

# IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: Whetung v. West Fraser Real Estate  
Holdings et al,  
2007 BCSC 990

Date: 20070824  
Docket: S80222  
Registry: New Westminster

Between:

**JESSICA ERIN WHETUNG**

Plaintiff

And

**WEST FRASER REAL ESTATE HOLDINGS LTD.  
Previously known as REVELSTOKE HOME CENTRES LTD.  
And REVELSTOKE HOME CENTRES LTD. and  
REVELSTOKE HOME IMPROVEMENT CENTRES LTD. (IN  
VOLUNTARY LIQUIDATION) o/a REVY HOME CENTRE**

Defendants

Before: The Honourable Mr. Justice W.G. Grist

## **Reasons for Judgment**

Counsel for the plaintiff

Robert D. Gibbens

Counsel for the defendants

Ross McLarty and Murray Wolf

Date and Place of Trial/Hearing:

January 9<sup>th</sup>, 2007 to January 26<sup>th</sup>,  
2007  
New Westminster, B.C.

[1] The plaintiff was injured near a display of garden supplies at a Revy Store operated by the defendant, West Fraser Real Estate Holdings Ltd. near White Rock, British Columbia, on May 31<sup>st</sup>, 2001. She and her mother and sister had come to the store to buy soil for containers the plaintiff's mother wanted filled at her home.

[2] Pallets containing soil, peat moss and other bulk garden supplies were displayed curb-side at the exit to the enclosed lumber yard of the store, close to the outdoor garden centre and a customer parking area. Ms. Whetung and a young man, Christopher Newcombe, who was shopping for similar goods, were standing adjacent to these pallets when the wooden arm of the gate used to block the lumber yard exit lane came down and struck them. In Ms. Whetung's case she was struck across the top of her head. Mr. Newcombe was struck across the shoulder.

[3] Ms. Whetung was a 25 year old ski instructor and had undergone a shoulder injury earlier that year. Subsequent to the incident at the Revy Store, Ms. Whetung developed dystonia, a crippling neurological disorder characterized by involuntary contractions of many of the major muscle groups in her body. The major issue presented by this case relates to causation of this disorder and, if caused by the incident at the store, assessment of the resulting disability, its effects upon the plaintiff's future earning ability and the costs of her future care.

[4] The defendant admits negligence with respect to Ms. Whetung being struck by the gate but says that Ms. Whetung was contributorily negligent in not taking reasonable steps to assure her own safety. The defendant says she should have appreciated the danger presented by the gate arm which was fixed to a controller

box displaying a decal showing a walking man and a motorcycle. These symbols were enclosed by a red circle with a diagonal slash through the centre.

[5] I don't agree that there is any contributory negligence on the plaintiff's part. The exit to the lumber yard had at one time been controlled by two arms that closed to the centre of 2 exit lanes. The arm and control box closest to the store had been disabled and pallets of garden products put on display in the exit lane next to the disabled control box. These pallets extended to within approximately one foot of the remaining exit lane. The one working arm swung up and down from the far side of the remaining lane. The end of this working arm came down perilously close to the pallets of garden products. The decal was displayed on the working control box on the far side of the remaining exit lane and it was partially obscured by an upright pipe stanchion placed to protect the mechanism. The sign did not give warning of the gate and would not have been seen by most customers. The arm itself had a spray painted "exit only" message on its face but this would have been difficult to see when the arm was vertical, above the control box on the other side of the exit lane. Further, any indication this gave that customers should not walk in the area was inconsistent with the use of the adjoining lane for product display.

[6] The working arm was activated by an employee using a garage door type of remote controller. The employee would activate the arm to allow vehicles to leave the lumber yard area. The arm, once it was raised, would stay up until the passing vehicle triggered a sensor which activated the arm in its downward motion. An engineer's report described the manufacturer's literature as indicating that the control arm came down immediately upon the vehicle passing the sensor. This was

inconsistent with the evidence of Mr. Paul Newcombe, Chris Newcombe's father, however. He remembered a vehicle exiting the area and waiting for it to clear before pushing his cart into the lumber yard to pick up bags of garden products. He then pushed his cart past three pallets of goods looking for the products he wanted before the arm came down. This indicates some considerable time passed before the arm came down striking his son and Ms. Whetung, who were walking behind him. Neither he nor Ms. Whetung's mother, who was with her, nor Ms. Whetung or Mr. Newcombe's son, realized the far side gate was in use before the arm came down.

[7] Although the arm appears to have been activated by an employee, no warning was given to customers in the area that the gate would be swinging down. Further, when Mr. Paul Newcombe returned later that day and spoke to a yard worker, he was informed that the worker himself had recently been hit by the arm. The yard manager also gave evidence of twice being hit by the gate.

[8] This evidence indicates that the gate arm was a known hazard and the close proximity of the gate to the display of bulk goods clearly put customers at risk. Customers seeing the products on display would often, as here, have been unaware that the gate arm would come down as it did, with considerable force and without warning. In my view customers shopping for these goods could not have been reasonably expected to anticipate the danger and without a warning would not have known they were putting themselves in a position to be hit.

[9] Ms. Whetung had sustained a shoulder injury on January 2<sup>nd</sup>, 2001, five months before the incident at the Revy store. She was demonstrating a jump to a

group she was instructing at Whistler and her bindings released. She fell onto her shoulder and the side of her face. She dislocated her shoulder and perhaps fractured her clavicle. She skied down the mountain and got medical attention at an aid station. She was given a figure-of-eight bandage and resumed her work as a ski instructor the next day.

