] However, before that with Reach ended, she added another position involving the same number of hours per week (seven), as a community counsellor in a parenting program that was also run by Options. It was to begin after the contract with the child through Reach ended (her payroll records indicate that it began in November 2016). The effect was that once the Reach position ended, she was still working a total of 35 hours per week in two jobs, as she had been previously, except now both positions were with Options.

[160] She maintained that if it had not been for the effects of the accident she would have added the Options position and kept the one with Reach, moving on to working with a new child with the latter agency. In that case, she would have worked with the child in the evenings to accommodate her other commitments at Options, or gone in

to work at Options early in order to finish in time for Reach's usual late afternoon session times. She maintained that she could have handled these responsibilities in addition to pursuing the online licensing officer courses, which did not require any commuting and had some flexibility to them. The fact that she had achieved good grades previously contributed to her belief that this was all "doable".

[161] When it was put to her that she would not have taken the second Options position if she was experiencing the symptoms that she claimed, she responded that she believed that with her "past work ethic, abilities and drive" she could handle it. She rejected the further suggestion that she left the job at Reach solely to take the second Options job, and not because of her accident symptoms. She explained that the second Options position had different duties than the one at Reach, which she believed she would be able to handle better. The Options position paid $1.85 per hour more than the one at Reach, but she also rejected the suggestions that an increase in that amount, or the opportunity to have both of the positions with the same organization would have been reasons to switch.

[162] In June 2019, following a consultation with Dr. Darby, she concluded that working a total of 35 hours per week in the two Options jobs was not sustainable. At the end of July, she requested to reduce the seven-hour-per-week position to two hours. She said that the problem had existed since the end of 2016, but she was reluctant to accept the reduction in her capability at that point, so she struggled through the intervening period, before finally accepting the need to cut her hours.

[163] She agreed that in April of 2019, Options had implemented a new model of parenting support, which involved her facilitating an eight week group program. She struggled with it, because it involved a different philosophy and required her to research child brain development and present a lot of examples to the group. It was once this responsibility was added to her workload that she started connecting with her doctors and realizing that she could not fulfil this seven-hour per week position. She maintained however that she had been struggling with that position in light of her injuries since she took it on in late 2016. Her supervisor, Jen Mantyka-Ogden,

confirmed that Ms. Williams could not finish the group sessions in the seven-hour position because “it was too much for her”.

[164] She continued with those reduced hours, along with the 28 hours per week in her position with the pre-natal support program, on a four day per week schedule. She found it tiring to have to “push through” the driving anxiety, OCD and vision problems to maintain those hours. She felt burned out a lot of the time, and it was stressful to “be present” for her clients and help them despite the limitations.

[165] She sought to downgrade the comments in her performance appraisal at work for the period February 2018 to June 2020, which credited her with taking on additional duties when required, orienting new staff, and completing tasks during periods of staff turnover or absences that would normally be done by the program manager. She said many of these duties were already in her job description, and although she may have done some extra tasks if no one else was available, it was not clear to her what tasks some of the other comments mentioned in the appraisal pertained to.

[166] She went on pregnancy leave on June 24, 2021. Dr. Darby and her obstetrician had recommended that she stop working a month or two before that, but she felt that she needed to be available for her clients and so she “pushed through” into June against that recommendation. She ended up being hospitalized for high blood pressure in relation to the pregnancy on both the day before and the day after her leave officially began.

[167] Overall, she described feeling less competent in her job and diminished in her ability to pursue further schooling. In particular, she feels less intellectually capable than she was before the accident. She agreed however, that her supervisor at Options has not raised any concerns about her performance, and in fact has supported her with her headache problems.

[168] She received an overall positive performance review from Reach for the period ending in August 2016, which included the period immediately following the

subject accident, and agreed that no concerns about her performance were ever brought to her attention while she was working for that agency. Her performance review from Options for the period ending in July 2016 contained numerous positive comments as well. Addressing that review, Ms. Williams said that she was keeping her injuries to herself and trying to work through them. Similarly, she attributed her positive reviews in 2019 (and 2020, because there were actually reviews for both years in the defendants' documents, which were treated as a single document in cross-examination) except for some issues raised with her time management, to having worked hard to ensure that her injuries did not affect the job and her clients.

[169] Ms. Mantyka-Ogden testified that among her strengths, Ms. Williams loves her job, is passionate about working with the vulnerable women to whom she provides support, works very hard, and is "extremely dedicated to learning everything she can". In addition, she is good at building rapport with her clients, who feel very "safe and supported" when she is working with them. She said that she has no concern with Ms. Williams's energy level.

[170] With respect to job challenges, Ms. Mantyka-Ogden described that Ms. Williams sometimes lets the needs of the clients interfere with her administrative obligations. Rather than just taking longer to complete administrative tasks, Ms. Williams does not get some of the tasks done. She said that this is something that Ms. Williams is aware of and is working on improving. It was discussed with her as part of her performance reviews.

[171] Ms. Mantyka-Ogden explained that the focus in performance reviews is on communicating to employees that their work is appreciated and valued and on the employees' strengths. She does not "save up a list of things that the employees have done wrong".

[172] Ms. Williams has disclosed her "emotional difficulties", and Ms. Mantyka-Ogden has offered support on behalf of the employer in a variety of ways, such as flexibility in scheduling to accommodate her bad days, and attending one or two of Ms. Williams's group sessions per month to provide her with support.

[173] Available resources in the workplace include access to a mindfulness tool, and workbooks on dealing with anxiety. She has encouraged Ms. Williams to seek counselling through the organization's employee assistance program. She has also assisted with Ms. Williams's headaches, by providing a larger computer monitor and a screen to reduce the glare from it, as well as changing the lighting in her work area.

[174] In the 2020 performance review, Ms. Mantyka-Ogden recorded that:

> [Ms. Williams's] ICBC case [i.e. this action] has created significant barriers to managing her stress levels and mental wellness, however she is very aware and seeks support to reduce work load or take time off to process this stress away from work.

She pointed out that taking time off of work interferes with Ms. Williams's duties. That review also described Ms. Williams experiencing some anxiety about providing services during the onset of the COVID-19 pandemic. She committed to accessing support for those feelings and implementing the strategies that she had learned during her counselling sessions.

[175] With respect to her current career plans, Ms. Williams testified that she feels too depressed, and lacks the motivation and energy, to pursue the remaining courses in the licensing officer program. At one point in her testimony, she said that she "hadn't really thought" about the program, and no longer considered it a possibility for her. Crucially from her point of view, she believes that she no longer has the ability to take in the kind of detailed information that is provided in the courses and implement what she has learned, as she could previously.

[176] Ms. Mantyka-Ogden said that while Ms. Williams could have access to numerous other positions at the same level in other Options programs, she would need further education – at least a bachelor's degree – to access more responsible and higher-paying positions in their field.

[177] Looking ahead to the end of her maternity leave, Ms. Williams testified that she plans to try to return to work in the pregnancy support program, because of the

fulfillment that it provides to her, although she is not certain how she will manage it in light of her ongoing difficulties.

[178] Her mother, who was working two days per week as of the trial dates but could be retired by the end of the maternity leave, is willing to provide child care. The unknown factor from Ms. Williams's perspective is how she will manage working full-time and parenting when she is experiencing fatigue and headaches. Before she went off on leave she was tired, anxious and depressed when she got home each day. At the time that she testified, her partner was participating fully in child care as she recovered from having a caesarean delivery, but he is not able to continue at that level of support on an ongoing basis.

12. Impact on Lifestyle

[179] As to her recreational and social activities, Ms. Williams explained firstly that she is currently completely unable to exercise. She has tried light physical activities and easing into them, but she is either unable to keep up, or the activity causes too much pain, especially from headaches. The basic exercise routine that she described to the occupational therapist in the months immediately after the accident caused her dizziness when she was using the treadmill, so she abandoned it, although it appears that she did not advise the therapist of that. Fatigue is also a continuing impediment to exercise. Even walking her dog on a daily basis is currently beyond her capacity.

[180] She does not go out with her friends unless the event in question is very important to one of them, and she tends to isolate herself even from her family and close friends. She agreed that she and her partner attended a friend's wedding in Mexico in March 2020 and "did relaxing things" while they were there, but she was also bothered by headaches during the trip.

[181] Ms. Carson said that Ms. Williams has essentially withdrawn completely from socializing with their group of friends, and no longer has her former extremely outgoing personality. For example, she did not respond when Ms. Carson contacted her to see if she needed help with her new baby. However, Ms. Carson also

conceded that her contact with Ms. Williams was relatively infrequent in the period immediately following the accident – at most two or three times in the summer of 2016 through to Christmas, and less than once per month in 2017. She was not sure how frequently she saw Ms. Williams in 2018.

[182] On the whole their time together has ebbed and flowed, she said, with times that they saw each other very frequently. Ms. Carson herself was not socializing with their friend group for a period of time because of a romantic relationship that she was involved in, but when she returned to socializing with them (which I understood was in 2018) Ms. Williams was not participating. For example, Ms. Williams did not take part in some renovations at the home of one of the group members that took place over several weekends that summer.

[183] Ms. Morrice's observation was that Ms. Williams could not be around large crowds, with lots of noise and people talking all at once. This meant that she could not be around her group of friends, which increased her depression. Ms. Morrice added later in her evidence Ms. Williams will "come out to things" involving a smaller group of friends, but will stay for a much shorter time than she would have before the subject accident and not participate to the same extent while she is there.
Ms. Williams was able to participate in Ms. Morrice's wedding and pre-wedding activities, but "not to the full extent", Ms. Morrice said. Her inability to go to the gym, which was an activity that she and Ms. Morrice enjoyed doing together, added to her depression. She was easily confused when she went grocery shopping, which embarrassed her and caused her not to want to go. "A couple of times" Ms. Morrice went shopping for her, after noticing that she had no food in the house.

[184] Although the occupational therapist who saw her in the months immediately following the subject accident had described her as being "independent" in her self-care, Ms. Williams remembered having had a hard time with those tasks at that point, and receiving support in her attempts to get back to her pre-accident abilities. When it was put to her that the therapist had recorded that by June of 2016 she was

working and doing housework, she responded that she was “trying” to do these things.

[185] In addition to her generally diminished ability to participate in housework, which she added is limited to tidying up the kitchen, Ms. Williams said that she no longer enjoys looking up recipes and planning meals, as she did before the subject accident.

[186] A psychiatrist who saw her for the Reproductive Mental Health Program through her health district described her as being “positive about the baby and the future”. As she had in relation to other positive comments to care providers, she responded that there may have been times when she felt that way, but things were not improving in every area of her life.

13. Irregular Attendance at Family Doctors and Incomplete Complaints

[187] The infrequency of Ms. Williams’s visits to family physicians, which arguably contrasted with the severity of the symptoms that she claimed to experience, and the contradictory statements that she is alleged to have made during some of the visits, were reviewed with her in cross-examination.

[188] She did not see Dr. Darby at all from January 2017 to January 2018. She pointed out that Dr. Darby had prescribed Seroquel to her at the 2017 visit and she had followed that recommendation. Her failure to follow up for the following year resulted from a lack of insight into the problems that she was having and “what kind of help might be available”, her fatigue at the end of the work day, and her driving anxiety. She prioritized keeping up with her work and maintain a positive attitude while she was there.

[189] After the subject accident, when fear of driving had become an issue, she would go to Dr. Meek’s clinic to reduce the distance that she had to travel, and avoid having to drive on main roads, rather than making an appointment with Dr. Darby. However, her attendance with Dr. Meek or his associates was also not extensive in

the two years following the accident. After seeing a doctor there on the day that this accident occurred, she went to that medical office four more times that month, once on September 17 of that year, but not again until May 2018. There was then a further gap until December 2018.

[190] She agreed that she was not reporting symptoms from the subject accident to any other medical practitioner during these gaps in attendance to Dr. Darby and to Dr. Meek and his associates. For example, when she saw Dr. Darby in January 2018 seeking lorazepam for panic attacks, she told the doctor that she had been off of all medication for the previous five months, indicating a lack of ongoing treatment.

[191] She rejected the suggestion that if her symptoms had been as debilitating as she claimed she would have sought such medical assistance. She explained that there were “so many barriers” preventing her from seeking support. She stressed that her focus was “just to keep going” with her job and rest on the weekends.

[192] In response to her own counsel’s comment that she was “not getting a ton of treatment” during that period, she reiterated that although she was not functioning well, she was unable to “connect the dots” about what was happening to her (in terms of the underlying causes, I infer). She did not know what kind of help was available, and was also feeling inadequate and depressed, which inhibited her from reaching out.

[193] She said that her anxiety about going to doctors prevents her from following through and getting there. She also suffers from extreme anxiety after visits - fearing that she has “missed something” (important, I took it) during them.

[194] To support the contention that she was fully capable of seeking medical attention as required, the defendants’ counsel pointed out that in May of 2018 she saw a doctor at Dr. Meek’s clinic for low back pain following a recent hike.

[195] Finally, during an appointment in December 2018, Dr. Meek told her to get re-connected with her family doctor. By that point she did not feel that he was providing her with any information about “how to get help” for her situation, and that she had

"hit a wall". She followed his advice and has re-committed herself to seeing Dr. Darby regularly since then.

[196] She said that she has seen Dr. Darby mainly in connection with her headaches and mood disorders.

[197] It was pointed out to her that during her appointment with Dr. Darby on July 19, 2016, which was apparently to renew an unrelated prescription, there was no mention of accident symptoms by her. She did not accept that this meant that the symptoms from the more recent accident were resolving – that might not have been the reason for her attendance that day.

[198] On August 10, 2016, about two months after the accident in issue here, she referred only to symptoms of her 2013 accident (which Dr. Darby mistakenly referred to as having occurred in 2012), in particular her right shoulder problems. She also described her "sadness" as being better, and described that she was "still anxious but has learned some coping strategies". Ms. Williams explained that the 2013 accident was her focus in that appointment, and that she would have wanted a separate appointment to talk about symptoms of the subject one. She added that her anxiety causes her to get mixed up and confused (in relation to what she discusses with her doctors, I took her to mean).

[199] More generally, she was unable to explain why she had still not brought the subject accident up with Dr. Darby by August 2016, if its effects were as severe as she claimed. She did point out that she had not seen Dr. Darby in the period immediately following the accident.

