What is this Case Worth?

Fact Scenario # 1

The Plaintiff, a 37 year old male, tripped and fell in a large hole in a parking lot of a local business after getting out of his car. The Plaintiff did not notice the hole prior to his fall. The Plaintiff had in fact parked in that area because when he pulled in he noted two larger holes in an area close to the building he was attending.

The Plaintiff suffered severe injuries to his left land, including immediate pain, abrasions, scrapes, swelling and dislocated fingers. He was later advised that he had suffered a fracture in his index finger and chipped bones in his middle and index fingers. He had two surgeries on his hands and would likely require more in the future. Even after the surgeries, he suffered from extreme stiffness in his fingers and his index finger would not bend at all.

He required assistance from his wife to button his shirts and had some difficulty with outdoor maintenance.

The Plaintiff had his own computer repair business which was registered as a sole proprietorship. He earned approximately $65,000 per year. As a result of the injuries from the fall, he could no longer do many parts of the repairs on his own, as many of the parts of his job required him to hold a part in his left hand while he worked with his right hand. To keep his business operating, he was required to outsource part of certain repairs to another local computer repair business at a cost of $100 per job. Two years after the accident, the number of outsourced jobs varied but averaged approximately 20 per month.

Fact Scenario # 2

The Plaintiff was 79 year old woman who was a back-seat passenger in a vehicle driven by a friend when they were involved in a collision involving another vehicle.

The Plaintiff was taken by ambulance to the hospital. She indicated she had pain in her left hip and groin. She also complained of cuts to her left knee and index finger.

As a result of the Accident, the Plaintiff suffered:

1. A fractured left hip;
2. A dislocated right hip;
3. Sporadic dizzy spells shortly after the Accident;
4. Whiplash; and
5. Abrasions and bruising.

The Plaintiff was hospitalized for one month. Three months after the Accident, she was still experiencing a lot of pain in her right leg and hip area resulting in difficulty in bending, standing and lifting as well as occasional dizziness.

Three years after the accident, the Plaintiff's ongoing ailments included:

1. Pain in her legs;
2. Reduced mobility in her legs;
3. Reduced sensation in her legs;
4. Pain in her neck; and
5. Headaches.

Although the Plaintiff was 79 years old, she had worked her entire adult life on the family farm (approximately 58 years). She was a hardworking individual who led an active lifestyle prior to the Accident. Immediately prior to the Accident, she drove a tractor for the farm, graded potatoes, cleaned up, made meals and did any other jobs required around the family farm.

The Plaintiff would try to make dinner for her family and the farm works; however, these tasks would take significantly longer for her to complete than these jobs would have taken prior to the Accident. The Plaintiff was able to do some light duty cleaning for the family, such as making beds and tidying up, but these tasks take her a significant amount of time to complete. Additionally, the Plaintiff had a housekeeper come in to perform additional cleaning work.

From her farmwork, the Plaintiff earned approximately $12,000 per year and that income stopped after the accident. She had no plans to stop working on the farm and many of her siblings lived into their mid 90s.

The Plaintiff attending ongoing physiotherapy sessions, but was receiving no other current treatment.

Fact Scenario #3

The Plaintiff is 45 years old. He lives alone and has no dependents. He was a passenger in a vehicle operated by his sister. The sister was killed in the accident. The operator of the other vehicle involved in the collision was entirely at fault.

The Plaintiff sustained no loss of consciousness. He was diagnosed with post-concussion syndrome by his family physician. A neuropsychologist diagnosed cognitive impairment arising from the accident. The cognitive impairment, according to the neuropsychologist, is very mild and the diagnosis is based upon comparison of the Plaintiff's scores with averages for his age and education (high school) cohort.

A neurologist, on IME, has given the opinion that there was no traumatic brain injury or consequent cognitive impairment but that the Plaintiff is experiencing post-concussive headaches. The headaches are intermittent and brought on by rapid neck/head movement. The neurologist's prognosis that they may be permanent, but that there is a 50% possibility of full or nearly full resolution if the Plaintiff undergoes specific physiotherapy treatments. The Plaintiff sustained no other injuries in the accident.

He has attended massage therapy, which has had no meaningful effect. He has gone to a number of physiotherapy appointments (the ones which are believed by the IME neurologist to offer 50% chance of resolution). These treatments have brought on nausea and vomiting for as long as 24 hours after each treatment. This has caused the Plaintiff to miss a few days of work. The treatment plan is for two treatments per month for six months then reassess.

The Plaintiff is a golf club pro. His income comes from a percentage of pro-shop profits and the lessons he gives to members. An assistant pro helps with lessons and has capacity for more. The assistant is paid a cut of the lessons he gives and a small percentage of pro shop profits. Both the pro and assistant pro are expected to work regular shifts in the pro shop in addition to their teaching responsibilities. The work is seasonal and the Plaintiff receives EI during off-months. His pre-accident income was relatively stable and comprised of an average of $50,000 per year from the pro shop and $25,000 from lessons in addition to EI benefits.