[10] On February 14<sup>th</sup>, 2001, Ms. Whetung again injured her shoulder when she was pushing off with her ski poles during a friendly race with those in her class. Her shoulder again came out of joint. This time she was advised to stay off work for a couple of weeks. She filed a Worker's Compensation claim in respect of the two incidents. Notwithstanding the injuries, she was able to participate in a qualifying program given at Silver Star later that season to improve her qualifications towards receiving a Level 4 Instructor's Certificate. This amounted to six days of hard skiing.

[11] Her shoulder injury however continued to cause difficulties. She took physiotherapy when she returned home to her mother's house in White Rock after the ski season that spring. Her shoulder was painful and she noticed a tremor in her hand on exertion. At times her arm became red and swollen and painful to light touch and at times there was a loss of sensation in her hand.

[12] Ms. Whetung does not recall being struck by the lumber yard gate. Her first memory after the incident was of being on the ground. She managed to get up and sit on a pallet of bagged soil. She was dazed and nauseous and didn't know how to respond to people who were trying to help her. Her mother and sister helped her to her mother's vehicle and she sat there for a time until she was taken to a local walk-

in clinic. Her mother left her there because she had to transport another daughter. Ms. Whetung was told at the clinic that she should go to emergency, but she couldn't remember her mother's or sister's cell phone numbers so she waited in a confused state in the waiting room until her mother returned. She then went to the hospital.

[13] She was seen at the Emergency Ward at Peace Arch Hospital and taken home from there by her mother and brought back again later that day. The medical records from this time and from subsequent medical visits record post-concussion syndrome resulting from a mild to moderate concussion, with no extended loss of consciousness.

[14] Through the next several weeks Ms. Whetung continued to have headaches, was sensitive to lights and was forgetful and confused. Her mother also noted the right side of her face appeared to be drooping and that she dropped things held in her right hand. Eventually she was seen by an neurologist, Dr. Smyth, in October 2003. He again attributed her symptoms to a post-concussion syndrome and assured that the effects would resolve with time.

[15] In August 2001 Ms. Whetung was placed in an office job by Inter West, her employer at Whistler. This was an alternate job placement during her continuing Worker's Compensation claim. She was seen by Dr. Regan, an Orthopaedic Surgeon, who scheduled her for orthoscopic shoulder surgery to tighten the capsule surrounding her shoulder joint. This was done in September 2001. Shortly after this she changed from her office job to a job in the rental shop at Whistler. The surgery appeared to bring about some improvement but she continued to have a variety of

symptoms related to the shoulder injury and was thought to have a Thoracic Outlet Syndrome, and later was diagnosed with Reflex Sympathetic Dystrophy, now called Complex Regional Pain Disorder, a condition thought to result from injury to the Brachial Plexes, a complex interchange of nerves in the shoulder. Symptoms included tremor in her hand, vascular changes causing swelling and redness in her arm and hand, heightened pain perception along her arm and loss of sensation in some fingers. She underwent a second surgery in April of 2002 to remove her first rib on the right side to try and relieve pressure on the nerves and blood vessels involved and a third operation on May 30<sup>th</sup>, 2002 to orthoscopically remove adhesions beneath her shoulder blade. Each of these surgeries seemed to bring some initial improvement but after a short time most of the symptoms continued.

[16] Ms. Whetung was only able to work for a short time during the winter of 2001-2002. She returned to her mother's home in White Rock and after the surgeries took treatment from a physiotherapist.

[17] In the Summer and Fall of 2002, Ms. Whetung began to experience neurological symptoms which resulted in a referral to Dr. Chong Lee, a Neurologist at the Movement Disorder Clinic at UBC. These included contractions pulling her neck and head down and to the right, and worsening tremor and cramping of her right hand. The first note suggesting the head and neck complaint is in a WCB report from August 2002 and Dr. Lee's clinical note of October 8, 2002, suggests dystonia and Reflex Sympathetic Dystrophy and use of Botox therapy. This therapy began in December 2002. Dr. Lee's clinical notes record hand contractions in

December 2002. This appears to have resulted in a confirmed diagnosis that dystonia was the cause of the developing symptoms.

[18] Dystonia is a condition marked by involuntary contraction of muscles in the body. It is thought to result from a dysfunction of the Basal Ganglia, a part of the brain located at the base of the skull. It can be secondary to stroke or head trauma or can come on for no apparent reason, in which case it is often thought to be the result of a genetic pre-disposition. It can affect only one focal muscle group, or will affect one side of the body, known as hemi-dystonia, or can be generalized over muscles on both sides of the body. It is an extremely painful condition and if it affects a significant number of muscle groups, it can be disabling with muscles contracting against each other causing spasmodic tremors and areas of the body frozen into contorted postures.

[19] One of the few treatments involves injection of botulism toxin (Botox) to disable an affected muscle. These injections wear off after 10 to 12 weeks and a new course of injections have to be administered. The condition most often has an insidious onset, with first symptoms of involuntary movement or cramping often not noticed by the person affected, and perhaps first noted by someone else. In cases where the condition is secondary to some known cause, it can and often has a delayed onset, sometimes years after the event. In Ms. Whetung's case her mother gave evidence of her head turning sharply to the right in August of 2001. The plaintiff also noted her right hand freezing onto the handle bars of her bike when riding to work in the summer and fall of 2001. The first symptoms of involuntary neck and head movements actually noticed by Ms. Whetung were in August 2002.

After the first clinical notes of dystonic movements in 2002, the condition became progressively worse with stronger contractions of her head and right arm progressing to dystonic contractions of her right leg, foot and hip, and most recently sharp abdominal spasms. Her present condition has taken a number of years to develop along this course.