[200] She could not confirm whether the doctor's record for the September 17, 2016 visit to Dr. Meek's clinic that she "is now well", in relation to the subject accident, reflected her exact words. As to the absence of any indications of problems at work from her injuries during that visit, she explained once again that she was not yet "connecting everything that was happening to her" to those injuries.

[201] More generally, she said that the further absence of references to post-accident challenges such as headaches and fatigue during these visits (for example, she referred only to increased anxiety during her January 2017 visit) was due to her anxiety when seeing the doctors, which would lead her to forget information, or to not relay it fully. She stressed that such omissions were not intentional, and also cautioned that she was unable to say exactly what she had told the doctors during these visits.

[202] While she did refer to headaches in her visit to Dr. Meek on December 17, 2018, he did not record any mention by her of anxiety or visual problems. She recalled having told him about her serious anxiety, including social anxiety and depression, which is why she had not "reached out" to him again until then.

[203] Notably it appears to have been a visit to Dr. Darby on December 18, 2018 (the day after she saw Dr. Meek) during which she referred to light sensitivity and headaches, in addition to anxiety, and advised Dr. Darby that anxiety had caused her not to go to doctors.

[204] As to there having been two visits to Dr. Darby a year apart dealing with anxiety (January 2017 and January 2018), Ms. Williams noted that she was in a DBT group by then, and was learning new tools to cope with that issue.

[205] As I understood her evidence, she had continued to see Ms. Sandhu for anxiety, because it did not involve making a doctor's appointment or travelling a significant distance.

[206] She rejected the broader suggestion by the defendants' counsel that this statement to a doctor in September 2016 that she was now well, her comment to Ms. Sandhu in October that her only anxiety was around the time of her period, and a comment to the occupational therapist in August that her anxiety and low mood "had returned to pre-accident levels" accurately indicated her actual condition during that period. She would not concede that those notes captured all of her conversations with those care providers during the appointments, and also raised

the possibility that she may not have been sharing her problems, but instead "wanting to be okay" and portraying that image. She denied that this had involved her not being honest with her care providers.

[207] Ms. Williams was in another vehicle accident on March 13, 2019. It seems to be common ground that it had no enduring effect on her existing symptoms. She saw Dr. Meek in relation to it, despite his previous direction that she should return to her family doctor, because it would have taken her two weeks to get an appointment with Dr. Darby. She agreed that this accident had heightened her anxiety and headaches, after which they both went back to their previous levels. The only ongoing effect that she referred to was that she reduced her driving after that accident, because her anxiety was more extensive. She had resumed driving a few weeks after the subject accident because it was a work requirement. It was not clear how she was able to reduce her driving in 2019 given that requirement. Regardless, she agreed that she had not missed any work following this 2019 accident.

14. Outstanding Treatment Recommendations and Ms. Williams's Plans

[208] Ms. Williams agreed in cross-examination that she has not pursued various modes of treatment that have been recommended to her by care providers, such as massage therapy or acupuncture. Dr. Sass recommended a chiropractor for her to attend in Abbotsford, but she did not want to drive that distance, and impediments such as fatigue, "feeling low" and "a combination of [her] injuries" prevented her from following through. When it was put to her that she would have found a way to get this treatment if her headaches were as severe as she described, she responded, "You would think that, I guess it's just too much for me".

[209] She has not tried the medications that Dr. Chawla recommended in his report, nor has she reviewed his report or discussed it with Dr. Darby.

[210] She said that she intends to continue seeing Dr. Krull and Dr. Sass, but that she is also open to any other treatment that is available to support her.

[211] She has not been able to find an OCD support group in Surrey, and does not consider one she found in New Westminster or Burnaby “doable”, I infer because of the driving required.

[212] In general, her search for assistance with her symptoms focuses on things that are covered by her extended health insurance or are free, because her finances are currently limited.

C. Expert Opinions

1. Soft Tissue and Other Physical Injuries

[213] The extent of Ms. Williams’s immediate physical injuries from the subject accident is not disputed. Dr. Locht, an orthopaedic surgeon, provided a report on behalf of the defendants, and Ms. Williams’s counsel did not require him to attend for cross-examination.

[214] In Dr. Locht’s opinion, Ms. Williams suffered “nonspecific” (that is, based on pain reporting, rather than objective findings or other evidence) soft tissue injures, or “strains/sprains”, to her neck region in the accident. It was probable that they were transient, and that recovery would have been reached no later than a month following that accident.

[215] The other immediate injuries that she described having received in that accident – a superficial traction injury to her right shoulder from the seatbelt and superficial facial and right wrist abrasions from the airbag – would also have been transient, and would likely have resolved within a few weeks.

[216] Thus, any functional impairment beyond approximately four weeks after that accident would not have been due to it.

[217] In addition, Dr. Locht’s opinion was that the right shoulder pain that Ms. Williams was experiencing before the subject accident, and the right-sided neck pain that she complained of when he examined her in June 2020, were likely the result of soft-tissue injuries that she sustained in her 2013 accident. Her current

problems were also described as “non-specific” because it is not possible for him “to ascertain the specific pathology responsible for the pain complaints”, other than his finding of an area of stiffness in the right trapezius (neck) muscle just above the shoulder blade.

[218] He based his conclusions on the persistence of reports of pain to the right neck and shoulder in Ms. Williams’s medical reports in the two years following the 2013 accident, and the absence of such complaints in the reports following the subject accident, except for reports on May 6 and 9, 2016.

[219] He said that a diagnosis of concussion from the subject accident, and the causation of her “headaches, cognitive difficulties, light sensitivity and mood effects”, were beyond the scope of his expertise.

2. Ongoing Symptoms, Including Concussion-Related

a) Dr. Chawla - Physiatrist

[220] In addition to his main qualifications, Dr. Chawla also has a specialty in pain medicine. His reports on behalf of Ms. Williams were prepared in 2019 and 2021.

[221] He diagnosed her with concussion and chronic post-concussive headaches as a result of the subject accident. Referring to the clinical signs of a concussion, he said that she “may have had” a brief loss of consciousness following the accident, and post-traumatic amnesia. These indicators were accompanied by physical symptoms, such as headaches. His findings were based on her self-report, as well as records from her emergency room visit on the day of the accident. He pointed out that no such symptoms were present after the 2013 and 2015 accidents.

[222] He was challenged about the absence of objective evidence of a loss of consciousness by Ms. Williams following the subject accident. He explained that the clinical assessment soon after the injury is what matters most, and in this case she reported her symptoms to the emergency physician, who diagnosed a concussion based on them, as did the occupational therapist who provided brain injury support, and Dr. Meek. One ultimately relies on the patient to describe a loss of

consciousness, he explained. As to the fact that Ms. Williams was not sure in her testimony whether she had lost consciousness, he pointed out that no one is sure on that point, since they will be confused and lose track of the amount of time for which they "black[ed] out".

[223] In his initial report, , he described Ms. Williams having had an improvement of the majority of her symptoms within the year after the subject accident, "after she attended [a] post-concussive rehabilitation program as well as medication and rehabilitation trials." However, he noted that she was still experiencing headaches three years after this accident, despite having tried a variety of "conservative" treatments. Post-concussive symptoms that persist for more than a year tend to plateau and rarely resolve fully, he explained. At that point "pain chronification" becomes a disease in itself, and has to be managed as such.

[224] In essence, Dr. Chawla's opinion was that Ms. Williams's symptoms and progress have indeed plateaued, and that "she will likely have ongoing headaches for the near foreseeable and future and be prone to flare-ups of the same."

[225] His prognosis with respect to her headaches remained unchanged in his follow-up report in 2021.

[226] He summarized the findings and opinions in Dr. Sass's report, but did not offer his own opinion about any such symptoms. In his follow-up report he quoted Ms. Williams as describing sensitivity to light and sound being "associated with her headaches."

[227] He described some options that could be "trialled" to provide her with some relief for the headaches. These were the medications amitriptyline, nortriptyline and gabapentin, or (trade names) Lyrica, Cymbalta or Effexor. Although they are not curative, such medications can "assist in the desensitization of pain receptors…and help decrease the intensity, frequency and bothersomeness" of her pain. He stressed that whatever relief she may obtain from them, it is highly unlikely that she will return completely to her pre-accident "baseline".

[228] He elaborated that such medications are trialled because it is not known in advance whether they will be effective. A lot of patients' symptoms do not change as a result of taking them, or there are side effects that outweigh the benefits.

[229] His opinion was that interventional pain management options like nerve blocks and injections are unlikely to assist Ms. Williams, because she does not have clinical signs of the headache-producing conditions that those treatments are designed to address.

[230] In addition to trials of these medications, it might be necessary to reinstate some of her previous treatments if her condition worsens.

[231] Any further concussions or whiplash injuries, which tend to have a cumulative effect on brain function, could significantly exacerbate her symptoms.

[232] In his opinion, the sleep disorder that she described was also a result of the concussion, but most of the symptoms of it had resolved by the time of his first report.

[233] With respect to mood disorders, in his 2019 report, Dr. Chawla explained the significant overlap among such disorders, post-concussion symptoms and chronic pain. He expressed the view that Ms. Williams's anxiety and need for additional mental health care since the subject accident may have overlapped with her pre-accident condition, and worsened as a result of her "increased burden of pain and sleep disturbance". Despite these observations, he deferred any opinion on causation, prognosis and treatment to a psychiatrist or psychologist.

[234] In his 2021 update, he elaborated that her condition was "suggestive" of severe Generalized Anxiety Disorder, based on her high score on a questionnaire that screens for it, and chronic depression. She described even more severe anxiety symptoms to him in 2021 than were summarized in his original report – frequent panic attacks, which she had not referred to when he spoke to her in 2019, and "significant disability in all spheres of her life". He pointed out however, that she has a history of panic attacks, both before and after the subject accident.

[235] He did not accept the suggestion in cross-examination that the statement by the occupational therapist in August 2016 that her anxiety and low mood had returned to pre-accident levels is inconsistent with the worsening mood disorders that she reported in subsequent years. These kinds of symptoms wax and wane, he said, and she could have experienced a period of remission of them followed by a relapse. Similarly, the focus of her immediate post-accident counselling on her relationship problems did not mean that she was not experiencing any accident-related mood symptoms. Anxiety may result from various things and counselling is intended to assist with the patient's overall mental health. With respect to the effect on her current condition of her pre-existing mood disorders, he expressed the view that the accident had affected her level of functioning in relation to those disorders. Crucially, the fact that she had a history of depression did not mean that she was disabled by it, in comparison to her present situation.

[236] More generally, the absence of some concussion-related complaints from the records of Ms. Williams's interactions with the occupational therapist and in her early post-accident visits to Dr. Meek may not be significant, he thought, since the diagnosis of concussion, which both care providers made, normally includes those kinds of symptoms.

[237] Similarly, he did not accept that the gap of one and a half years in her visits to a family doctor meant that she was not experiencing any limiting symptoms during it. He acknowledged that it is a long period of time not to seek medical assessment if there are such symptoms, but said he would not conclude anything from it if he were seeing the patient himself. After the initial critical three-month period in which the majority of improvement occurs, the brain continues to recover on its own, and there is not much else doctors can do, he said. Ms. Williams would have been given information by the occupational therapist, and the further rehabilitation at that point consists of "gradually getting back into things". In fact, he recommends that recovering patients not be "over-medicalized". While he acknowledged that most people will seek medical attention if their symptoms increase, it would be a

"simplistic assumption" that Ms. Williams's symptoms did not increase just because she did not seek such attention.

[238] One positive note was that Dr. Chawla did not expect that there will be any "spontaneous declines" in Ms. Williams's work function.

[239] He thought that she might benefit from better ergonomics in her work station, such as by using a sit/stand desk. He recommended that she continue working, in at least a part-time capacity, because the structured routine that work provides has been found to assist in managing chronic pain and chronic mood conditions in those who suffer from them.

[240] When he was confronted with Ms. Williams's ability to work full-time for two and a half years following the accident, he did not agree that this meant that she should be able to continue doing so. In his experience, people can "push through" their symptoms for a period of time before experiencing burnout. Ms. Williams was receiving assistance in a number of ways during that period, and the level of functioning that she demonstrated is not a reflection of her lifelong ability to continue. He agreed that it was possible however, that if her symptoms were as severe as she claimed in 2017 she would have sought some additional help.

[241] His opinion was that the decline in Ms. Williams's exercise activity was likely the cumulative effect of both the 2013 and 2016 accidents. He noted that this activity "had been affected more significantly after both accidents".

[242] He described the impact on her home functioning as being most significant in the first year following the subject accident, and did not think it likely that the 2013 accident played any role in those difficulties. While she had made "reasonable recovery" in her home functioning by the time of his 2019 report, his opinion was that she will continue to experience limitations in it, due to headaches and her mood disorder. Like her work performance, her functioning will fluctuate, depending upon the severity of her headache pain.

[243] In overview, he felt that her prognosis had worsened since his original report. In the second report he recommended that she receive bi-weekly household assistance with the heavier aspects of house cleaning and laundry. He clarified that he was not suggesting that she should not do any housework, but rather that with her headaches and other post-concussive symptoms she only has so much energy, and in light of her work commitments some of that energy has to be re-distributed, including by pacing her housework efforts.

b) Dr. Krull - Psychologist

[244] He began to see Ms. Williams after she was referred to him by her counsel in 2019 for a medical-legal report for this litigation. After he saw her, he expressed the opinion that she needed immediate treatment, so he began treating her as well, at the end of January 2019. By the time he testified in the trial he had seen her 64 times in that capacity. His report was prepared in 2021.

[245] His opinion was that Ms. Williams suffered “significant symptoms” of anxiety, depression and chronic pain as the result of the subject accident. As Dr. Chawla had, he referred to the reciprocal relationship between pain on one hand and anxiety and depression on the other – pain exacerbates anxiety and depression, and they in turn exacerbate pain.

[246] He described her anxiety as being “severe”, and noted that the typical symptoms of it that she exhibits include “nervousness, irritability, worry, flashbacks, startle reactions, fear, panic attacks and apprehension [the expectation of something bad happening, which is accompanied by negative emotions]”.

[247] Her OCD, which he included in his description of her anxiety-related problems, has also emerged since the accident.

