

SUPREME COURT OF NOVA SCOTIA
Citation: Gillis v. MacKeigan, 2010 NSSC 22

Date: 20100125
Docket: Syd No. 262862
Registry: Sydney

Between:

John Lloyd Gillis

Plaintiff

v.

David MacKeigan Jr.

Defendant

LIBRARY HEADING

Judge: The Honourable Justice Frank Edwards

Heard: January 12, 2010

**Final Written
Submissions:** January 18, 2010

Subject: Assessment of damages; personal injury.

Facts: Plaintiff, now aged 64, suffers from chronic pain, PTSD and depression following a car/pedestrian accident in June 2005. Plaintiff already on CPP disability pension because of a heart condition. Following bypass surgery in 2000, he was able to enjoy a number of recreational activities. The 2005 accident totally disabled him from continuing to enjoy those activities. He now spends much of his time sitting in a chair looking out the window.

Issue: Appropriate quantum of damages.

Result: General damages assessed at \$75,000.00. Plaintiff also awarded for past and future costs of medication and for cost of housekeeper. No award for past or future loss of income.

Declined to make separate award for loss of lifestyle though that factor considered in assessing general damages. (See *Stapley v. Hejslet*, 2006 BCCA 34.)

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Counsel: Derrick J. Kimball and Nash T. Brogan, for the plaintiff
No one appearing for the defendant

By the Court:

[1] This is an assessment of damages. A default order with damages to be assessed was issued on October 9, 2007. The Section A and Section D insurers, as well as the Defendant personally, were given notice of the hearing before me but did not appear.

[2] **Facts:** This claim arises out of a pedestrian/motor vehicle accident that occurred on June 12, 2005. The Plaintiff was standing in a driveway located on 20 Muir Street in North Sydney when the Defendant who was driving a 1995 GMC truck, suddenly and without warning, backed his vehicle down the driveway and struck the Plaintiff violently, knocking him to the ground. The Defendant then fled the scene.

[3] The Plaintiff was taken to the Northside General Hospital by ambulance where he presented with injuries to his right hip, right hand and various abrasions. X-rays of his pelvis and right hip revealed a possible undisplaced hairline fracture. X-rays of his right hand revealed a fracture of the fifth metacarpal.

[4] The Plaintiff was followed by his family doctor, Dr. Peter Poulos. A bone scan in August 13, 2005 confirmed a fracture of his right pubic bone and also disclosed a fracture of his right 6th rib. Symptoms attributed to his accident included upper and lower back pain, right hip and leg pain and right hand pain.

[5] Mr. Gillis had to walk with crutches for approximately two months following the accident. The Plaintiff then relied on a cane which he still continues to use to this date. He received various therapies such as physiotherapy, chiropractic treatments, a psychologist, a psychiatrist and a pain management specialist. Medications for pain included Dilaudid, Tylenol #3, Percocet and Amitriptylene.

[6] The accident has also had a psychological impact on the Plaintiff. He was diagnosed with Post Traumatic Stress Disorder (early onset), with a Major Depression. Medications for this included Lorazepam, Effexor XR, Trazadone and Cipralex.

[7] The Plaintiff is 64 years old (DOB: January 22, 1946). When I saw him he could easily pass for someone in their mid to late seventies. At the time of the

accident Mr. Gillis was not working and was in receipt of CPP Disability Benefits. However, he said he had secured part time employment as a taxi dispatcher and would have earned approximately \$3,900.00 per year, an amount permitted under CPP regulations without affecting his benefits.

[8] The Plaintiff is claiming damages as a result of the injuries sustained in the hit and run accident.

[9] I heard evidence from the Plaintiff, John Lloyd Gillis, his daughter Jacqueline Pygiel, and taxi company owner, John Lyle. Also in evidence was the Plaintiff's medical chart and a book of expert reports (medical and actuary).

[10] Dr. Poulos, the Plaintiff's family physician, has provided an excellent summary of Mr. Gillis' symptoms and treatment in a letter dated July 3, 2009 (attached hereto as Schedule A). The letter is confirmatory of the evidence I heard from Mr. Gillis himself.