[20] Her present condition renders her totally disabled from employment and unable to perform many of the activities of daily living. She is dependent on her mother who has had to leave her employment to care for her daughter. Her head is pulled down and to the right. Her head moves involuntarily to the right every second or so and then is forced back towards centre. She has difficulty seeing where she is going. She is right hand dominant and her right arm is bent upward at the elbow and her hand is turned in and the fingers clenched. The hand posture also contracts rhythmically and the hand is virtually useless for gripping or even stabilizing objects.

[21] Her right leg is subject to cramping, forcing her knee and hip into a flexed position. Her right foot turns inward. She uses a cane and can stand and walk short distances. She cannot navigate stairs safely and generally needs her mother's support to get up or down the flight of stairs in her mother's home. She has trouble sitting and finding a posture that will let her sleep. Struggling against the contraction of the affected muscles causes muscle pain in otherwise unaffected areas of her neck and back.

[22] She remains able to use her left hand. She can prepare a cup of tea or heat a prepared meal and can usually shower and use the bathroom and dress herself in loose clothing. She cannot put on socks or tie shoes.

[23] Her condition improves a number of days after the Botox injections. She then has a couple of weeks of diminished symptoms, with the Botox eventually wearing off. The Botox injections are given to her at the UBC Clinic. Her mother lives in a community north of Victoria and the round trip usually requires three days away from home.

[24] The sharp contractions in her abdomen require injection of a medication to relieve the spasm. If this is not done she can lose consciousness and has to be admitted to the Emergency Ward and may require a number of days in hospital. This condition is intermittent and she may be free from these attacks for several months. At other times they may be weekly events.

[25] The significant issue in this case is the cause of the hemi-dystonia in Ms. Whetung. There has been no lack of esteemed neurological opinion in the evidence heard. In short, the principal evidence relied on by the plaintiff, given by Doctors Rajput, and Calnes, Neurologists, and Dr. Honey, a Neurosurgeon, attributes Ms. Whetung's condition to the blow to her head received when hit by the gate arm.

[26] The evidence called by the defendant was given by Doctors Chen and Beckman, both Neurologists. Each attributes the condition to a different cause. In Dr. Chen's opinion the condition is Psychogenic; generated by a psychiatric

disorder. Dr. Beckman relates her dystonia to the shoulder injury she sustained as a ski instructor in January and February 2001.

[27] Doctors Rajput, Calnes and Honey give similar theories of onset of Ms. Whetung's hemi-dystonia. Dr. Rajput has headed the Movement Disorder Clinic at the University of Saskatchewan since 1968. He has had particular experience following individual dystonia victims over a number of years and has conducted autopsy studies following their deaths. Dr. Calnes held a similar position with a clinic devoted to the same sort of studies at the University of British Columbia until he stepped down in 2005. Both physicians hold the Order of Canada for their work at those clinics. Dr. Honey is a Neurosurgeon and an Associate Professor at UBC. He was consulted on this case because of his considerable experience in performing brain surgery designed to help patients with various movement disorders.

[28] Dr. Chen is a Senior Scientist with the Western Ontario Hospital in Toronto. He deals primarily with dystonia patients and has extensive experience with movement disorders at distinguished research facilities. Dr. Beckman is a Neurologist in private practice and began his training in movement disorders at the UBC Clinic. He has a generalized neurological practice but sees a considerable number of patients with dystonia.

[29] Deciding which of the opinions of these experts is most credible is a daunting task. The law indicates a three-step process in determining an issue on expert evidence. The first step is to appreciate the qualifications and judge the impartiality of the experts involved. Secondly, the trier of fact must question whether the facts

upon which the expert opinions were based are supported by the evidence. Finally, the convincing force of the opinions should be assessed (*R. v. Muchikekwanape* 2002 MBCA 78).

[30] The opinions of Doctors Calnes, Rajput and Honey are largely consistent in presentation of the logical elements which lead them to attribute the plaintiff's dystonia to the trauma of the head injury. Firstly, hemi-dystonia is seen as consistent with the patient having received a head trauma resulting in injury to the Basal Ganglia. Head injuries capable of this form of brain injury are almost always of severity greater than the concussion suffered by Ms. Whetung, but each of these experts was of the view that the medical literature included cases of similar trauma resulting in motion disorders. They also felt that the onset of dystonia in Ms. Whetung was within the parameters of the expected delayed onset of the condition. This was so even though Dr. Calnes initially had concluded that the head injury was in 2002 rather than 2001. These opinions discounted a peripheral injury such as the shoulder injuries Ms. Whetung had suffered skiing as incapable of resulting in an injury to the affected area of the brain. A psychogenic disorder was rejected in that each expert viewed hemi-dystonia to be inconsistent with such a cause. Further, although Ms. Whetung developed considerable periods of depression, this was viewed as a reactive feature stemming from an inability to recover from her original injuries and the disabling onset of the movement disorder, and not a cause of the dystonia itself.

[31] The experts presented by the defence discounted this theory of causation. These two experts, however, also differed from each other in accounting for the

plaintiff's condition. Dr. Chen was of the view that the head trauma was insufficient to account for an injury to the Basal Ganglia. He also was of the view that the onset of dystonia was sufficiently distant from the head trauma to further counter-indicate the traumatic diagnosis. Dr. Chen did not examine the plaintiff and based his opinion on a review of the clinical reports of treating physicians and other care providers, and on review of surveillance videos. Dr. Chen noted reports which, in his view, indicated the influence of a psychiatric disorder. In particular, in some instances the plaintiff reported a distribution of numbness and pain in her hand which did not correlate anatomically to the nerve distribution to that part of her body. He also referred to the set of reports outlining psychological counselling she received to counter the effects of depression. Dr. Chen felt the diagnosis of a psychogenic disorder was supported by these clinical records. He also disagreed that hemi-dystonia was invariably related to trauma. Dr. Chen did agree with the plaintiff's experts that a peripheral injury was not likely responsible for Ms. Whetung's condition.