[248] Her depression has also been chronic and significant since the accident, he said, falling into the category of “moderately severe”. Typical symptoms of that disorder that she exhibits include “inability to experience pleasure, feeling

down…slowing of mental and physical processes…, social withdrawal, low motivation, guilt, self blame…fatigue and cognitive impairments…"

[249] He said that when they are considered together, the symptoms of these two disorders are "in keeping" with a diagnosis of Post-Traumatic Stress Disorder (PTSD). In the course of direct examination to clarify his report, he explained that while Ms. Williams did not meet all of the criteria for that diagnosis under the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the principal authority for psychiatric diagnoses, the DSM is a research document rather than a clinical one, and in a real-life clinical setting her situation would be treated as a "PTSD-like" diagnosis. In any event, a diagnosis is more of a "narrative", and the real question is how it fits in with the other conditions in a person's life.

[250] With respect to chronic pain, he described Ms. Williams as continuing to suffer from "body aches and pains, particularly headaches". He did not purport to offer any opinions about these physical injuries, but reiterated the mutually reinforcing relationship between the pain that they cause and her problems with mood.

[251] Yet another effect of the accident, according to his report, was an acute exacerbation of Ms. Williams's underlying attachment disorder. He explained that she has a long history of anxious, insecure attachment to those closest to her, both in family and romantic relationships. Any threatened separation causes her to become "panicked, afraid, insecure and emotionally needy".

[252] What is significant for the present case is that this dysfunctional level of attachment can extend beyond human relationships, and encompass things such as "[a sense of] security, esteem from others, job, income, [or] familiar surroundings". The disorder leaves her with a "very sensitive and precariously balanced emotional system" and when a loss is threatened, or actually occurs, her system can suddenly go to "fear, panic and emotional disorganization". This can happen very suddenly and be very disturbing. She ends up with the sense that she can no longer trust anything, comparable to a person who has survived a natural disaster, and even

after she recovers a sense of stability, she is more susceptible to it being shaken the next time there is a threat.

[253] In Dr. Krull's opinion, these effects, which resulted from the accident, have led to a significant loss of function at work and in the rest of her life. This included loss of emotional and cognitive function, which has caused her to "lose faith" in her abilities in those areas, including her confidence in relating to her co-workers. A persistent effect is losing her train of thought, which makes her reticent in speaking at work more than absolutely necessary, and leads to anxious over-focus later on the mistakes she might have made. This costs her a lot of the cognitive and emotional energy, which she formerly devoted to the job itself.

[254] This overinvestment in managing her emotions, and lack of remaining resources to actually handle the world around her carries over into her domestic responsibilities, he explained. Her pervasive lack of trust and fear of loss also leaves her feeling disconnected from those around her. He said that she does not feel safe even in the confines of her own home.

[255] Beyond her inability to carry on household activities to the standard she met before the accident, other effects of these disorders on her lifestyle are a lack of confidence in socializing, followed by ruminating about her interactions with others and berating herself about perceived mistakes during them.

[256] Ultimately his opinion was that these "deeply emotional" impairments affect all aspects of her life. As he put it:

> To an outside observer, it may appear to be an overreaction to a not unusual motor vehicle accident. However, given her very tenuous grasp of basic trust, such an incident has profound implications to how she relates to herself, others and the world and how she functions when her trust is shaken.

[257] He emphasized that the prognosis is always guarded in motor vehicle injury cases that involve this kind of reciprocal pain-mood disorder relationship. The addition of Ms. Williams's underlying attachment difficulties means that she "has a very difficult road to full emotional recovery", and even with prolonged physical and psychological treatment the prognosis is "fair at best". That prognosis is "mildly

better” for a partial recovery that would allow her to manage work, home and even motherhood. That prospect will be aided by her history of a strong work ethic, but Dr. Krull nonetheless questioned her ability to handle work and motherhood in the near term.

[258] Addressing Ms. Williams’s future treatment needs, he said that she has seen some” modest success” from psychotherapy. Despite the complications provided by the “notoriously difficult to treat” attachment disorder. In his view, the treatment he has provided thus far has been effective, and he strongly recommended that it continue. He has been meeting with her bi-weekly, but often even less frequently due to the state of her finances. He suggested that in future they should meet weekly, with the expectation that the treatment will then take another two to three years.

[259] The focus on cross-examination was on the apparent contradiction between Dr. Krull’s opinion that Ms. Williams’s current symptoms are due the subject accident and the records that show (1) the presence of those symptoms before the accident and (2) their absence from her reports to her care providers for a significant period of time after the accident.

[260] With respect to the indications in the records of her pre-accident anxiety and depression, his view is that these issues have been present for a long time, in variable degrees. He explained that they have “fluctuated up and down” and have continued. For example, in her psychiatric consult in February 2015 she described chronically high levels of anxiety. Her pre-accident difficulties also included anxiety with social situations and public speaking, which she reported in September of that year, and he agreed that her self-medicating at the time of that report met the criteria for the drug use disorder that were diagnosed by the psychiatrist.

[261] He also accepted that at least in that June 17, 2016 session with Ms. Sandhu, she was describing herself as being better able to deal with her anxiety.

[262] To the extent that the 2013 accident may have played a role in her situation, his understanding was that she had been "pretty steady on her feet" (in terms of her mental health, I infer) between it and the subject accident.

[263] With respect to her post-accident symptoms, he was not prepared to accept the suggestion that the anxiety that she reported to Ms. Sandhu on June 9, 2017, about a month after the accident, was solely due to the stress of beginning the relationship with her current partner, even though that was the context in which she referred to it during that particular session. He did accept that the effects of the relationship were the topic of both that session and the following one on June 17, and that the relationship was "a stressor" in her life at that point. He later agreed that this relationship was a "significant contributing factor" in her anxiety, but also pointed out that the relationship and the accident could not be treated as being disconnected from each other (I took him to mean that both factors contributed to her situation). He accepted that as late as February 2020, when she was described by her family doctor as experiencing "melancholia and depression, post MVA", her relationship could still have been a contributing factor to her mood issues.

[264] While he conceded that nothing in Ms. Williams's reports to care providers from the accident to the end of June 2016 supported a diagnosis of PTSD, he maintained that the symptoms had emerged or in some way become part of her memory by the time he began to see her, because she was clearly symptomatic by that time.

[265] He accepted that "generally" one would expect to see complaints with respect to anxiety in the "reasonably contemporaneous" period following the accident, if it had triggered those symptoms. He later added, when addressing the absence any reference to the subject accident during the visits to doctors in September and October of 2016, that he would "hope" to see something of that nature, if the accident was playing a role. As to his expectation that Ms. Williams would have sought further assistance if her symptoms had actually increased, he observed that although she "was not afraid to ask for help", she liked to "push through" and attempt

to continue working despite her difficulties. He has seen her during periods in which she is pushing through at work in that manner. In response to the suggestion that one would expect that symptoms causing disability at work would cause a patient to return to their doctor for further assistance, he reiterated that “lots of times” she would “tough things out” at work. Later, when it was put to him that with therapy she should be able to return to working her former full-time hours, he described her as “paying an emotional tax” in order to be good at work, and that he would like to reduce her anxieties in connection with work before her therapy concludes.

[266] Along the same lines, he said that a significant spike in her anxiety that was noted during a medical visit in January 2017, which was not accompanied by any reference to the subject accident “could be interpreted” as more likely to have resulted from her relationship problems. He also conceded that there was nothing in the diagnosis of generalized anxiety disorder that was made during her next visit, which was not until January 2018, that was connected to the subject accident.

[267] Also absent from the records up to 2018, he agreed, were any references to chronic pain. In particular, her reports to him of ongoing back pain were not echoed in her comments to general practitioners – the back pain she reported in May 2018 apparently occurred after hiking. That visit was also her first report of chronic headaches. He agreed that her report on January 28, 2019 of chronic headaches, which she said had been going on for the last three weeks, coincided with the start of her therapeutic relationship with him. In other words, those were likely the same headaches that she was reporting to him.

[268] He disagreed that this all means that any subsequent increase in her anxiety is not due to the accident. The problem can be dealt with, yet resurface later, just like her pre-existing symptoms (that is, from before the accident). He rejected the further proposition that the symptoms that he observed could have been a flare-up of those pre-existing ones. He explained that they could have been triggered by the memory of the subject accident – he has seen her engage in anxiety behaviour just from talking about that accident.

[269] Similarly, the comments of the occupational therapist that same month that her anxiety from the accident had "largely resolved", as had the headaches (except for the fallout from the intense hike), and the therapist's assessment that her headaches were causing a "low/moderate" level of interference with her daily life, were put to him to undermine the connection between the subject accident and the situation that his report describes. He did not accept that this meant that the symptoms he observed were not related to the accident. He did accept though, that the evidence supporting his description of Ms. Williams's headaches and their effects came mainly from her.

[270] He confirmed in re-examination that he was aware of the records that show Ms. Williams's pre-accident mood disorders, and the absence of some of her claimed symptoms from the records of her post-accident medical visits. His awareness of them does not change his opinions, he said, with the exception that the post-accident records that showed her doing well at times affect his prognosis "maybe a little bit", by revealing "oases of good functioning in there".

[271] It is clear from the records that Ms. Williams's March 2019 accident caused a short-term elevation in her anxiety symptoms. This was very shortly after she began seeing Dr. Krull. It was put to him that it would have been difficult at that point for him to determine whether her symptoms were caused by that recent accident, the subject one, a re-emergence of her pre-existing symptoms or her relationship issues. He explained that "it was clear that a lot of it was fundamentally coming from 2016" [that is, the subject accident], and that she connected a number of her symptoms to it. While that accident did not cause her mood disorders, it exacerbated them.

[272] An additional stressor was her pregnancy, which began to cause her difficulties in both her personal life and at work, starting in early 2021. This included her fears of developing post-partum depression. Dr. Krull explained that her "emotional footing" is not really strong, and that it does not take much, whether it is a single factor or a combination of them, to upset it. Her relationship was still a source

of stress at that point, and the workplace pressures caused by the pandemic were an additional stressful issue. He acknowledged that a psychiatrist with Fraser Health had identified only “moderate” mood symptoms when he saw Ms. Williams in February 2021, rather than the severe ones he has described, but disagreed with that psychiatrist’s findings that Ms. Williams was not suffering from any intrusive thoughts at that stage. In fact, he has observed that she had “all kinds” of such thoughts, he said, relating to whether she would be adequate as a mother once her child was born.

[273] He agreed with that psychiatrist’s diagnosis of generalized anxiety disorder, but could not speak to the further component that it was “in partial remission on Trintellix”, since medication and its effects are not part of his expertise. In his view however, the extent of any remission could be “very temporary”. Responding to the psychiatrist’s opinion that the disorder was of “mild severity”, he explained that this would be true “until something came up”, and that it would not take much “to make it spike”. He also did not agree that the psychiatrist’s follow-up report in May of 2021 that her symptoms had reduced with treatment.

[274] Dr. Krull was cross-examined on his own clinical notes from that same period in May, which could be interpreted as showing an improvement, over the course of three sessions that month, in her anxiety level about her forthcoming examination for discovery in this action. He explained that “this is the nature of treatment” - he does not take advances and declines in her condition too seriously, because they are temporary and tend to fluctuate. When Ms. Williams is not stressed and has support from her family and therapist she can manage fairly well, but when she is “rocked” by some event she “goes off kilter”.

[275] His testing and impressions of Ms. Williams’s ability to care for herself and perform household tasks led him to quite different conclusions than those of the occupational therapist, who had reported that she was independent in those areas of her life.

[276] He rejected the suggestion that Ms. Williams had not demonstrated any cognitive problems during his work with her. In fact, she had described not being able to "think straight" at work, or to think in ways that would help address her anxiety. He has also seen her being "blocked" and unable to remember things, or becoming disoriented, although sometimes she is able to resolve the problem herself.

[277] Dr. Krull was also challenged on his opinion that a further two to three years of therapy will be required to address the effects of the accident. Specifically, it was suggested that he should be looking to wind up their therapeutic relationship and move Ms. Williams to a regime under which she was capable of monitoring her own mental well-being. He stressed that the foundation for her being more independent is for her to have a feeling of safety in their therapeutic relationship, which she has demonstrated by disclosing more and attending more regularly over time. Gaps in treatment can allow symptoms to "re-constellate". It is only when that feeling of safety has been sufficiently achieved that they can look to moving her towards independence from therapy. In his experience, working with clients with attachment disorders takes time, and as a result he stood by the anticipated frequency and duration of sessions that were outlined in his report, adding that being able to meet with him twice a week would be even more beneficial.

c) Dr. Okorie – Psychiatrist

[278] He saw Ms. Williams on behalf of the defence and provided a report in July 2021, and provided a response to Dr. Krull's report the following month.

[279] The essence of his opinion is that the subject accident aggravated her pre-existing generalized anxiety disorder, and complicated it with the development of OCD. She meets the diagnostic criteria for both disorders. She did not meet the criteria for a diagnosis of major depression, and he offered the opinion that any depression following the subject accident had "fully and completely remitted." He said that waxing and waning of symptoms is typical of most psychiatric conditions,

and that it is found in approximately 95% of the patients he sees in his clinical practice.

[280] He said that her self-reports and medical records indicate that her pre-existing anxiety and depression were aggravated by the “trauma, pain and related functional limitations” from the subject accident.

[281] It is also his opinion that she did not sustain a concussion in the subject accident. In his view, her subsequent cognitive difficulties can be explained by her “anxiety, sleep disturbance, fatigue, headaches, and pain.” Despite her reports of a loss of consciousness and amnesia to a family physician and at the emergency ward on the day of the accident, he pointed out that “the human brain does not encode every detail of all events that occur during wakefulness”. When it was put to him that her inability to remember having reversed her vehicle after the collision (as described by Mr. Fedalizo) could represent objective evidence of a loss of consciousness, he maintained that this simply meant that she could not remember having done it.

[282] Ms. Williams’s self-report of her post-accident behaviour (shocked, emotionally overwhelmed and tearful) was indicative of a panic attack, he believes, “considering her history of anxiety and depression”.

[283] He explained that in light of such heightened emotional distress, which can distort awareness and memory, it is problematic to diagnose a concussion from her self-report. If there is no objective cognitive assessment by trained clinicians (such as the results of tests administered by paramedics at the scene, or doctors in the emergency ward), the diagnoses should be based on the subject’s immediate post-collision behaviour, and the results of any subsequent imaging scans.

[284] He elaborated that in most cases cognitive assessments – consisting of questions by Emergency Health Services about loss of consciousness at the scene, and the Glasgow Coma Scale being applied at the scene and at the hospital – will

be available. If those are not available, a diagnosis can still be made based on the person's behaviour.