Since the accident, the Plaintiff has been able to keep working without missing pro-shop shifts, but has been unable to do lessons due to the movement involved. The assistant pro has covered all lessons and is well liked by the membership. The Plaintiff is also well liked but he has been the pro for 20 years and his teaching methods are perceived as outdated by some of the younger members.

The Plaintiff was a regular drinker before the accident, but his drinking has increased since. There has been no diagnosis of depression by any care provider. He has missed a few shifts in the pro shop due to hangovers and the assistant has advised the club president. The Plaintiff has refused to get counselling or attend AA.

Issues

- General damages
- Loss of earning capacity
- Mitigation
- Additional information important to resolution

Fact Scenario #4

The Plaintiff is a 52-year-old female (46 years old at the time of the accident), married, with one dependent (a teenager). She was operating her own vehicle, (a small vehicle) at the time of the accident when she was t-boned on her driver's side. Her vehicle was written off and there was significant protrusion into the driver's compartment around the Plaintiff's lower legs.

The Plaintiff was dazed at the accident scene and may have had a brief loss of consciousness. Upon attending the emergency department, she was noted as having spasms of her hands and feet and "shaking and unable to explain why she was shaking." The hospital records further indicate that she was unable to move her feet at all- "Feet extended and toes curled with spasm." Significant lower leg contusions and bruising were noted, however, no fractures upon x-rays. She was released from hospital the next day and was provided with a full leg brace to her ankle on her right leg and within a few days developed severe pain and muscle cramps in both legs with tingling and discoloring of her toes.

The Plaintiff was immobilized for a few weeks after the accident and for the subsequent few months her left leg felt stiff and cramped, but generally resolved albeit some left leg symptoms which continued to wax and wane over the next few years. Her right leg, however, worsened requiring several continued attendances to the emergency department and reported hematoma, contusion and swelling around her right calf and foot areas. She was prescribed anti-inflammatory and pain medication and continued to use crutches and attend emergency over the next year.

The Plaintiff continued to undergo investigation, which included a two-week hospital admittance due to her right leg complaints where investigation noted weak pulses in her foot and discoloration. She was also noted to be anxious and emotional throughout and was prescribed morphine and physiotherapy was attempted at that time. During one such hospital admission, her right leg symptoms were so severe, discoloration and lack of pulse in her right lower leg, that she was "prepped for a leg amputation" and arrangements were being made to airlift her to the QE II in Halifax. In the end, the amputation did not take place and the doctors were ultimately able to get her symptoms under control.

The Plaintiff underwent numerous assessments and treatment by orthopedic and physical medicine rehabilitation specialists. The general medical consensus was a diagnosis of Late Stage Complex Regional Pain Syndrome Type 1 (Reflex Sympathetic Dystrophy- RSD). Further, as a result of the injury, the Plaintiff had three serious episodes of blood clotting/ Deep Vein Thrombosis (DVT) in her right leg, which subsequently required morphine and blood thinner, which she must remain on for the rest of her life.

The Plaintiff also developed significant anxiety and Post Traumatic Stress Syndrome (PTSD) as a result of the accident and neuro-psychological treatment was also referred.

The Plaintiffs psychological symptoms worsened over time with significant weight loss, sleep difficulties, and the spreading of her RSD symptoms and chronic pain to other areas of her body. Further, she developed a serious drug addiction owing to the opioid/narcotic pain medication she was required to take.

At the time of the accident, the Plaintiff had a short history of working in a home-based business, in an area in which she had prior training and experience. Just prior to this, she had a 20-year work history, working 2-3 jobs at the same time in the hospitality industry mainly (requiring her to be on her feet most of the time). She had a grade twelve education with her only work experience being physical in nature.

The evidence was uncontradicted that the Plaintiff could not return to work in any capacity due to her RSD/chronic pain and neuropsychological symptoms. She qualified for CPP benefits in Section B paid ultimately out a lump sum for her weekly income loss of benefits (WI).

The Plaintiff's ongoing symptoms generally limited her function, including household abilities and recreational activities. She was compliant with her medical treatment and proactive in attempting to mitigate her damages. Late in the claim under the care of the Pain Management Clinic she was prescribed medical cannabis which helped to alleviate her symptoms slightly.

The Plaintiff's physical health prior to the accident was good. Further, she had no psychiatric history aside from six psychological attendances in the year prior to the accident. She attended for a Defence Psychiatric IME wherein the assessing psychiatrist confirmed her situational stressors of the death of both her parents and some family and financial stress in the year before the accident. Thus he opined that her pre-accident emotional issues were being managed on low dose anti-depressants, however, "the accident augmented and sustained any existing depression symptoms". Accordingly, he diagnosed her with DSM-5 Major Depressive Disorder.

Issues

- General Damages
- Psychological -Thin Skull v. Crumbling Skull
- Loss of Income
- Cost of Care / Valuable Services
- Future Care