[32] Dr. Beckman's opinion was consistent with that of Dr. Chen in that he felt the neurological effects of the head injury were unlikely to account for the onset of dystonia. In his view the shoulder injury compounded by the three surgeries to the shoulder area could account for a peripheral onset of the condition. Dr. Beckman acknowledged, however, that it was not understood how a peripheral injury might result in lesion in that portion of the brain responsible for the motion disorder. Notwithstanding this and acknowledging the theory was controversial, he cited studies that supported this form of causation.

[33] The opinions of each of these witnesses carried considerable weight as a result of the witnesses' impressive scientific credentials and the support they cited from the clinical records and the medical literature. However, in my view the convincing force of the evidence supported the attribution of the movement disorder to the traumatic effects of the head injury caused by the blow from the gate arm.

[34] In my view the telling features supporting this view of causation over the contrary defence opinions are these:

1. In respect of Dr. Chen's opinion;

(a) Dr. Chen's opinion that Ms. Whetung's condition was a psychogenic one was given without Dr. Chen having carried out an examination of the plaintiff. He agreed on cross-examination that such a diagnosis required that the patient's presentation should convincingly demonstrate the psychogenic nature of the disorder and that it would have been better to have examined her personally. He also agreed that this deficit contributed to an inability to exclude an organic condition.

(b) Dr. Chen's criteria supporting a psychogenic cause for the condition included the requirement that the patient show evidence of a psychiatric disorder. In this case he identified the evidence of bouts of depression noted in the clinical records. However, the other professionals commenting on her depression consistently attributed these to a reaction to a prolonged disability and her progressively

worsening condition. There was no evidence of depression or other psychiatric condition predating onset of the first of the symptoms identified by Dr. Chen as being attributable to what he diagnosed as a psychogenic condition, that being the tremor that developed after the second shoulder injury.

(c) Dr. Chen's opinion of a psychogenic cause was not shared by Dr. Chong Lee, the Neurologist who treated the plaintiff during the development of her symptoms. Dr. Lee spoke of the symptoms comprising the onset of dystonia in his December 4<sup>th</sup>, 2002 letter, describing a gradual progressive onset of symptoms and his comment was that distraction tests of the plaintiff indicated a traumatic and not a psychogenic basis for her condition.

(d) A psychogenic disorder is more likely to have an abrupt onset and a static course and is less likely to be one that develops progressively as did Ms. Whetung's condition in its evolution to hemi-dystonia.

2. In respect of Dr. Beckman's opinion:

(a) Dr. Beckman attributed the onset of dystonia to the original ski injury. He said at page 8 of his December 3<sup>rd</sup>, 2004 report:

It is my opinion that she developed a soft tissue injury to her right upper extremity and neck following the ski accident of January 2001 which once again was exacerbated by the shoulder dislocation with her poling in February of 2001. This

led to a regional pain syndrome with associated tremor. Dystonia can often begin as a tremor. I believe the dystonia arose as a result of her soft tissue injury in January/February 2001.

In presenting this opinion Dr. Beckman argues with considerable force that there are several factors which reduce the likelihood of a traumatic cause stemming from the incident involving the blow from the gate arm. These include the fact that the injury was of lesser severity than expected in cases of onset from head trauma, and also the longer than would be expected time period until onset of dystonic symptoms. However, in my view his report does not fully discuss features of a diagnosis of peripheral onset which present even more difficulties in attributing causation, in that there seems to be no good physiological theory of how peripheral injury could bring about changes in the brain precipitating dystonic symptoms.

Further, he does not discuss features attributed to a peripheral onset which do not easily fit the history of Ms. Whetung's case. Peripheral onset is said to bring on dystonic symptoms in the injured part of the body. The injury he identifies in his diagnosis is the soft tissue injury of the neck and shoulder and the first dystonic symptom he describes is the tremor in the right hand. In cross-examination he said he viewed the shoulder injury proximate enough to the symptoms in the hand to satisfy this requirement. I found this to be somewhat unconvincing.

Further, his explanation did not deal in a satisfying way with how the peripheral onset could then progress to other areas, resulting ultimately in hemi-dystonia.

3. Dr. Beckman discounted the history taken by Dr. Smyth of increased tremor following the incident at Revy. Exacerbation of tremor from this incident would support the theory of the head trauma being responsible for the condition. I viewed the discounting of Dr. Smyth's clinical comment made during the first neurological examination of the plaintiff, five months following the injury, as too dismissive of an important aspect of the history taken by Dr. Smyth.
  
4. Dr. Beckman says that the tremor seen in her right hand in the spring of 2001 is the first symptom of the onset of dystonia. Without this, the shoulder injury is even less proximate to the onset of other dystonic symptoms than the head injury. He includes the tremor as both a feature of Regional Pain Syndrome and a dystonic symptom. However, considerable medical opinion relates the onset of the tremor to the Brachial Plexus injury alone, an injury eventually diagnosed as resulting in a Complex Regional Pain Syndrome. This condition was treated by three surgeries and the symptoms attributed to it found some resolution through this course of treatment. The preponderance of the medical opinion is that the shoulder injury developed into CPRS and that the onset of tremor was related to this separate condition. I

found this more convincing than Dr. Beckman's view that the tremor also qualified as an early symptom of dystonia.

### **COST OF FUTURE CARE**

[35] The cost of future care is the most significant head of damages. The principle to be applied in determining whether proposed future care services will be accepted as a basis for compensation is that expressed in ***Andrews v. Grand & Toy Alberta Ltd.*** [1978] 2 SCR 229. This case establishes that damages will be awarded, "to the extent, within reason, that money can be used to sustain or improve the mental or physical health of the injured person."