[285] He agreed that he had "opted to conclude that psychological reasons are a better fit" in this case than a concussion.

[286] Here, he found Ms. Williams's behaviour after the accident to be "organized, goal directed and not confused". Despite what he described as her "inconsistent" reporting of loss of consciousness and amnesia, she was able to give him an adequate history of the events related to the accident.

[287] He administered the MoCa cognitive test to her during his interview and she scored 27/30, which is in the normal range. He said that it would have been higher if it were not for her rising anxiety during the interview.

[288] Her self-reports of anxiety and depression on the screening tests that he administered were in the "severe" range. He agreed that he had not included an explanation of those tests or an interpretation of their results in his report. The anxiety score was reviewed with him in his direct examination and the depression score was explained in cross examination. What was significant from his perspective was that she did not meet the criteria for a diagnosis of depression, and that her self-report was inconsistent with that.

[289] Although the anxiety and OCD cause her "emotional distress, interpersonal/social stress, and poor time management", he did not believe that they were causing any significant functional limitations in her work at Options. However, he agreed with the suggestion that having OCD is exhausting for a person.

[290] It was pointed out to him that although he had referred to her giving up her position at Reach and being unable to sustain the additional hours at Options, because of her anxiety, he had not addressed her response to losing those positions. He had previously agreed that it was important to understand patients' responses to stressors. He accepted that it was appropriate for her to reduce her

hours of work to reduce her anxiety, and he accepted that such losses would have been difficult for her.

[291] The potential loss of her opportunity to become a childcare licensing officer was not addressed in their interview, he explained, because he did not receive that information from her or from the medical records.

[292] He also did not address Ms. Williams's decline in self-esteem from her loss of fitness and her weight gain, although he did address her fitness regime before the subject accident. He also referred to her description of becoming very depressed and neglecting her self-care shortly after the subject accident.

[293] He made only sparing reference to Ms. Williams's visual problems in his reports, explaining that he did not need to make any further reference to them in order to reach his opinions. He had not been provided with Dr. Sass's material and did not consider it necessary to review it.

[294] Because of "her personality vulnerabilities – possible borderline, anxious and dependent traits", Dr. Okorie expressed the concern that excessive therapy could cause maladaptive dependence on her therapist and erode her "self-efficacy". As a result, he recommended "rounding up" her therapy and introducing her to self-directed resources to consolidate her coping skills. He pointed out that Dr. Krull himself had described her as only achieving modest benefit from her work with him so far.

[295] He acknowledged that Dr. Krull would know Ms. Williams better than he does, but maintained that his interactions with her allowed him to make a diagnosis. The only significant benefit of having an opportunity to follow her over time would be to monitor her treatment, he said.

[296] He found her current dose of Trintellix to be too low to manage her disorders effectively, and added that there was limited research on how safe it was for pregnant women to take. Although she had passed the stage of pregnancy where the effect on the unborn child was a significant concern when he saw her, he

recommended switching her to a safer and better researched anti-depressant, to address her higher risk for post-partum depression.

[297] With respect to prognosis, he explained that:

> As demonstrated by Ms. Williams's history, GAD [generalized anxiety disorder] and OCD are chronic conditions that fluctuate in severity and can become complicated with episodic major depressions depending on the patient's treatment, circumstances and coping capacity.
>
> Consequently, I would recommend review of her treatment based on parameters discussed above and long-term therapy with moderate-high doses of an effective antidepressant coupled with education about the need for treatment compliance to enhance outcomes for her disorders.

[298] His reference to "long-term therapy", which appears to be at odds with his recommendation of "rounding up" that therapy, was not explored further.

[299] He disagreed with Dr. Krull that Ms. Williams has developed PTSD as a result of the subject accident. Instead, he said that she has incorporated driving anxiety into her "wide range of anxious themes". He also disagreed with Dr. Krull's characterization of her anxiety and depression before the subject accident as sub-clinical and insignificant. In his view, she would not have attended hospital, taken psychotropic medications and attended multiple therapy sessions in that case.

d) Dr. Sass - Optometrist

[300] He was qualified in the sub-speciality of neuro-optometry. The defendants' counsel did not oppose him being qualified in that area of expertise, but they do not accept that it encompasses the ability to diagnose brain injuries.

[301] He explained that optometry is mainly concerned with measuring and correcting refraction errors in eyesight, and with monitoring eye health. However, vision actually takes place in the brain - the mechanisms of the eye simply gather the information that the brain will then have to deal with. Neuro-optometry deals with the issues that arise from the neurological aspect of vision. The issues include problems with the processing of this visual information, and with related issues such as focus and eye movement.

[302] To identify problems in these areas, he conducts a battery of tests that address the connection between what the patient sees and how it is interpreted. According to him, none of them “test what they purport to test”, so it is necessary to “build a profile [from a number of tests] to get information from”, and “approach things from different angles”.

[303] These neurological aspects of vision frequently arise in the context of concussions, and approximately 50% of Dr. Sass’s practice was concerned with those effects.

[304] In addition to the testing, Ms. Williams completed a behavioural questionnaire in November of 2018, in which she endorsed quite an extensive list of vision-related complaints, which included, but also extended beyond, the ones that she described in her evidence.

[305] He prepared reports with respect to Ms. Williams in February 2019 and July 2021. He updated her progress during the intervening period and reviewed some additional documents for the second report, including more recent records from Dr. Darby’s and Dr. Chawla’s reports. He said that his impressions were “pretty much the same” in both reports.

[306] Based on his testing, his opinion is that Ms. Williams suffers from oculomotor dysfunction (relating to eye movements) and visual processing dysfunction (relating to visual thinking). Based on her reports to him, he also found that she suffers from photophobia (light sensitivity) and headaches. In his opinion all of these conditions are probably related to her 2016 accident.

[307] He explained that oculomotor dysfunction is a broad diagnosis that includes problems with saccades (the quick movements of the eye during functions like reading), pursuit (tracking the movements of objects), and fixation (the direction of vision at something). Her resulting symptoms include problems with reading, such as skipping lines and small words, having to use a finger to keep her place, and poor comprehension.

[308] More important than the accuracy of her eye movements, he stressed, is the amount of energy it requires to move her eyes and acquire the visual information around her. He believes that this likely contributes “a great deal” to her fatigue increasing over the course of a day.

[309] Visual processing dysfunction encompasses problems with Ms. Williams “doing something with what [she] sees”. These skills are “fundamental to the coding and decoding involved in processing written language”. Visual processing dysfunction leads to “lower efficiency with computer and book work, fatigue, and cognitive dysfunction.” He elaborated in cross-examination that cognitive dysfunction includes taking longer to understand written material, even if it is eventually understood properly (He acknowledged that anxiety, causing a person to try to be more careful, could be a contributing factor in the speed of comprehension.)

[310] In his second report he added findings that her visual fields are constricted. This can occur as a result of anxiety, such as in the “tunnel vision” that some people describe experiencing during panic attacks. That reduced peripheral vison in turns leads to more anxiety, for example leading to Ms. Williams “startling” when vehicles seem to appear suddenly in her field of vision.

[311] The mechanism of photophobia is poorly understood, but it is common following a whiplash or brain injury, Dr. Sass said. It is difficult to manage other than by shielding the person from sources of uncomfortable light, or avoiding those sources.

[312] Her headaches, especially the frontal ones, are likely caused by the preceding three issues, he believes. In his experience, frontal headaches are usually eyesight-based. He believes that using supportive lenses during “deskwork” should help her somewhat. In general, headaches are also associated with whiplash and “head injuries”.

[313] Because they occur when she changes posture, he thought that her complaints of dizziness likely originated in her vestibular system, which maintains

balance and information about body position, rather than being caused by a brain injury . Damage to the vestibular system is not within his area of expertise.

[314] He administered a test for “right-brain cognitive deficits” which showed no indication of them, but Ms. Williams’s complaints of slower thinking speed and difficulty multi-tasking suggest that she may have deficits in sensory integration or cognition. These are also outside of his area of expertise, and he suggested that she be referred to a neuropsychologist, who deals with them, for an assessment.

[315] Given that two years had passed since the accident by the time of their first meeting, and that the significant improvement from concussion symptoms often occurs soon after the injury, Dr. Sass concluded in his first report that the possibility that Ms. Williams’s vison-related problems “will improve without treatment is diminishing”, although they are unlikely to worsen either. By the time of his second report, when five years had passed, the possibility was described as “faint”.

[316] The extent of the visual symptoms that a person experiences varies according to the demands placed on them, he explained, and as a result he thought it was unlikely, without further intervention, that she could succeed in post-secondary education, or in an occupation that has significant visual demands (like her current one, which involves a lot of reading, computer use and information processing). Despite this, he agreed with the suggestion that if she is able to succeed in using the computer even half the time at work, then on the basis of her current four day per week schedule, and spacing out her assignments, there is no reason that she would not be able to pursue further education. He qualified his agreement by pointing out that this would depend on the educational program, and would perhaps require some further modifications at work.

[317] He offered the opinion that Ms. Williams was “surviving” in her current job with adaptations, but at “a great energy cost” to her, which may not be sustainable. These problems are also likely to impact her comfort and quality of life significantly.

[318] He was unable to say what effect her current mental and emotional status, or the medication she was taking, were having on her headaches and fatigue[3].

[319] His main recommendation was for visual therapy to rehabilitate her identified deficits, which he expected would lead to "significant improvements in her daily activities". He "hoped for" improvement in her light sensitivity from this therapy[4] as well. In his second report, he added that visual therapy can be expected to reduce her headaches by increasing the efficiency of her visual skills. It would also integrate her vision with other skills, which he felt would reduce her headaches "and frustration while increasing her 'multi-tasking' abilities".

[320] Maximum results would be obtained from weekly therapy sessions, for about three months. During his work with her so far, she has become more aware of her peripheral vision, and has been able to achieve quicker, more accurate eye movements and greater coordination of them.

[321] He said that he had prescribed supportive lenses to her for reading and using the computer, and recommended ongoing use of sunglasses, hats and visors to deal with light sensitivity.

[322] In addition to the neuropsychology referral that I have previously described, Dr. Sass also recommended that she be referred for assessment in relation to the vestibular issues that he suspected, which may be responsible for her problems with dizziness that occurs with postural changes. Since, according to him, she has a pre-existing neck injury (from the 2013 accident, I took it), and light sensitivity, dizziness and headaches commonly result from such injuries, assessment by a specialized type of chiropractor or osteopath should also be considered.

[3] He also mentioned nausea, but it was not clear to me that she was claiming to have suffered from it.
[4] Although his report indicated that the cause of photophobia as a stand alone issue is uncertain, when he was elaborating on his report in direct examination he also referred to it as a symptom of visual processing problems. I infer that he is referring to the latter issue here.

[323] The foundations of Dr. Sass's opinions were challenged by reference to the absence of related complaints, or the contradictions in her medical records from the post-accident period.

[324] He had not reviewed the records of Ms. Williams's last visit to her own optometrist before he began to see her. He verified her previous prescription, and in his experience other optometry records tend to be "light" in the things he is interested in. As a result, he was unaware that in October 2018 she had told Dr. Hanberg that her light sensitivity had "mostly resolved".

[325] The symptoms that she reported in the questionnaire that she filled out for him in November of 2018 were not contained in any of the medical records for the first month following the accident, and only headaches and "mild" light and noise sensitivity were reported to the occupational therapist. He agreed that he would expect to see the other symptoms contained in some medical record in the four months after the accident, if they had been caused by it, although he pointed out that vision problems can play a role in headaches and light sensitivity, as well as fatigue.

[326] When the absence of any complaints about her current visual symptoms in the year and half after the accident was then put to him, he said that in his experience patients will not necessarily seek treatment in relation to such problems. In response to the further proposition that she would have sought assistance if the issues were having an impact on her work, he said that people often do not see the connection between their symptoms and their vision, or the care provider fails to ask the necessary questions that would allow the care provider to make the connection.

[327] When it was suggested that the absence of any request for medical assistance in relation to them meant that the symptoms were not that significant, he said "I almost agree with you", but in re-examination he elaborated that there were a variety of reasons why Ms. Williams might not have sought assistance, such as that she was working less so her symptoms were not being aggravated.

[328] With respect to the relationship between some of her symptoms and a neck injury, he agreed that there are no entries reflecting such a complaint in her post-accident medical records, although he suspected that an entry in Dr. Darby's records from September 29, 2016, which had no details entered but bore the heading "[d]isorders [of] muscle, ligament and fascia" related to her neck. When it was suggested that the absence of any entries relating to her neck made it difficult for him to assume that there was such an injury, he responded that symptoms can fluctuate depending on the demands that were placed on her. He agreed however that his reference in the reports to Ms. Williams having received treatment for a neck injury "could be an error".

[329] He agreed that with nothing beyond a report on the day of the accident it is difficult to conclude that a soft tissue injury has occurred, but also pointed out that unless the care provider asks pointed questions, the injury may not be recorded.

[330] As to the year-long gap between visits to a family physician, he added that patients with these kinds of complaints "tend not to get anywhere with practitioners", and that she may have chosen not to go back after having had such an experience.

[331] He would however expect symptoms of the kind she described to show up in her job performance, and agreed that if her reviews were good, that suggested that the symptoms were "at the milder end".

[332] When it was put to him that he was assuming that Ms. Williams has a brain injury based on the concussion diagnosis, he said that he comes to it through his own testing and interviewing, which he then connects to her history. He was not prepared to agree that diagnosing a brain injury necessarily falls outside his expertise, when that was suggested to him. In fact, he was not certain which profession actually has the expertise to make such a diagnosis. There is no definitive test for the presence of such an injury, and while the current research may yield "biomarkers" to enable a diagnosis, at this point other professionals are using the same observational skills that he uses.

3. Vocational and Economic Issues

a) Dr. Van Den Berg – Vocational Rehabilitation Consultant

[333] His doctorate in psychology focused on the impact of chronic pain on work performance, and his current practice include the effects of chronic pain, psychological trauma and brain injury.

[334] He administered a series of tests to Ms. Williams, over about a five-hour period, and reviewed her medical records, the other expert reports that were prepared on her behalf, and her employment history. This led him to the opinion that she has "sustained a reduction in her vocational capacity, competitive employability and job options" as a result of the effects of the subject accident. He described these effects as a "cluster of post-concussion, vision, headache and psychological symptoms".