[11] There is no question but that Mr. Gillis suffers chronic pain as a result of the accident. He also suffers from PTSD which Dr. Foley describes in his December

8, 2008, letter as “early onset, mild to moderate severity”. As well, Mr. Gillis has a problem with major depression. This is all attributable to the June 2005 accident.

[12] I am also satisfied that Mr. Gillis was significantly disabled prior to the accident. He underwent quadruple bypass surgery in 2000 following a number of heart attacks beginning in 1983. Mr. Gillis has been on a CPP disability pension since 1983. Although he claims he was “back to normal” following the bypass operation, I am sceptical. In 2002, for example, Mr. Gillis expressed an interest in going back to work. Dr. Poulos had reservations about him doing so (note March 5, 2002). Heart specialist Dr. Baillie described Mr. Gillis’ decision not to go back to work as a “good decision” (note September 12, 2002).

[13] The accident in June 2005 no doubt worsened what was already a bad situation. I am satisfied that the accident had a significant negative impact upon Mr. Gillis’ enjoyment of life. Prior to the accident, Mr. Gillis was able to enjoy a fair number of recreational activities. His daughter, Jacqueline Pygiel, described how her father enjoyed hunting, fishing, curling, swimming and boating. Mr. Gillis especially liked going for long drives in his car. He can no longer do any of that. For that he is entitled to be compensated.

[14] I am satisfied that the accident has had a severe negative impact upon Mr. Gillis' quality of life. I note that there is no medical evidence to link his leg "giving out" to the accident. But, the accident has taken a persistently troubled but not totally disabled individual and rendered him totally disabled. Here, I am speaking of totally disabled in a recreational sense, that is, Mr. Gillis can no longer partake in any of the activities that had made his life enjoyable. In legal parlance, the accident has taken Mr. Gillis beyond the *Smith v. Stubbart* type of case. I assess general damages at \$75,000.00.

[15] Counsel referred me to *Stapley v. Hejslet*, 2006 BCCA 34 where the Court awarded additional non pecuniary damages for loss of lifestyle. I am not satisfied such a claim can be made out on the facts in this case, but I have obviously taken change of lifestyle into account when I assessed general damages.

[16] **Care Costs:** Mr. Gillis is entitled to be reimbursed for the medication he has taken as a result of this accident. I fix that amount at \$1,604.43. He is also entitled to the future cost of such medication which I fix at \$7,207.98 (\$700.88 per year x 10.28418 - per page 9 of Actuarial Report).

[17] **Valuable Services:** Reimbursement for past housekeeping expenses since August 2006 (182 weeks at \$75.00 per week = \$13,650.00). I assess further cost of valuable services at \$27,039.40 (\$3,900.00 per year x 6.93318 - per page 11 of Actuarial Report - to age 75).

[18] **Past and Future Wage Loss:** I am not satisfied that the claim under this head has been proven. There is no evidence of earnings between 2000 - 2005 other than the CPP disability pension. I am sceptical of the evidence of John Lyle who says he offered Mr. Gillis a part-time job as a taxi dispatcher “a couple of days before the accident”. I decline to make any award under this head.

[19] **Costs:** The matter took a full day of court time but it was an uncontested proceeding. It still required a fair amount of work by Counsel but I do not feel it appropriate to assess costs under Tariff A. I will allow \$6,000.00 plus disbursements of \$4,910.81.

[20] **Summary:**

General Damages

\$ 75,000.00

PJI (2.5% x 4.5 years)		8,437.50
Care Costs:	past	1,604.43
	Future	7,207.98
Valuable Services:	past	13,650.00
	Future	<u>27,039.40</u>
Subtotal		132,939.31
Costs + Disbursements		<u>10,910.81</u>
Total		\$143,850.12

Order accordingly.

J.

SCHEDULE "A" in Gillis v. MacKeigan, 2010 NSSC 22

Dr. Peter Poulos

Northside Family Practice
145 King Street
North Sydney, N.S.
B2A 3S1

Phone: (902) 794-3301
Fax: (902) 794-8429

July 3,2009

Kimball Brogan
Barristers & Solicitors
121 Front St
Wolfville,N.S.