[36] Two Occupational Therapists presented evidence and their views as to what was reasonably required were in some respects markedly different. Ms. Henry, who was called by the plaintiff saw the plaintiff on two occasions, first in September 2004 and again in September 2006. Ms. Williams, called by the defence, saw her in November 2006. The form of housing support Ms. Whetung will reasonably require is the major element in the cost of future care. Ms. Whetung presently lives with her mother in her mother's home in a rural area north of Victoria. This is not an arrangement either she or her mother would prefer for the future and there are some difficulties presented by both the home and its location. Ms. Whetung would rather return to the Squamish-Whistler area, or failing this live somewhere in the greater Vancouver area. Her mother has suspended her career in computer systems design for most of the last five years in order to provide care for her daughter and she would like to return to her work and regular activities. Further, it is clear that access to

services from the area they now reside in is not optimal and that the residence itself has features that do not conform to Ms. Whetung's needs.

[37] Ms. Henry recommends a Live-in Care Aid be employed. She finds that Ms. Whetung's level of physical, cognitive and emotional functioning reasonably requires that she have help available for meal preparation, homemaking, and transportation needs, as well as someone who can provide help during acute episodes of diaphragm spasm by administering injections or otherwise seeing to emergent care. This level of care can be obtained through several agencies who provide the service through a Live-in Care Aid. Because such a person is not required at all times and may well not be required through the night, for example, this service is charged out on the basis of ten hours of service per day at an average cost of approximately \$245 per day or \$90,275 per year. The present value of the cost of this level of care over Ms. Whetung's expected lifetime, with inclusion of GST and PST, is \$2,269,000 (rounded to the nearest \$1,000). The alternative spoken of in Ms. Henry's report is that Ms. Whetung continue to live with her mother with support provided by way of a hired care attendant for Ms. Whetung during weekdays when her mother is at work, or travelling for work purposes. The cost of this service would likely be \$35,000 to \$45,000 on an annual basis.

[38] If she were to live with her mother, modifications to the home would be required. If she were to live independently of her mother a more appropriate residence could be chosen. Ms. Whetung also requires mobility aids, special supplies and equipment.

[39] Ms. Williams does not accept that Ms. Whetung needs a Care Aid available on a twenty-four hour basis. She also introduces the options of a Family Care Home or a semi-independent housing resource where Ms. Whetung could live in her own apartment with a home support worker attending twice per day and staff on call in the building for more emergent needs. A Family Care Home would entail living in a home managed by resident caregivers who would provide care to Ms. Whetung and others resident in the home. Ms. Williams estimated the cost of care in such a facility to be \$24,000 per year.

[40] In discussing the possibility that she continue to live with her mother or move to live with her sister, Ms. Williams does not detail what is likely required by way of hired support, but presumably she sees the need for similar in home assistance as indicated by Ms. Henry in her description of support needed should Ms. Whetung remain with her mother. Ms. Williams agrees that there is a need for home adaptation and special equipment to accommodate Ms. Whetung's needs should she remain with her mother.

[41] Which of these care models is appropriate to the needs of Ms. Whetung? Firstly, it is clear on the evidence that both Ms. Whetung and her mother would like to lead separate lives. Ms. Whetung was on her own through much of the year when she worked as a ski instructor and enjoyed her own residence and friends of her own age. Her mother had her own career and was at a stage where her children were all nearly of an age to be on their own when Ms. Whetung was disabled. Since Ms. Whetung has been dependent on her she has been away from her work and the relationship between them has not been without friction. I am of the view that the

standard expressed in Andrews does not require family support to be factored into the care model if the family relationship is not one the parties want to adopt. This consideration extends to the prospect of Ms. Whetung living with her younger sister, who now resides at University and is a young person with her own separate life.

[42] The proposal that the Care Home model be adopted also has difficulties. The description of a Care Home given in the evidence was of a private home where a limited number of persons with medical needs, or who require some level of help and supervision in day-to-day living, receive room and board and help from the persons running the home. Ms. Whetung rejected this as a way of living she would want to adopt. She would much prefer to have a more independent home base and the home care option does not offer a good prospect for such an independent life. As Ms. Henry pointed out, this form of care may not offer much of a social setting for her or a facility which would aid in the opportunity to interact with others of like age and mental ability. I agree that this form of care would result in Ms. Whetung being overly restricted to activities in the home with few options for participation with others in outside activities.

[43] The two remaining models presented in the evidence are firstly, that Ms. Whetung live independently with a Live-in Care Aid, and secondly, the possibility presented by Ms. Williams of her having her separate apartment in a facility that provides full-time resource people to provide assistance and necessary medical care to those living in the separate apartments. I think either of these models has the prospect of meeting Ms. Whetung's needs, however, as Ms. Williams indicated, the sort of facility she speaks of does not yet exist. It apparently is a proposed type of

facility that might find physical form in Victoria. Details of the level of assistance that can be provided and the cost of the facility were not available. Any such facility would have to include a person trained to meet the emergent needs presented when Ms. Whetung suffers diaphragm spasm. Failing a timely injection she will lose consciousness and need care in the emergency ward, followed by a period of hospitalization.

[44] In my view this option cannot form the basis of assessment of damages without evidence of what care will be available and the cost of such a facility, leaving the Live-in Care Aid as the only prospective model of care that meets the consideration established in *Andrews* of reasonable use of money to sustain the plaintiff's mental and physical health. Accordingly, using the average of the rates presented by Ms. Henry, damages sufficient to sustain this form of care over Ms. Whetung's expected lifespan will be awarded. As indicated, this amounts to \$2,269,000.