[335] Although she appeared to work to the best of her ability in all of the testing, she twice narrowly failed one of the tests that measures effort, before passing it on the third try. Overall, Dr. Van Den Berg thought that her mood disorders, pain and visual processing issues played a role in her performance during the testing, leading to variable effort during them, and "depressed" results. Her stamina also declined towards the end of the testing.

[336] Significantly, he found that her elevated anxiety and depression had an equal or greater impact on her vocational situation than her headache pain. Other notable results, particularly in light of Dr. Sass's findings, were extremely low scores in tests that measured her cognitive processing speed.

[337] On the other hand, she had no difficulty understanding instructions or complex concepts, and did not demonstrate any problems with her memory and concentration. Until it began to decrease at the end of the day, her speed in completing the testing had been average, and in general her perseverance in the testing was good, he said. These positive attributes did not cause him to question the accuracy of his testing of her effort level however - he has found that testing to

be a “pretty accurate” refection of the problems that will be encountered in the workplace.

[338] He agreed that the visual therapy provided by Dr. Sass could improve her visual and cognitive issues, and thereby her functional ability in the workplace.

[339] Her measures of general somatic complaint, pain severity, and pain-related anxiety and depression were very high. In contrast, her answers on a pain questionnaire described it as being at much lower levels. He explained that the former measures have a significant psychological component, and that that latter is more consistent with mild to moderate headaches with occasional severe ones. However, even headaches in that range can wear the person down, and affect their response to stress and cognitive ability, thus affecting their overall sustainability in a job.

[340] Dr. Van Den Berg considered Ms. Williams to be limited to part-time work (up to 50% or 18.75 hours per week) within a select range of jobs that fit her remaining abilities and work history. The reduction from the 75% that she was working before going on leave is necessary to support her durability in her employment, and prevent any further disability. Working at any greater amount would leave her without any “buffer” to deal with things that come her way in the job. To maintain her employment, she requires compensatory strategies, accommodations and ergonomic support.

[341] He was aware that none of the other experts had recommended a reduction in her hours of work to that level, and that there were recommended treatments that had not been tried yet, but he explained that once one adds the psychological, visual and sleep problems to her headaches, the question becomes how long she can sustain working at 75% in her current position and “who will hire her” if she loses that position.

[342] He was doubtful that she could sustain the extended periods of sitting necessary for the report-writing component of the licensing officer position. Even if

she did the position on a casual basis, he would be concerned about adding it to her current amount of computer work, although she could do it instead of her current position.

[343] He agreed that further visual and psychological treatment could lead to a resolution and return her to her pre-accident levels. This could change the current unlikelihood of her succeeding at post-secondary education or jobs with significant reading demands.

[344] He believed that her best option would be remaining with her current employer, with whom she has an established relationship, as it would be difficult to convince a new employer of her abilities, in light of her limitations and need for accommodations. Her positive reviews in that current position are a reflection of having an established position with a supportive employer, he believed.

[345] Should finding a new position become necessary, she would qualify for similar support worker roles in the non-profit industry or, with six to eight months of retraining, certain medical office assistant positions, such as in a multi-disciplinary clinic, or as an office assistant/general support worker.

[346] Her symptoms place her at greater risk of prolonged periods of employment instability in the future if she loses her current job. Based on the research on this issue and his own experience in working with disabled employees, she is also at risk of having to retire two to three years earlier than she otherwise would have.

[347] In the absence of the subject accident, he believed that she would have been able to maintain 35 hours per week of employment in her existing positions[5]. Those positions aligned with her abilities and interests, and the employment prospects in her field are good. He also believed that it was a realistic option for her to pursue work as a day care licensing officer, which she told him she planned to do on a part-time casual basis, in addition to her existing positions.

[5] He had the mistaken understanding that the position she took up for seven hours per week in late 2016 was with Reach, rather than Options, but nothing turns on this.

[348] Dr. Van Den Berg's recommendations were that:

- Ms. Williams undergo further treatment for her depression, anxiety (including with respect to driving), pain coping and symptoms of PTSD. This should consist of exposure therapy, eye-movement desensitization and reprocessing (EMDR), and cognitive-behavioural therapy (CBT). He thought that an additional 28-30 hours of such treatment would be required.

- She take part in a chronic pain program, such as the one offered through Surrey Memorial Hospital, which requires a referral from her physician. She can also access online support through the PainBC website.

- She receive 12 to 15 hours of vocational counselling to identify additional jobs that she is capable of performing; and

- She be provided with ergonomic support for any job (like her current one) that requires prolonged sitting – a height adjustable desk, an ergonomic chair, and anti-fatigue mat, and a cordless phone headset. He said that accommodations like this are common in the modern workplace and most employers fund them.

[349] With respect to the facts and assumptions underlying his opinion, He was under the impression that Ms. Williams's issues with cocaine had not continued beyond her mid 20s, whereas her health records show it continuing into 2018. He agreed that the combination of substance use with anxiety could lead to psychological vulnerability in the longer-term.

[350] He was also under the impression that Ms. Williams had only been able to sustain her second position with Options for 12-18 months before having to give it up once additional responsibilities were added. He agreed that the two and half years for which she was actually able to maintain that position were a better indicator of her ability to manage in it.

[351] He had the mistaken impression that the symptoms of Ms. Williams's 2013 accident had fully resolved, which is contrary to Dr. Darby's report of December 2016. As previously summarized, her visits to Dr. Darby to address the 2013 accident included one in August 2016, which was after the subject accident. The symptoms of pain and numbness in her right arm, and pain and numbness in her neck and right shoulder that she described in those visits, were the same ones that she had described to him as being among her ongoing ones.

[352] He agreed that in that report Dr. Darby had recommended that Ms. Williams undergo CBT to address her ongoing anxiety.

[353] With respect to her longer-term career goals, he confirmed that the lower end of the range of earnings for a licensing officer includes the amounts that she is already earning in her other two positions. In addition, his research reveals that the full-time job opportunities for a licensing officer are not abundant, although there are a lot more part-time and casual positions available.

[354] He was unaware that the Justice Institute indicates that supervisory experience beyond what Ms. Williams possesses is required for this position. Despite this however, neither of the two available positions he identified, required it, and he believed that the main requirement would be experience with the childcare industry and its training and licensing requirements, which she clearly does.

b) Peter Sheldon and Thomas Steigerveld– Labour Market Economists

[355] Mr. Sheldon performed calculations that were intended to identify Ms. Williams's lifetime earnings if the accident had not occurred, and the amount that she will have lost if she is only able to work 50% of the time, as Dr. Van Den Berg recommends.

[356] To arrive at the earnings without the accident, Mr. Sheldon assumed that she would have continued in her main job at Options for 28 hours per week at her current rate of $25.73 per hour, or $37,600 per year. To this was added the average

of 6.5 hours per week that she would have worked in the second Options position that she had to give up. Its wage by the time of trial would have been $22.57 per hour, or $7,200 per year. This leads to yearly “without accident” earnings of $44,800.

[357] When projecting her future earnings based on that salary, the total figure has to be adjusted for labour market contingencies that may arise. There are two ways to approach that issue. “Risk only” contingencies address the average probabilities that a female in B.C. with one or two years of post-secondary education could be forced out of the labour market, into unemployment, or into part-time work. This leads to a discount on the overall earnings of 10.9% and earnings to age 70 of $1,049,876. “Risk and choice” contingencies (which are also known as “average” labour market contingencies) include the average probabilities that a female in B.C. would choose one of those outcomes, in addition to the probability of her being forced into them. This leads to a much higher discount of 37.7% and earnings to age 70 of $733,951.

[358] Mr. Sheldon explained that a finding that Ms. Williams is strongly attached to the workforce could lead to a decision to apply the “risk only” contingencies.

[359] If, as Dr. Van Den Berg recommended, Ms. Williams is restricted to working 50% of the time, that is a loss of $22,200 per year. Calculating the present value of her total loss starting on August 22, 2022 (she would be on maternity leave until then) a multiplier of 26.305 is to be used. This results in a present value of her loss to age 70 of $583,971, or $524,938 net of risk-only contingencies.

[360] The present value of her non-wage benefits (which are generally estimated as being 10% of earnings) to age 70 can similarly be determined by applying the multiplier of 26.305 to their annual value.

[361] Dr. Van Den Berg’s prediction that Ms. Williams may have to retire two to three years early can be addressed by identifying the total earnings in Mr. Sheldon’s table of cumulative earnings, which run to age 70, that corresponds to her expected retirement year (and compensating her for the additional loss as a result)

[362] Mr. Sheldon agreed with the suggestion that the "risk only" contingencies would not account for voluntary departure from the workforce due to pregnancy, whereas risk and choice would. One way to account for future maternity leave was to subtract that year of earnings from Ms. Williams's cumulative table of earnings to age 70. The problem with employing the "risk and choice" model to account for that is that it would then apply for the rest of her working life, even if she has a strong attachment to the labour market.

[363] The defendants provided a response report from Mr. Steigerveld. Ms. Williams's counsel did not require him to attend for cross-examination.

[364] Mr. Steigerveld questioned Mr. Sheldon's use of the "risk only" continencies in his calculations. He made the point that since Ms. Williams's future labour force participation over the next 35 years is unknown, even to her, it is reasonable to apply average (his preferred term for "risk and choice") contingencies, which include people with both above and below average participation, as well as part-time work. To illustrate the impact of Mr. Sheldon's choice, he pointed out that the "risk only" deduction is less than one-third of the one for "risk and choice".

[365] There are also some differences in the way that Mr. Steigerveld would calculate negative labour market contingencies, which would lead to a higher overall estimate of earnings for Ms. Williams than Mr. Sheldon's, but on balance they are similar to Mr. Sheldon's "risk and choice" contingencies. His present value multiplier is also very similar to what would result if Mr. Sheldon had calculated his using "risk and choice" contingencies.

[366] Finally, Mr. Steigerveld produced tables for calculating Ms. Williams's earnings to age 70 (which, once again, is the same as Mr. Sheldon's "risk and choice" contingencies) and multipliers to show the present value of each $1000 earned by her, based on both the actuarial approach used by Mr. Sheldon and the economic multipliers used by him. The difference in the approaches is that the actuarial approach applies the multiplier and then applies any deductions to the result, whereas the economic approach includes the deductions in the multiplier

itself. The results of both will basically be the same, if "risk and choice" contingencies are applied to the product of the actuarial multiplier.

D. Matters to be Decided

1. Essential Findings of Fact

a) Plaintiff

[367] Ms. Williams's counsel points out that the expert evidence is uncontroverted that the subject accident caused anxiety, OCD, headaches, oculomotor dysfunction, visual processing dysfunction and photophobia, all of which are ongoing and permanent. The only areas of disagreement in that evidence are whether (1) her depression, which was also caused by the accident, is ongoing or in remission; and (2) whether she suffered a concussion in the accident.

[368] With respect to depression, its continuing nature is said to be supported by Dr. Krull's two and half years of closely following her progress, which places him in the best position to offer an opinion; Dr. Chawla's diagnosis in his 2021 report of "mood disorder suggestive of…chronic depression"; and the supportive observations of Ms. Carson and Ms. Morrice. Dr. Okorie conceded that the symptoms of 95% of psychological conditions wax and wane, and he was prevented by his single encounter with Ms. Williams from gaining information about some of the losses she had suffered and their impact on her, or monitoring her response to treatment over time. The additional flaw in his opinion on this point is that he did not explain Ms. Williams's high score on the self-screening tool for depression in his report, and instead wrote that she did not report symptoms that would support a diagnosis of major depressive disorder. Her counsel argues that Dr. Okorie had an obligation to explain why he rejected indications from her that pointed towards ongoing depression.

[369] The factual finding that Ms. Williams suffered a concussion is supported by Dr. Chawla's diagnosis, which included concussion-related headaches, as well as Dr. Sass's opinion that the visual conditions he diagnosed are commonly caused by a concussion. Her counsel stresses that the symptoms of concussion-related visual

symptoms closely align with Ms. Williams's own testimony about her experiences since the accident.

[370] The absence of visual symptoms in the post-accident medical records should not be weighed against Ms. Williams, her counsel argued. A lack of attention to such symptoms by care providers was in keeping with Dr. Sass's expectations. When assessing the challenge by the defendants' counsel on his ability to diagnose a concussion, one must keep in mind the fine line between that diagnosis and his unchallenged ability to diagnose damage to the vision system, which is part of the brain.

[371] Although Dr. Sass also referred to a neck injury as a potential cause of such visual symptoms, Ms. Williams's counsel submits that such a finding would be inconsistent with the evidence as a whole, particularly Dr. Locht's conclusions that any soft tissue injuries were resolved within a month of the accident. As a result of that conclusion, there is no other explanation in the expert opinions for her ongoing headaches, the evidence with respect to which was not challenged, except a concussion.

[372] Dr. Okorie's opinion that there was no concussion has several weaknesses, it is argued. He was not provided with any evidence with respect to Ms. Williams's symptoms and claimed that he did not need them in order to reach his conclusions. While his reasons for ruling out a concussion do not depend on the existence of visual symptoms, evidence pointing towards another diagnosis should still have been part of the factual context within which he reached a conclusion, and his blanket rejection of it, without knowing the details, should raise concerns. Further, the fact that Ms. Williams's other symptoms can explain her cognitive difficulties does not in itself rule out concussion as a cause. Finally, while counsel argued on the liability issue that Mr. Fedalizo's evidence should not be believed, if his allegation that she moved her vehicle after the collision is to be accepted, that is further evidence of a gap in her memory that Dr. Okorie was not able to take into account in forming his opinion.

[373] To the extent that it is necessary to resolve conflicts in the expert opinions, Dr. Okorie's unwillingness to consider information that could provide balance to his opinion means that he has fallen below the necessary standard of objectivity that is required from an expert, and tips the balance in favour of Dr. Chawla and Dr. Sass on the contested points.

b) Defendants

[374] On the concussion issue, the defendants' counsel point to Ms. Williams's relatively detailed memories of the events immediately following the subject accident, as well as her ability (according to Mr. Fedalizo) to move her vehicle, to speak on the phone and with pedestrians, and to get out of her vehicle herself. These are the kinds memories and goal-directed behaviour that caused Dr. Okorie to reject the likelihood of such an injury. The scan at the hospital also provided no objective evidence supporting it.

[375] The defendants' counsel concede that Ms. Williams certainly experienced an exacerbation of her pre-existing anxiety, developed OCD, and also suffered "some" depression, headaches, and sensitivity to light and sound. However, they say that the severity of these conditions that she claims is inconsistent with the measures that she actually took to seek assistance for them. Concerns include her lengthy gaps, after the summer of 2016, in attending to family physicians or seeking other assistance in relation to the subject; the absence of accident-related complaints from some of her later physician visits, and from her ongoing counselling, which focused mainly on relationship problems; and her ability to hold a second, part-time job into late 2016, and immediately replace it with another part-time job with Options.

[376] It is said to be particularly unbelievable that Ms. Williams would fail to "connect the dots" about the fairly extensive and serious visual problems that she testified about, as she claimed, rather than seeking the assistance of a doctor. She also does not appear to have expressed any concern to her care providers about the loss of the opportunity to pursue training as a licencing officer, which she testified was very important to her.

[377] While they fairly acknowledge that the records of her visits to caregivers would be unlikely to contain all of her accident-related complaints, the defendants' counsel submit that if the situation had actually been as Mr. Williams described in her testimony, at least some of those details would have found their way into the records.

[378] Counsel also submit that Ms. Carson and Ms. Morrice provide only limited support for the effects that Ms. Williams claims. Ms. Carson's level of involvement in Ms. Williams's post-accident life, and her opportunity to make observations about it, were not actually that extensive, and the extent of the social activities that Ms. Morrice described Ms. Williams being able to participate in with her actually tends to undermine somewhat Ms. Williams's self-portrait of post-accident isolation.

[379] The other essential point being made on behalf of the defendants is that there remains significant scope for improvement in Ms. Williams's condition, if she follows the various treatments that the expert witnesses have recommended. This is not an allegation that she has failed to mitigate her damages, but rather than her current condition is not permanent in all respects, and does not reflect her maximum potential improvement.

[380] Dr. Chawla identified several medications that could be trialled, and while there is no guarantee that they will prove to be effective, the defendants' counsel submit that it is unlikely that he would have recommended them if he had no expectation of improvement. Dr. Sass expects significant improvement when Ms. Williams embarks on visual therapy with him, and even though only modest success has been obtained from working with Dr. Sass so far, his opinion is that the recommended treatment will result in at least some further improvement.

c) Discussion

[381] As a preliminary matter, during Ms. Williams's cross-examination the defendants' counsel put numerous contradictions between her trial testimony and her statements to previous care providers to her. I have summarized what I consider to be the most important ones. In some cases, she did not recall having made the

previous statement that was being attributed to her, or was not prepared to accept its entire contents.

[382] The defendants' counsel helpfully confirmed that they were content with the contradictions that Ms. Williams was able to recall and accept, and were not seeking to prove that the balance of them had been made. Such proof would of course be required before these statements could be used as admissions against interest and/or prior inconsistent statements: *Cunningham v. Slubowski*, 2003 BCSC 1854, at paras. 14-16.

[383] Accordingly, I have considered only those alleged contradictions in which Ms. Williams either explicitly accepted that she had made the previous statement, or gave a response that was premised on a complete or partial acceptance of it. Similarly, I have not placed any emphasis on omissions of the symptoms that she currently claims or their severity from previous reports, unless she expressly or impliedly conceded that she had failed to include the information at the time.

[384] Even with those reservations however, Ms. Williams's version of events in her testimony was still meaningfully contradicted by those statements to her care providers about her situation that she admitted to making, both before and after the subject accident. Her narrative of a steep decline from a relatively high level of functioning, one that encompassed virtually all aspects of her life, was not borne out by that material. She frequently struggled to address in a plausible way the clear evidence that her mental state was quite vulnerable before the accident, that some of her symptoms have waxed and waned since it occurred, and that she has been able to maintain her function in some areas of her life. While I did not find her to be deliberately deceptive at any point, a degree of caution is still required before accepting those parts of her evidence that are not objectively supported.

[385] There is no dispute that her actual physical injuries from the accident were as Dr. Locht described, and that they would have been resolved according to the timelines that he provided.

[386] Of the disputed factual issues, the most straightforward is her mood disorders. It is common ground that her anxiety was aggravated by the subject accident, and that as a result of it she suffered from some depression and developed OCD. The disputed matters are whether her depression is in remission and the overall severity of the mood orders that she experiences.

[387] As I have summarized, she struggled at times with mood issues before the subject accident, mainly with anxiety, but also at times with depression. These issues generally arose in the context of her intimate relationships, and sometimes with an overlay of substance abuse. She had required psychiatric intervention over a concern about self-harm and was receiving ongoing counselling. The effect of the 2013 accident on her much-valued fitness level was also a cause of anxiety. Obviously, the defendants take their plaintiff as they find her in terms of her pre-existing vulnerabilities, but when one is determining how much harm was actually caused by the subject accident, it is important to recognize that Ms. Williams was already in a somewhat precarious mental state before it occurred.

[388] I am satisfied that the effect of the subject accident was to tip her over into a more serious set of mood disorders, which interfered to a much greater extent with her function than what she had been experiencing previously.

[389] In this regard, I think Dr. Okorie's diagnosis that the subject accident "aggravated and complicated" Ms. Williams's pre-existing, diagnosable generalized anxiety disorder, and added OCD to the mix, offers the clearest explanation of what occurred. I found his comment that Ms. Williams has "incorporated driving anxiety into her wide range of anxious themes" to be a be a good example of the relationship between her pre- and post-accident mental states.

[390] Dr. Krull certainly had the benefit of a long-term relationship with Ms. Williams, but I found that he tended to underplay her pre-accident mood problems and to portray the post-accident ones as more continuous and pervasive than her statements to care providers would suggest. There is no particular reason to doubt his additional diagnosis of an attachment disorder or his description of its

effects, which Dr. Okorie did not deal with in his response report, but since I took those effects to be “fear, panic and emotional disorganization” (in other words, anxiety) when a threatened separation occurs, and since it was also unquestionably aggravated by the subject accident, I think it is likely just another source of the same symptoms.

[391] Ultimately, I do not think much turns on Dr. Okorie’s inability to make a diagnosis of depression when he saw her, which I accept. He drew what I found to be a convincing distinction between the amount of time with a psychiatric patient that is required to make a diagnosis, and the longer period that would be required to monitor their treatment. Despite this, there is no question that she has been depressed since the accident and remains vulnerable to becoming depressed again, so her presentation at that particular time, which he characterized as a remission, does not rule it out as a consequence of the accident, or a continuing vulnerability. At most, it shows that it is capable of remission.

[392] I accept that Ms. Williams’s anxiety is serious and ongoing, and that it impacts her functioning at home and at work. The OCD, which she described in a particularly compelling way and for which support was provided by her friends’ testimony, is also clearly quite debilitating in itself.

[393] I am not satisfied however, that her anxiety has been continuously severe since the subject accident. As the records show, there appears to have been quite a lengthy period in which her immediate post-accident anxiety was less acute, and her symptoms were not serious enough to seek assistance. She appears to have been comfortable describing a wide range of issues to her family doctors over time, and I do not think she would have hesitated to seek assistance with this problem if it had reached a disabling level. It certainly became much more serious during the course of the post-accident period, to the extent that even Dr. Okorie agreed that part-time work was justified in order to manage it.

[394] Ms. Williams's headaches, which she described as one of her most troubling symptoms, are inextricably bound up with her concussion diagnosis, which is contested, so that issue must be resolved first.

[395] While the evidence in support of it is less than ideal, on balance I am satisfied that she did suffer a concussion in the subject accident. Dr. Chawla's opinion that this occurred depends in part on emergency records and a diagnosis contained in them that were not independently proven in the trial, which lessens the weight that can be attached to his opinion. (Of course even then only the fact that the emergency diagnosis was made would have been admissible; it would not have been admissible as an opinion in itself.) And, although it was greatly to her credit that she conceded it, Ms. Williams herself cannot support a loss of consciousness in her own testimony. Nevertheless, I think that there is also a body of circumstantial evidence that lends support to Dr. Chawla's opinion, and convinces me that a concussion occurred. Dr. Chawla found the post-accident headaches to be consistent with such an injury. Although he is not qualified to diagnose it, Dr. Sass's evidence was that the visual symptoms that he was qualified to identify are frequently associated with concussions as well. The range of symptoms that the occupational therapist described were of the same nature. The fact that the only other explanation in the evidence for the visual symptoms would be a neck injury, which in this case resolved quickly after the accident, also lends some weight to the conclusion. Although she suffered a neck injury in the 2013 accident and still suffers shoulder pain from that accident, it seems clear that she had no visual symptoms until after the subject accident.

[396] I appreciate Dr. Okorie's opinion to the contrary, but on balance I find that it is less grounded in the overall evidence than Dr. Chawla's. The emergency report on which Dr. Chawla relied did indicate a loss of consciousness, and presumably involved the type of professional assessment of her mental state that Dr. Okorie considers to be essential. While Ms. Williams could not confirm a loss of consciousness in her own testimony, neither could she rule it out. As to the alleged purposefulness of her behaviour immediately after the collision, phoning her brother

would certainly meet that definition, but Ms. Zawadzka described her as “shocked” and I am reluctant to accept Mr. Fedalizo’s allegation that she moved her vehicle in the aftermath, in the absence of confirmation of that observation by a more reliable witness.

[397] I am certainly satisfied that Ms. Williams suffers from ongoing headaches, and that they can at times be very troubling to her, both in their frequency and their severity. But as in the case of her anxiety, I am not satisfied that they are as serious as she described. Once again, there is evidence that their severity declined in the immediate post-accident period and that there was a gap of time during which the ones she suffered did not prompt the need for medical assistance. I also found it odd that the only ongoing remedy she had sought out for such a debilitating problem as of the time of her testimony was the use of essential oils, and in the episode she described involving an apparently harrowing experience with a headache when she was on the way to dinner with her family, it was able to be resolved by taking Extra Strength Tylenol, an over-the-counter medication.

[398] Much the same can be said about the visual symptoms. Dr. Sass’s actual diagnosis of them was not challenged, and there seems no reason to doubt it, but the absence of meaningful reference to them between the immediate post-accident contact with the occupational therapist and a point after she had come to see him raises that same concern about how severe they could have been in the interim. The reality, as Ms. Williams conceded to her credit, is that she did not really have a comprehensive awareness of her visual issues until she was instructed about them by him, at which time she was able to “connect the dots”. Since then I think that her legitimate symptoms have been incorporated into her overall narrative of serious disability, and have thereby been re-cast as somewhat more serious and pervasive. Dr. Sass may well be right that some of these problems fall between the cracks with other kinds of health professionals, but I would still expect her to have been describing the symptoms somewhere, particularly to her regular optometrist, even if she was unable to link it to her visual system, if they were as debilitating as she now claims.

[399] To be clear, I accept that she has visual symptoms, and that times they are very troubling. For example, there is no reason not to accept Ms. Morrice's anecdote about Ms. Williams being incapacitated by watching a movie from the back row.

[400] I think that Dr. Sass's opinion also sufficiently explains the cognitive symptoms that Ms. Williams has described, although Dr. Krull also referred to there being cognitive effects of her attachment disorder.

[401] With respect to prognosis, Dr. Sass expected the visual therapy to have a meaningful beneficial effect on Ms. Williams's visual symptoms, including her headaches. It is difficult to put much weight on the possibility of improvement in the headaches from the medications that Dr. Chawla suggests however, in the absence of any indication by him of a likelihood that any of them will be effective.

[402] The psychological symptoms are less straightforward. Dr. Krull's guarded prognosis is bound up in his belief that the most significant underlying problem is Ms. Williams's attachment disorder, which is considered difficult to treat, although he allowed for the "mildly better" prospects of a partial recovery. Dr. Okorie sees the length of Ms. Williams's therapeutic relationship with Dr. Krull as a potential impediment to recovery and suggests that it be wound up in favour of a focus on self-management and a more effective psychotropic medication. He characterized her conditions as chronic and fluctuating in severity depending on the circumstances, rather than being susceptible to complete resolution. More optimistically, Dr. Van Den Berg, who, as it happens, is also a psychologist, agreed with the suggestion that his recommended program of therapy could lead to a resolution of her psychological (as well as visual) symptoms to her pre-accident level. There is no principled reason not to assign at least some weight to that more optimistic forecast, as well as the partial recovery Dr. Krull allows for, and I think the fairest overall balancing of these opinions is to say that the possibility of meaningful improvement in her psychological symptoms remains.

2. Non-Pecuniary Damages

a) Plaintiff

[403] Ms. Williams's counsel characterizes the harm suffered by Ms. Williams as a result of the subject accident as "severe permanent injuries that go to the very core of who she is as a person". In contrast to the fit, socially active and positive person she was before it occurred, the injuries she received have caused her to enter a downward spiral, during which she has lost contact with her friends, lost interest in her self care and developed severe compulsive behaviours that she finds embarrassing. Five years after the accident she is still displaying a precarious emotional state, so much so that Dr. Okorie concluded that the therapy she was receiving from Dr. Krull must not be working. Her counsel accepts that her pre-accident anxiety would likely have continued at some level, but the point is that it was previously manageable.