[45] The next most significant category of the cost of future care is the expected cost of medications. Ms. Whetung is on a variety of medications, including Botox administered four times per year. Also notable amongst the medications is the cost of Cessamet, an oral medication derived from marijuana. This is a very expensive medication and has a projected cost of nearly \$60,000 per year. The medical evidence in support of use of the medication is, in my view, not compelling, and there is also the prospect of marijuana itself being used on a medical need basis. Accordingly, I am not convinced that the cost of Cessamet is one that can be sustained in this case. Other prescribed medications will require expenditure of

\$11,700 per year. Applying the present value multiplier, the projected cost is \$277,400.

[46] The annual cost of physiotherapy, three times per week, is \$ 6,240. Applying the multiplier this is a projected expenditure of \$ 147,955.

[47] The services of an occupational therapist are required to advise and review Ms. Whetung's initial set up in a separate residence and to replace her mother's role as case manager. The cost of the first should be approximately \$750 and the ongoing case management should be available for approximately \$2,000 per year, or \$47,400 to cover the expenditure over her lifetime.

[48] The household modifications and equipment I think justified on the evidence consists of the following:

<b>Description</b>	<b>Item Cost</b>	<b>Likely Replacement Period</b>	<b>Present Value</b>
Stand up wheelchair	\$22,558.12	6 years	\$75,366.00
Batteries	\$ 742.00	3 years	\$3,952.00
Maintenance	\$ 100.00	annually	\$1,527.00

		TOTAL-----	\$ 80,845.00
Adjustable bed,	\$1,793.00	-----	1,793.00
bed rail, and	\$ 255.00	-----	255.00
differential cost of			
mattress	\$ 400.00	10 years	1,137.00
		TOTAL-----	\$ 3,185 .00
Adjustable recliner	\$ 1,149.00	10 years	\$ 3,265.00
Computer stand	\$ 300.00	15 years	\$ 624.00
(differential cost)			
Bath lift	\$ 1,595.00	10 years	\$ 4,532.00
Chopping board	\$ 127.05	5 years	\$ 654.00
and one-handed			
can opener			
Kitchen trolley and	\$ 202.95	10 years	\$ 576.00
jar opener			
Various aids,			\$ 1,500.00

canes, cane repairs, grab bar, toilevator, transfer pole, bed rail, etc.			
		<b>TOTAL-----</b>	<b>\$ 95,181.00</b>

[49] The Plaintiff's claim for a sauna to alleviate pain is rejected as likely an item more akin to an amenity to be financed from non-pecuniary damages.

**PAST AND FUTURE WAGE LOSS**

[50] The next question of damages relates to loss of expected past and future earnings. Ms. Whetung's record of earnings as a ski instructor does not provide a sustained record of substantial earnings. She moved to the Whistler area in 1999. Prior to this she worked at ski hills in Alberta and Ontario. Originally she is from the Ottawa area and skiing was a major focus during her adolescence and early adult life. At Whistler over the two years prior to her injuries she had achieved some limited seniority among ski instructors and more significantly had some seniority with respect to the Ski Esprit Program. She was assigned to this program by her employer, Inter West.

[51] Employment as a ski instructor is seasonal and usually will extend from the start of December through to the Easter long weekend. The Esprit Program caters to skiers who come for a 3 or 4 day stay and want a skiing guide and instructor and

an introduction to the après ski and nightlife facilities. The pay is based on an hourly rate with a negotiated bonus rate, and employees can expect some perks from equipment and hospitality providers and tips from customers. Ms. Whetung also expected to supplement this income from off season casual employment. Her reported income in the 2000 taxation year, which would include most of her Inter West earnings from the 1999-2000 ski season was \$9,140. Through 2001 she earned \$13,839. This would have included payment for office work and work in a rental shop run by Inter West. This was work given her to defray the cost of Worker's Compensation premiums. Her earnings subsequent to 2001 were approximately \$14,000 per year and would have been almost exclusively Worker's Compensation payments.

[52] I think it unlikely that Ms. Whetung lost earnings from the onset of dystonia until 2004. Prior to this she was struggling to recover from the persistent problems associated with the shoulder injury and would not have wanted to abandon her hope of return to work as a ski instructor. Accordingly she would have followed the same course of treatment and rehabilitation with the support of the Work Safe payments. Starting in 2004, however, but for the onset of the movement disorder, she would have returned to work at the ski hill, or more likely, realized her options had become more limited and moved on to a less physical form of employment. I think this would have meant she would have made efforts to upgrade her education to take some training. If this were to take a year, there is little lost opportunity for any substantial period of wage loss prior to trial. There may however have been the opportunity for

some part-time or seasonal work and for some employment in 2006, and I think this would be adequately compensated by a past wage loss award of \$25,000.

[53] The plaintiff's evidence was that she wanted to upgrade her ski instructor's certificate from the level III she held to a level IV qualification. This is a high level of certification and of the 1,400 ski instructors working in the Whistler area, only 65 were certified to this level. She realized that even with this qualification working as a ski instructor was unlikely to be a satisfactory long term form of employment and said that ultimately she intended to go back to school and enrol in studies to qualify for a psychology degree. She hoped this, and her skiing background, might allow for her to open a small business providing a home in the Whistler area where young aspiring competitive skiers could board and get psychological support during their sports training.

[54] Assessment of loss of future earnings in cases involving young disabled persons is always a very speculative exercise. Evidence of aspirations has to be judged against what often is limited evidence of academic ability and future prospects. Here, Ms. Whetung had been out of school since 1996 when she took one business course at Algonquin College during the time she lived in Ontario. She had respiratory problems through high school until she underwent surgery to remove a cyst from her lung in 1995 and it is not clear that she completed enough high school courses to qualify as a high school graduate. Notwithstanding that most of her family have gone on to University training, I am not satisfied that it is likely that but for her disability, she would have gone back to obtain University entrance and to go on to a University degree. It is also uncertain that she would have actually gone

on to obtain level IV certification. She was able to attend the level IV training course at Silver Star in 2001, but it is clear from the evidence of Mr. Kamstra, the General Manager of the Whistler Ski and Snowboard School, that this level requires exceptional ability. His assessment was that Ms. Whetung needed greater commitment to the goal than he had seen from her at Whistler if she were in fact to gain full certification. This last comment is of limited significance in that, as Ms. Whetung acknowledged, through her late 20's she would have been looking at moving on from this form of seasonal employment in any event. As said, I don't think the evidence indicates she would have gone to University. Rather, I think it more likely she would have remained associated with the skiing community, developing an opportunity in the hospitality industry. She has shown culinary interest and ability and I think this was more likely the form of employment she would have pursued.

[55] In assessing quantum, it is my view that the projection of potential income from this form of future employment would exceed that of females having only high school graduation. I expect Ms. Whetung would have obtained diploma level training in a culinary school in preparation for this form of employment and that her future earnings are best represented in the evidence by the chart showing earnings for BC females with diploma level training in recreation. This chart relates to a different form of employment but a form of employment with a similar level of education, and indicates a step between those having high school graduation and the statistics for University graduates and I think it a better forecast of her prospects. The present value of expected earnings after discount for average level of risk,

under this category is \$466,653. With inclusion of the value of employer paid benefits valued at 10% of earnings, the loss of prospective earnings is \$471,332.

[56] The evidence from Mr. Struthers, the Economist called by the plaintiff, was that some cases might be better represented by deducting risk only contingencies that don't include factors such as voluntary absence from the workforce. In this case I don't find factors individual to Ms. Whetung to prompt application of this form of variation from application of the average contingencies deduction.

### **NON PECUNIARY DAMAGES**

[57] The plaintiff suggests Ms. Whetung's loss indicates that non pecuniary damages should approach the upper end of the maximum that can be awarded for this head of loss. The defence's position is that Ms. Whetung retains essentially normal cognition and is able to participate, with limitation, in a number of activities, factors that should mitigate from an upper limit award.

[58] Neither Counsel have given me the exact figure for the upper limit, however, from the authorities I expect it is something slightly in excess of \$300,000.

[59] Ms. Whetung is able to function in performing daily activities in a very limited manner and has limited ability to participate in outside activities. Her cognitive abilities are not impaired by loss of brain function, however she does have difficulty in managing day-to-day affairs because of the persistent pain she suffers. She is a young person, now 31 years of age, and faces a very challenging future. She was up until the time of the collision a person whose life centered on outdoor athletic

activity. The problems with her shoulder would have limited this somewhat, however not to the very dramatic degree now evidenced. In my view the loss approaches the upper end of the continuum and an appropriate award would be in the sum of \$250,000.

**THE IN TRUST CLAIM**

[60] The last issue in relation to damages is the in trust claim for the services provided by Mrs. Whetung, Jessica Whetung's mother. It is clear from the evidence that Ms. Whetung has been essential as a caregiver to her daughter and has been an advocate in obtaining the resources that have sustained her. She has left her own employment to provide this care. The plaintiff's suggest a similar payment as would be required for a live-in care aid for a 9-month period. I accept this as a reasonable assessment and award the sum of \$67,500.

**COLLATERAL COVERAGE**

[61] Over the last several years Ms. Whetung has received benefits which have defrayed the cost of her treatment. These have come from Work Safe BC, Indian Affairs, and Vancouver Island Health Authority (VIHA). She has also received income replacement payments from Work Safe BC. There is a significant issue relating to these sources of funding and whether they are collateral benefits which should reduce the damages assessed in respect of cost of care and lost income.

[62] Ms. Whetung received Work Safe BC benefits on sustaining the original injuries to her shoulder in January and February 2001. These continued to include

extended coverage for the subsequent onset of Thoracic Outlet Syndrome and Complex Regional Pain Syndrome, subsequent conditions related to her shoulder injuries. The three operations on her shoulder were managed as care provided under her Work Safe claim. The onset of dystonia was also included as an aspect of her claim and she has had coverage for her Botox treatments. Many of her prescription medications and at least a portion of her physiotherapy have been paid from this source. She has received short term disability wage replacement benefits and more recently has been accepted for a permanent functional impairment award granting her income replacement of \$1,395.33 per month.

[63] The inclusion of coverage for dystonia has been extended as a development attributed to the shoulder injuries. This seems to have happened as a result of the chronology of the onset of this syndrome, along with progression of symptoms relating to the shoulder injury. There does not appear to have been a focused determination of the cause of the dystonia as contrasted to other features of her overall condition done by Work Safe BC, as has been presented on the evidence at this trial. As already indicated, the evidence here, with the exception of the opinion of Dr. Beckman, attributes the dystonia to a cause separate from the shoulder injuries.

[64] The question arising on acceptance of the movement disorder as resulting from the separate cause of the head trauma is how to deal with the past coverage and the prospect of ongoing coverage of the effects of the disorder under the Work Safe claim when calculating damages relating to this condition?