[404] Her counsel submits that this degree of impact justifies an award in the range of $200,000. He relies on recent decisions of this Court in which some combination of concussion, emotional or psychological harm and other vulnerabilities (and in one case, soft tissue injuries and "significant anxiety and depression, with no concussion) led to awards in the range of $150,000 - $200,000:

Name	**Relevant Circumstances**	**Award**
Conroy v. Rodin, 2021 BCSC 861	The 56-year-old plaintiff had pre-existing anxiety and depression, for which she had sought regular counselling. The trial judge found that the accident had caused a concussion, exacerbated her anxiety and depression, and led her to develop alcohol use disorder. The injuries were found to have a significant impact on the plaintiff's sense of identity and self-worth.	$150,000
Cole v. Sandhu, 2020 BCSC 709	The 29 year-old plaintiff, "a formerly active and social young woman", suffered soft tissue injuries and anxiety and depression as a result of the accident, which created "an indefinite cycle of chronic pain, anxiety, and depression that has impacted all aspects of her life." There was no concussion involved. The plaintiff had a history of anxiety and depression before the accident, and the trial judge rejected the defence argument that	$175,000

	her current mood problems were unrelated to the accident. The judge found that the plaintiff's inability to pursue her hoped-for career due to her injuries played a role in her continuing mood disorder.	
Blackburn v. Lattimore, 2021 BCSC 1417	The 38 year old plaintiff suffered "post-concussive syndrome, with symptoms of dizziness, balance difficulty, light and noise sensitivity, cognitive dysfunction, headaches, and fatigue. The [a]ccident also caused psychiatric injuries in the form of anxiety and depression. These symptoms [had] improved but are not resolved…As well, the plaintiff suffered neck and lower back soft tissue injuries which, while chronic in nature, [had] significantly improved." The effect of her injuries was that she had effectively confined herself to her home, abandoned her personal life and neglected her self-care. Before the accident she had taken counselling to assist her with mood-related problems arising from a difficult relationship, which was successful in resolving those problems.	$180,000
Sharp v. Song, 2021 BCSC 1422	The 47-year-old had several psychological conditions before the accident, including PTSD, anxiety and depression, but was functioning well. He addressed them through prescription medication and cannabis use. The first accident in question was found to have caused a concussion, soft tissue injuries, tinnitus, PTSD, depression and anxiety, and the second one briefly aggravated them. The trial judge found that the injuries had rendered the plaintiff "a shell of his former self" and that it was unlikely that he would ever return to his pre-collision functioning.	$200,000

[405] Counsel points to the parallels between loss of the sense of self and the inability to pursue career ambitions that Ms. Williams has experienced as a result of her injuries and those that were experienced by the plaintiffs in *Conroy* and *Cole*. Also helpful in its similarity to her experience is the "complex and mutually reinforcing relationship" between the plaintiff's emotional injuries and their concussion that was found to exist in *Blackburn*. Finally, *Sharp* contains an authoritative statement of the law on the effect of pre-existing conditions, which may well pre-dispose a plaintiff to more serious consequences than others might have suffered, but which only lead to deductions from the award when there is a measurable risk that they would have detrimentally affected the plaintiff regardless of

the defendant's negligence, citing *Dornan v Silva*, 2021 BCCA 228 at para.63. (The defendants' counsel did not seek any such deduction here.)

[406] Ms. Williams's counsel also points out that the visual problems and OCD are more serious than any of the comparable injuries contained in these decisions, and her relatively young age - younger than all but one of the plaintiffs in them - means that she is likely to suffer from the effects of this accident for many years to come.

[407] Finally, her counsel submits that this is a case in which Ms. Williams's loss of household capacity should be compensated under the heading of non-pecuniary damages. She testified that her partner provides significant assistance with these tasks in the home, and Dr. Chawla recommended that she be provided with assistance with them. There was no evidence of the level of assistance required or the rates to pay to provide it, so it is better addressed as an aspect of her overall pain, suffering and loss of enjoyment of life.

b) Defendants

[408] Their counsel submit that an award in the range of $80,000-$110,000 would be more appropriate here. They have provided decisions of this Court that span that range (and extend slightly above it) and that involve, among other injuries, relatively young plaintiffs who experienced significant mood disorders, ongoing headaches, and in two of the decisions, concussions:

Name	**Relevant Circumstances**	**Award**
Purewal v Uriarte, 2020 BCSC 1798	The 27-year old plaintiff suffered soft tissue injuries that led to chronic, mild thoracic outlet syndrome, ongoing headaches (including migraines), and conditions related to her sacroiliac joint and pelvic ring. (She had a concussion as well, but there were no residual effects.) The injuries also caused anxiety and post-traumatic stress, which developed into a major depressive disorder. She did not have any psychological issues before the accident. A witness metaphorically described the plaintiff's "light" as having gone out. She was likely to suffer chronic pain and headaches throughout her life, but there was a	$80,000

	significant likelihood that her psychological symptoms could improve.	
Leung v Draper, 2020 BCSC 219	The 40-year-old plaintiff suffered chronic pain syndrome in her neck and upper back and chronic headaches. The trial judge found that these injuries were likely permanent but that their symptoms could be lessened. The accident also caused "a constellation of adjustment, anxiety and depression related disorders", including somatic symptom disorder, although the judge found that they could be meaningfully improved with treatment. Other soft tissue injuries and psychological symptoms had resolved by the time of trial.	$90,000
Evans v Keill, 2018 BCSC 1651	The 39-year old plaintiff was left by the accident with chronic pain to her neck and back, which was exacerbated by a variety of movements, and ongoing headaches and migraines. She had achieved a 60% improvement in these physical symptoms by the time of trial, but the trial judge was satisfied that this improvement had plateaued and the balance of her symptoms were permanent. The accident also caused two major depressive episodes, somatic symptom disorder, social withdrawal, two suicide attempts and excessive alcohol consumption. The prognosis on those issues was "cautiously optimistic".	$110,000
Alragheb v. Francis, 2020 BCSC 1712	The 31 year old plaintiff suffered injuries from two accidents, the second of which aggravated the symptoms of the first at a point when he was 75-80% recovered. This left him with chronic pain, PTSD and major depressive disorder. (He had also received a concussion in the first accident, but its effects were not long lasting). His physical injuries and headaches had largely resolved by the time of trial but the effects of the chronic pain and psychological problems were ongoing.	$120,000

[409] This range is said to correspond more accurately to the actual level of seriousness of Ms. Williams's injuries.

[410] If Ms. Williams had sought damages for loss of household capacity as a discreet heading, the defendants' counsel would have agreed that one to two years of assistance while her child is a toddler would have been reasonable, until the

improvement in her symptoms that Dr. Sass envisions is achieved. Four hours of assistance per month at $35/hour yields a range of $1,680-$3,360.

c) Discussion

(1) Principles

[411] The purpose of non-pecuniary damages is to compensate a plaintiff for "pain, suffering, loss of enjoyment of life and loss of amenities": *Jackson v. Lai*, 2007 BCSC 1023 at para. 134.

[412] Among the factors that can influence the amount of the award are the age of the plaintiff, the nature of the injury, the severity and duration of the pain, and the degree of disability, emotional suffering and impairment of life experienced by the plaintiff, including impairment of their important relationships and lifestyle pursuits: *Stapley v. Hejslet*, 2006 BCCA 34, at para. 46.

[413] The amount of the award is driven by what is required to ameliorate the condition of the plaintiff in their particular situation. Their need for solace may not necessarily correlate with the seriousness of their injury. Because of this need to recognize the specific circumstances, there can be no general "tariff" of awards: *Lindal v. Lindal*, [1981] 2 S.C.R. 629 at 637. Nevertheless, other decisions dealing with similar circumstances can serve as a guide in arriving at an award that is just and fair to both parties: *Kuskis v. Tin*, 2008 BCSC 862 at paras. 135-136.

[414] As Ms. Williams's counsel has suggested, it is a matter of discretion whether to address a claim for loss of household capacity as part of the non-pecuniary loss or as a segregated pecuniary head of damage: *Liu v. Bains*, 2016 BCCA 374, at para. 26. However in *McTavish v. MacGillivray*, 2000 BCCA 164, the Court explained that including the claim in non-pecuniary damages was best suited to a situation in which the plaintiff "performed the tasks with difficulty or functioned with the tasks undone and never to be done", but "when family members by their gratuitous labour replace costs that would otherwise be incurred…their work can be valued by a replacement cost" (para.69).

(2) Application

[415] Considering the cases that have been cited, taking care to look at them for guidance rather than as a tariff, and recognizing the advantage that the trial judges in them had of assessing a living human being rather than a thumbnail biography and a list of symptoms, I would say that on the whole the cases relied on by Ms. Williams's counsel lack the degree of skepticism about the extent of the plaintiff's injuries and the degree to which they interfere with their life that the evidence leaves me with here. Several of those plaintiffs were incapacitated in all aspects of their lives, with little hope for improvement, whereas Ms. Williams's injuries, while serious, have waned at times since the accident and are susceptible to being improved to a degree. The cases put forward by the defendants' counsel, although involving serious injuries, lacked an all-encompassing loss of ability to enjoy life and held out meaningful hopes for the plaintiff's improvement. As a result, I find them a more helpful guide to what might be fair here.

[416] In light of the severity of the injuries I have found were caused by the accident and the prospects for improvement, I will make an award of $140,000. I have included as a component of this award a loss of housekeeping function that is commensurate with the degree of impairment that I have found. I accept that Ms. Williams frequently lacks the energy to engage in household tasks because of the tiring effects of her injuries, as she and several of the experts describe. I have kept in mind that her evidence was that her partner fills in the gaps of what she is unable to do, so that household tasks get completed, but I do not read the Court of Appeal in *McTavish* as prohibiting the inclusion of an award for loss of household capacity under non-pecuniary damages in that situation, only that suggesting it is "best suited" to a situation in which the tasks are left unperformed.

3. Impairment of Past Earning Capacity

a) Issue

[417] This is a narrower area of dispute than under some of the other heads of damages.

[418] Counsel agree that Ms. Williams's gross past income loss from her Options positions (from the date of the accident until she went on maternity leave) is $19,140.06[6], plus $640 from Reach. After the application of a 25% income tax deduction the net award would be: $14,835.05.

[419] Where they disagree is on whether Ms. Williams is also entitled to compensation for income that would have been earned at her position at Reach from the date that the position ended on November 30, 2016 to the start of her maternity leave. The gross amount involved would be $34,839.

[420] The position of Ms. Williams's counsel that lost earnings from Reach should be included rests on her testimony that if it had not been for the accident, she would have taken on another child to work with as a behavioural interventionist at Reach after her contract ended, but also added the part-time position with Options - adjusting her schedule as required to accommodate all three positions.

[421] The defendants' counsel submit that this is unlikely, especially if one takes into account the time required by the licensing officer program that she was also pursuing. What is more likely, they say, is that she would have added only one seven-hour per week job to her main position at Options. Further it makes sense, they argue, that she would have chosen the one with the higher rate of pay. Counsel point out that she previously chose to work only at Options and Reach, even though she described having had a private behavioural interventionist position between 2012 and 2015 as well.

b) b. Discussion

(1) Principles

[422] A claim for what is often described as "past loss of income" is actually a claim for loss of earning capacity; that is, a claim for the loss of the value of the work that

[6] The defendants' counsel included a payment that Ms. Williams received from WorkSafe in their total, but the amount lost by her in her earnings from her actual employer is the same.

the injured plaintiff would have performed but was unable to perform because of the injury: *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141 at para. 30.

[423] When assessing loss under this heading, past hypothetical events (that is, what a plaintiff would have earned but for the accident) are to be treated the same way as future hypothetical events -- they are to be given weight in accordance with their relative likelihood. They do not have to be proven on a balance of probabilities: *Gill v. Probert*, 2001 BCCA 331 at para.9.

(2) Application

[424] In light of the fact that she had given up a previous behavioural interventionist position because she did not want to be doing three jobs at once, I do not think there is any reasonable possibility that if the accident had not occurred Ms. Williams would have added the additional seven-hour Options position and kept the one at Reach. I agree with the defendants' counsel that her plan to complete the licensing officer program would have made such a choice even less likely.

[425] Accordingly, the award under this heading will be $14,835.05.

4. Impairment of Future Earning Capacity

a) Plaintiff

[426] Ms. Williams's counsel points out that even Dr. Okorie accepted that her pre-maternity leave reduction in hours to 28 from 35 per week was appropriate, in light of her injuries and their effects. Dr. Van Den Berg expressed the view that a 50% reduction was required in order for her employment to be sustainable, and Dr. Chawla recommended "part-time work and [that] fulltime capacity work may be more challenging for her to maintain." He also pointed out that even working from home during the pandemic, with the resulting greater autonomy and the elimination of driving, did not meaningfully improve her situation.

[427] The expert opinions do not predict a significant increase in her functioning. Dr. Okorie concluded that the treatment that Ms. Williams was receiving from Dr. Krull must not be working, and Dr. Krull himself gave a guarded prognosis for a

substantial recovery - “fair at best” even if she has prolonged further treatment. Dr. Sass believed that her current visual symptoms make it unlikely that she can succeed in a job that has significant visual demands, or in post-secondary education, although he allows for the potential of some improvement with therapy.

[428] The added demands of motherhood, the impact of which on her ability to carry on her employment had yet to be tested as of the trial dates, must also be taken into account. Her counsel submits that parenting is the type of “normal life demand” that Dr. Van Den Berg envisioned when he recommended reducing her work hours to ensure employment sustainability. Most importantly, she already struggled to cope with work in light of her injuries without that added responsibility.

[429] As a result of the various factors, counsel submits that it is “very likely” that Ms. Williams will suffer “a significant permanent loss of function” that will restrict her to as much as 50% of full-time employment.

[430] When attaching a value to this loss, he submits that Ms. Williams’s demonstrated strong attachment to the workforce to this point in her career, in particular the evidence that even now she is “driven to perform well at work” weighs in favour of the “risk only” approach to the earnings involved. The 10% that Mr. Sheldon also suggested would accurately capture non-wage benefits should also be added to any projection of her loss.

[431] To this should be added the possibility that she will have to retire two to three years early, as Dr. Van Den Berg described.

[432] In addition to the impairment of her earning capacity in relation to her current employment, there are also positive contingencies that arise from the evidence and also have to be given weight.

[433] The first is the realistic possibility that she would have been able to complete her courses and become a licensing officer, which is supported by her ability to complete two of the courses and obtain good marks, while working full time. Using the median rates of the two positions, for comparison, she could earn 35% more in

the licensing position than the current one. The evidence was that licensing positions are more frequently available on a part-time or casual basis than full-time, but there is also a possibility that she would have obtained full-time employment in that capacity (which needs to be given some weight, I took counsel to mean).

[434] As Mr. Sheldon pointed out, the tables of her future earnings do not include the positive contingencies such as career advancement or upgrades in training.

[435] The possibility that she will make enough improvement through visual therapy to be able to complete the required courses to obtain that position is small, counsel argues, and even if such improvements occur the effects of her other injuries would likely require her to reduce her hours of employment to accommodate the courses.

[436] The second positive contingency is that she could have maintained her position at Reach, as well as those at Options, as was argued in relation to her impairment of past earning capacity claim. The evidence of her friends Ms. Carson and Ms. Morrice showed that this was well within her pre-accident capacity.

[437] Using Ms. Williams's actual Options and Reach earnings to this point, and her likely earnings as a licensing officer, and applying them to Mr. Sheldon's calculations, provides the following ranges for consideration, the lower number applying "risk and choice" and the higher applying "risk only":

- Loss of seven hours per week from earnings in Options positions: $168,000-$241,000;
- 50% reduction in earnings: $404,000 - $577,000;
- Early retirement: $48,000-$160,000;
- Positive contingency of becoming a licensing officer: $545,000-$779,000
- Positive contingency of continuing to work at Reach: $122,000-$175,000

[438] Keeping in mind that damages for future loss are to be assessed rather than calculated, Ms. Williams's counsel submits that an award of $600,000 is appropriate.

b) Defendants

[439] Their counsel submit that the projections of Ms. Williams's future capacity to work being put forward by her counsel are not consistent with the evidence as a whole.

[440] Of the experts, only Dr. Van Den Berg goes as far as to recommend her working 50%.

[441] While Dr. Chawla moved from encouraging her to work "part-time or full-time" in his first report to suggesting that full-time "may be more challenging for her to maintain" in his second, he also recommended trials of medications that may assist in improving her function, and did not envision any "spontaneous decline" in that function.

[442] Dr. Krull offered a "mildly better" prognosis for a partial recovery than the "fair at best" he provided overall. Such a partial recovery would allow her "to reasonably manage home, work and motherhood", he believed.

[443] Dr. Sass held out the possibility that visual therapy might improve her symptoms and function to the point where she could work full time and resume her education.

[444] Dr. Okorie found her current reduction to 28 hours per week reasonable, but also anticipated improvement with further treatment.

[445] Finally, although she identified some areas for improvement, Ms. Mantyka-Ogden described Ms. Williams as an excellent and valued employee and gave her strong performance reviews.

[446] The defendants' counsel submit that the conclusion that emerges is that Ms. Williams is capable of returning to her 28-hour per week position at Options

following her maternity leave, and that there is a real and substantial possibility that she will be able to improve to the point where full-time hours are possible. Specifically, their position is that it would be reasonable for her to work 28 hours per week for two to four years following the conclusion of her leave, until her child is between three and five years old. By that point, the increased independence of her child and some improvement in her symptoms should combine to permit her to manage full-time hours. (A viable alternative, they say would be to maintain the 28 hours and add one course at a time towards the licensing officer position.)

[447] Counsel concede that there may be some difficulties when she first returns from maternity leave, and attempts to balance work and parenting a young child, but say that the counselling and visual treatment that she will have been able to take by then will lead to some improvement, making her situation somewhat easier.

[448] This disagreement with respect to Ms. Williams's capacity obviously carries over to the quantification of her loss. The defendants' counsel argue that the labour market contingencies recommended by Mr. Sheldon are unrealistic in light of the possibility of a voluntary reduction in her participation, whether due to having additional children, or to different choices being appropriate as she ages. More importantly, the award sought on her behalf unreasonably fails to allow for the realistic possibility of improvement in her condition and an increase in hours.

[449] At the other end of her working life, Dr. Van Den Berg's opinion about Ms. Williams possibly having to retire two to three years earlier is described as speculative in light of the potential for improvement, and is not supported by any of the other expert opinions.

[450] In the defence analysis, the most likely outcome of a return to full-time work within a relatively short period would lead to a loss in the range of $14,400 to $28,000, based on a loss of $7,200 per year for two to four years.

[451] An alternative would be to assess Ms. Williams's loss under the capital asset approach, as explained in *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d), 353 (S.C.) at

para. 8. Viewing Ms. Williams's capacity to work as a lost or impaired asset to this extent could lead to an award of one- or two-years' salary: $45,000 - $90,000.

[452] The defendants' counsel submit that the $118,000 that results from applying Mr. Steigerveld's risk and choice multiplier to the $7,200 per year that she would lose by working 28 hours per week until age 70 is the maximum loss that is supported by the evidence.

[453] There are also difficulties with compensating her for losses associated with the licensing officer position, they say. She had completed only two of the ten required courses as of the fall of 2015, had not yet scheduled further ones, and could have maintained her 28-hour per week Options position and pursued them in the additional spare time. She would also have had to complete a practicum or a cumulative online course to complete the program, and gain additional supervisory experience to compete for jobs. Assuming all of this could have been accomplished, there is still the relative lack of full-time and regular positions, as identified by Dr. Van Den Berg.

[454] Given these obstacles, and her likely progress of two courses per year, the defendants say that it is speculative whether any loss will result from a loss of capacity in this field. If the possibility of such a loss is found to be realistic, then the capital asset approach to valuing it, as previously discussed, would adequately compensate her.

c) Discussion

(1) Principles

[455] *Rab v. Prescott*, 2021 BCCA 345 at para.47 helpfully clarified the correct approach to a claim for damages of this nature. First, the judge must determine whether the evidence discloses a potential future event that could lead to a loss of capacity. The next question is whether the evidence shows a real and substantial possibility that the future event will lead to a pecuniary loss. Finally, the value of that

possible future loss must be assessed, including the relative likelihood of the possibility occurring.

[456] The identified loss may be quantified either on an earnings approach or a capital asset approach: *Perren v. Lalari*, 2010 BCCA 140 at para. 32. The capital asset approach, which focuses on the loss or impairment of the plaintiff's earning capacity as an asset available to them, will be more appropriate when the loss is not easily measurable. Even when that approach is used, there still has to be proof of a real and substantial possibility of a future event leading to an income loss: *Perren* at para. 32. In other words, there is no award for a loss of capacity in itself.

[457] Even when it is clear that the future event will lead to a pecuniary loss, as in the case of a significant and lasting injury, "it may still be necessary to assess the possibility and likelihood of future hypothetical events occurring that may affect the quantification of the loss, such as potential positive or negative contingencies": *Rab* at para. 29.

[458] In essence, "the award involves a comparison between the likely future of the plaintiff if the accident had not happened and the plaintiff's likely future after the accident has happened": *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para 32.

(2) Application

[459] As the focused submissions anticipated, the criteria that were clarified in *Rab* are obviously met here. Ms. Williams's current headaches, visual symptoms and mood disorders are virtually certain to continue to lead to impairment. It is also certain that this "event", which is ongoing, will lead to a pecuniary loss by her to some degree. The contested matters are how much she will be able to work, including the possibility of returning to full time hours and being able to complete the licensing course; the likelihood of having maintained the Reach position along with the others; and how likely she was to have completed the additional training and remained engaged in the workforce throughout her life if the accident had not occurred.

[460] On the question of how much she will be able to work, I found Dr. Van Den Berg's report and testimony to be insightful and helpful in many respects, and I fully appreciate his concern that Ms. Williams needs some residual capacity built into her working hours to cope with the effects of her injuries and remain resilient. But while I think that the possibility of her only being able to work 50% is a possibility that must be given some weight, the 75% favoured by the other experts seems much more likely, particularly given the degree of confidence that Dr. Sass attached to the effectiveness of the visual therapy, which will address some of her major work impediments. There is also a possibility that she can achieve a return to full-time if all goes well in her treatments, which is meaningful but not as likely as 75%, in my opinion. I certainly cannot agree that it can be projected as definitely occurring within two to four years, as the defendants' counsel argue.

[461] For the reasons that I provided when dealing with impairment of past earning capacity, I do not think that there is any reasonable possibility that Ms. Williams would have continued on with both a position at Reach and 35 hours per week at Options if the accident had not occurred, so compensating her for the loss of the Reach position when the reduction from full-time hours at Options has already been taken into account would be double-counting.

[462] I do not regard it as a complete certainty that Ms. Williams would have completed the licensing program and gained employment in that field if the accident had not occurred. She had completed only 20% of the required course work, albeit in a manner that showed promise, and even if the vacancies Dr. Van Den Berg found did not insist on supervisory experience, the fact that the Justice Institute views it as essential is entitled to some weight, and she has not acquired enough of yet. In addition, while she was still functioning at a much higher level before the accident than after, she still had several vulnerabilities that could have derailed this career project if they had been triggered. I would rate the possibility of completion as being more likely than not, but no higher degree of likelihood than that.

[463] With respect to quantification of her loss, I think this is a situation in which the lost earnings involved are capable of calculation, so that approach is preferable to the capital asset method.

[464] I conclude that Ms. Williams's demonstrated attachment to the workforce justifies applying the "risk only" contingencies to her loss of earnings. Although I have found the effects of her injuries to be less pervasive and debilitating than she perceives and described them, there is no question that they were more than sufficient to push a less dedicated person into unemployment, or more minimal employment. Employment in her chosen field is clearly of immense importance to her, her supervisor commended her dedication, and several of the experts commented on her wish to push through her symptoms to complete her work.

[465] For the same reasons however, I would say that the tendency towards early retirement identified by Dr. Van Den Berg, while certainly possible, is quite unlikely. I would give it minimal weight.

[466] At the end of the day, I think that the way to ensure that the assessment required under this heading is rooted in the evidence to the maximum extent possible is to consider the outcomes that have the greatest likelihood and then modify them to the extent required to allow for the possibility that they will not occur, and that other less likely possibilities will.

[467] If Ms. Williams is only able to work 75% of the time to age 70, which is the most likely result, the present value of her total loss using the risk only analysis would be $294,616 (25% of 44,800 x 26.305). As I have found, there is some likelihood that she could return to full-time work along the way, which means that this loss would end, and a smaller risk that her work hours could reduce to 50%, meaning that the loss would increase to $589, 232. (50% of 44,800 x 26.305). The loss of non-wage benefits would be 10% of either figure.

[468] The same approach can be taken to the income she could have earned if she qualified as a licensing officer, which was likely to be 35% higher than her current

rate of pay, even if only the median rates of each position are compared, as her counsel suggests. Of course, I have been unable to find any greater degree of likelihood that this would have occurred without the accident than that it is more likely than not, and even if it would have, the evidence is that full time work as a licensing officer is not generally available. Assuming a completion date for the program, at two courses per year, of 2021, followed by the necessary practicum or qualifying course, and part-time or casual work in approximately the same amounts as her second Options position, there is a possibility that the 25% of her full-time income that is currently missing could have increased by 35% in 2022 from the $11,200 per year that it currently constitutes – an additional $ $3,920per year. Using Mr. Sheldon's multiplier for an increase beginning in 2022 – also 26.305 - the resulting additional loss of that additional amount to age 70 would be $103,115. In reaching this conclusion, I have found it more likely that Ms. Williams would replace the part-time Options position with the higher-paying licensing officer one.

[469] Weighing the likelihood of these various possibilities as best as one can, and adding the present value of 10% for non-wage benefits as Mr. Sheldon suggests, I conclude that an award of $400,000 for impairment of future earning capacity would fair in all the circumstances.

5. Cost of Future Care

a) Plaintiff

[470] Her counsel's submissions track the recommendations of Dr. Krull and Dr. Sass. Weekly visits with Dr. Krull for two and a half years (the mid-point of his recommended range) at $175/hr will cost $22,750. Three months of weekly sessions with Dr. Sass at $130-$150 each will cost $1,800.

b) Defendants

[471] On the psychological care issue, the defendants' counsel agree that some future sessions with Dr. Krull are reasonable, but not to the extent he recommends, because it is unlikely that two to three years of the same treatment she has been receiving will lead to any significant improvement. They point to Dr. Van Den Berg's

recommendation of CBT to teach skills for coping with pain, which aligns with Dr. Okorie's view that she should be transitioning to more self-directed forms of treatment. The upshot is that counsel support 12-20 further sessions, at a range of $175 (Dr. Krull's rate) - $200/hr, of an award of $2,100-$4000.

[472] They consider therapy from Dr. Sass to be reasonable, but attach the rate of $120/hr mentioned in his report to it. They acknowledge however, that at a higher rate, up to a maximum of $1,700 would be reasonable.

c) Discussion

(1) Principles

[473] Claims made for future care must be both medically justified and reasonable. An award "should reflect what the evidence establishes is reasonably necessary to preserve the plaintiff's health": *Milina v. Bartsch (1985)*, 49 B.C.L.R. (2d) 33 (S.C.) at paras. 199 and 201; aff'd (1987), 49 B.C.L.R (2d) 99 (C.A.). The standard is one of real and substantial risk of future pecuniary loss, through the plaintiff incurring costs of care: *Graham v. Rourke (1990)*, 74 D.L.R. (4th) 1 (Ont. C.A.).

[474] The requirement is one of medical justification, as opposed to medical necessity and it "requires only some evidence that the expense claimed is directly related to the disability arising out of the accident, and is incurred with a view toward ameliorating its impact": *Harrington v. Sangha*, 2011 BCSC 1035, at para. 151.

(2) Application

[475] The evidence amply justifies awards for both ongoing psychological counselling and visual therapy. The only questions are with respect to the manner in which the counselling is to be delivered and the extent of it that is required.

[476] I am not convinced by Dr. Okorie's prediction that ongoing engagement with Dr. Krull will make Ms. Williams's situation worse by leading to over-attachment. There was no suggestion that this has occurred during the lengthy time they have already worked together, and it is hard to see what that would change during any additional period. My difficulty, in terms of finding medical justification, is that it does

not appear that Dr. Krull's treatment has led to much discernible improvement in her condition either, although it is clear that she finds it comforting to work with him. On the evidence, the treatment that seems to have a reasonable prospect of achieving such an improvement are the CBT and related therapies recommended by Dr. Van Den Berg. He recommends 28-30 hours of therapy, at $200 per hour. I will award $6,000 for that purpose.

[477] It is common ground that the visual therapy should be funded. I am unable to account for the difference between the $1,800 being sought by Ms. Williams's counsel and the $1,700 that the defendants' counsel acknowledge would be reasonable. To be certain that this therapy is completed without Ms. Williams having to pay out of her own pocket, I will award the slightly higher amount.

[478] The total award under this heading is $7,800.

6. Special Damages

[479] The parties' have agreed to special damages of $13,076 for treatments from Dr. Sass ($306), treatments by Dr. Krull ($11,720), and mileage ($1,500), plus $793.94 for WorkSafe BC's subrogated health care costs, for a total award of $13,869.94.

7. Summary of Damages

[480] The damages awarded are:

- Non-pecuniary: $140,000
- Impairment of past earning capacity: $14,835.05
- Impairment of future earning capacity: $400,000
- Cost of future care: $7,800
- Special: $13,869.94

[481] Any required calculations on which the parties are unable to agree can be referred to a registrar, who will certify the results.

IV. COSTS

[482] Ms. Williams has succeeded in establishing liability and obtaining a remedy, although the damages were not in the amounts that she sought (see *Loft v. Nat*, 2014 BCCA 108 at para.46), so in the absence of any other factors that might affect costs, she is entitled to receive them, at the ordinary scale of difficulty. If there are such factors, counsel can arrange to make written submissions on costs, according to whatever schedule for the exchange and filing of the submissions is suitable to them.

"Schultes J."