[65] The plaintiff is not claiming the past cost of medication and therapy that might be isolated as specific to treatment of dystonia, and due to the delayed onset and progressive nature of the disorder, much of the past payment of wage benefits can be accounted for as payable by Work Safe BC in any event as a result of the conditions relating to the shoulder injury. However, the treatment by way of Botox injections and much of her disability after dystonia became her prominent complaint in 2004, have been the subject of the Work Safe claim and now are the subject of assessment as part of the damage claim. In addition, subsequent to judgment there may well be further overlapping payments. The 2006 classification by Work Safe BC and the resulting further income replacement payments are identified as subject to automatic review in April 2008, as stated in the Work Safe BC letter of May 11<sup>th</sup>, 2006. Her health benefits are also to be re-assessed after a two-year term. The Work Safe process is independent of this court action and the evidence of Maria Batta and Judy Proctor, two Work Safe Officials responsible for administrating Ms. Whetung's claim, is that it is uncertain what might happen with respect to Ms. Whetung's coverage after re-assessment, and that it depended on the evidence presented to the board.

[66] In light of this, deductibility of collateral benefits pertaining to income payments made prior to trial and income payments and health care benefits likely to be covered subsequent to trial, concerns a quantum affected by the likely outcome of the Work Place BC review. In my view this review will take into account evidence such as has been presented in this trial and further coverage relating to the movement disorder is not likely to be offered. The question then of overlapping

payments concerns payments of income replacement received prior to trial that cannot be justified on shoulder complaints alone, and the receipt of further income replacements and health care benefits not related to the shoulder injury subsequent to trial and until the review. All of this, however, is dependent on whether the payments can be classified as collateral benefits which the defendant can take the benefit of in reducing the quantum of damages.

[67] The law in relation to deductibility of benefits from the damage award is sometimes difficult and cases where benefits paid under the **Worker's Compensation Act** are paid partially because of a condition that is later recognized as not resulting from the compensable injury, but in fact caused by some other actionable event, are going to be rare. It is not surprising that there is no direct authority dealing with the question.

[68] In **Ratysh v. Bloomer** [1990] 1 S.C.R. 940, the Supreme Court of Canada considered the deductibility of collateral wage benefits and McLaughlin, J. made specific reference to Worker's Compensation wage benefits at para. 99:

As a general rule, wage benefits paid while a plaintiff is unable to work must be brought into account and deducted from the claim for lost earnings. An exception to this rule may be where the court is satisfied that the employer or fund which paid the wage benefits is entitled to be reimbursed for them on the principle of subrogation. This is the case where statutes such as the *Worker's Compensation Act*, expressly provide for payment to the benefactor of any wage benefits recovered.

The relevant provisions of the British Columbia statute are Sections 10(2) and 10(6):

**s.10(2)** Where the cause of the injury, disablement or death of a worker is such that an action lies against some person,

other than an employer or worker within the scope of this part, the worker or dependent may claim compensation or may bring an action. If the worker or dependent elects to claim compensation, he or she must do so within three months of the occurrence of the injury or any longer period that the board allows.

- s.10(6)** If the worker or dependant applies to the board claiming compensation under this part neither the making of the application nor the payment of compensation under it restricts or impairs any right of action against the party liable, but as to every such claim the board is subrogated to the rights of the worker or dependent and may maintain an action in the name of the worker or dependant or in the name of the board; and if more is recovered and collected than the amount of the compensation to which the worker or dependent would be entitled under this part, the amount of the excess, less costs and administration charges, must be paid to the worker or dependent. The board has exclusive jurisdiction to determine whether to maintain an action or compromise the right of action, and its decision is final and conclusive.

Here the cause of Ms. Whetung's disablement as a result of dystonia founds an action against the defendant, and in my view the wording of these sections applies to the circumstances of the present case. The payment of compensation does not impair the right of action against the defendant, and the Board is subrogated for that part of the Work Safe BC coverage attributable to the effects of dystonia. On *Ratych* principles deductibility as a collateral benefit is not available to the defendant.

[69] A case cited by the defendant bears some comment. In *Salmi v. Greyfriar Developments Ltd.* [1995] A.J. No. 1089 (ABCA) Worker's Compensation benefits

paid to an employee as a result of a work related accident during the period of time he was found to be entitled to pay in lieu of severance were deducted from the assessment of damages as being comparable to earnings received from new employment during the appropriate severance period. The situation is not one where a right of subrogation such as expressed in Section 10 of the British Columbia statute would apply and accordingly non-deduction would inevitably result in double payment.

[70] The additional forms of coverage which have at times been available to Ms. Whetung are health coverage extended by the Vancouver Island Health Authority and benefits through Indian Affairs. She is recognized as having status by Indian Affairs through her native heritage. The coverage she has received from these sources, however, has only been received in situations where no coverage was available from the Worker's Compensation system or from any other source. Coverage under these two authorities was only offered in a limited number of instances. The Vancouver Island Health Authority policy in respect of residential or home support care they might offer is restricted to cases where there is no third party award for future care. Similarly, the evidence of Mr. Yu, who is the Manager administering Indian Affairs, Non-Insured Native Health Benefits Program, was that as the name of the program suggests, coverage only extended where some other program or source was not available.

[71] Again, in respect of collateral coverage, these are social programs available to a proportion of the population, but on the evidence, as a resource of last resort. I think the decision of our Court of Appeal in *Fullerton v. Delaire* [2006] BCCA 339,

has application in respect of the significance of this collateral source. The defendant's obligation should not be put aside on the basis of possible double coverage where the social source is only prepared to be called on should any prior obligation fail.

**SUMMARY**

[72] In summary, the award of damages is as follows:

1.	Cost of future care:	\$2,837,686
2.	Past loss of earnings:	\$25,000
3.	Future loss of earnings:	\$513,318
4.	Non-pecuniary damages:	\$250,000
5.	In trust claim for Mrs. Whetung:	\$67,500
	<b>Total:</b>	<b>\$3,688,504</b>
		=====

***W.G. Grist, J.***