Dear Mr. Kimball:

Re: John Lloyd Gillis
D.O.B.Jan22,1946
Car/Pedestrian Accident: June 12, 2005

This letter is in reply to your request for a medical-legal report on my patient John Gillis, with regards to injuries that he sustained in a truck/pedestrian accident on June 12,2005. I am his family physician and he has been under my care for the past 23 years. I am a general practitioner that is duly licensed to practice in the province of Nova Scotia.

My initial contact with Mr Gillis following this accident was on June 30,2005 in my office. He reported to me that he had been hit by a truck on Tobin Rd on June 12,2005. He was backed over by a truck and had sustained a fracture to the 5th metacarpal of his right hand, as well as an injury to his pelvic region. He was complaining of pain in his right hip, upper leg and groin. In addition he had pain in his low back and coccyx [tailbone] region. He was initially treated in the Emergency Dept of the Northside General Hospital by the Emergency Room physician Dr. Eslier Aguilar. He was referred to an orthopedic specialist, Dr. Kevin Orrell who saw Mr. Gillis on June 17,2005. Dr. Orrell performed a closed reduction of his right 5th metacarpal fracture and applied a cast. The X rays of his pelvic and right hip were initially interpreted by Dr. Aguilar and Dr. Orrell as being negative for a fracture but the radiologist's interpretation questioned the possibility of a fracture of the superior ramus of the right pubic bone. A repeat X ray was performed on July 13, 2005 and it showed an undisplaced fracture of the middle of the superior ramus of the right pubic bone. He also had a bone scan performed on August 11,2005 and this confirmed the fracture in the right superior pubic ramus that extended into the medial aspect of the acetabulum [right hip joint]. The bone scan also showed an area of uptake in his anterior left 6th rib consistent with a fracture. No specific treatment was required for the rib fracture other than pain relief. His pelvic fracture was undisplaced and a stable fracture so he was permitted to

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weight bear but within the limits of pain. On his initial visit with me he complained of being unable to " lift his right leg up" and when he tried to put full weight on his right leg he had severe pain. On examination he experienced pain when I moved his right leg. Any hip flexion or rotation also caused pain. On his initial visit he had been taking Tylenol #1 for pain but this was ineffective thus I prescribed Dilaudid 1.0 mg to be taken every 3-4 hours as required for pain.

His next visit with me was on July 11, 2005. He had his cast removed from his right hand. There was swelling in the dorsum of his right hand with tenderness over the 5th metacarpal. He had ongoing pelvic, low back and right groin pain. He was still unable to fully weight bear on his right leg due to pain. I refilled his Dilaudid prescription for pain on the date.

He was seen again on July 21,2005 in my office. On that visit his repeat plain X ray report was available thus I was able to tell him that he had a pelvic fracture. He continued to be experiencing pain. He could not sit for any length of time and this pain was waking him up at night despite taking the Dilaudid. He had resumed driving his car by this time. It was on this visit that he first reported to me that he was experiencing nightmares with regards to the events of the accident. He described having to hold onto the side of the truck to prevent himself from being pulled under the wheels.

He returned to my office on August 4,2005. On this visit he describes that he was in "pain all the time". When he sits for any length of time his pain increases. When he tried to stand his pain was more severe. He also continued to have pain in his right hand. At this time he was not ambulating very well. He continued to require to take Dilaudid for pain.

On August 15,2005 I was notified by Dr. S. lies, the radiologist that interpreted his bone scan, that the scan confirmed that there was a right pelvic fracture that extended to his acetabulum. I in turn contacted Dr. K. Orrell who advised repeat X rays and he arranged to see him in his office with these X rays on August 17,2005.

Mr. Gillis was referred to physiotherapy, however there was a delay in this treatment being initiated. This was caused by the delay in getting the insurance company approval for coverage at a private clinic. As this was taking a considerable length of time, I decided that he should attend the physiotherapy clinic at Harbor View Hospital. He started treatment at Harbor View Hospital but soon thereafter he was transferred to Northside Physiotherapy. With this treatment he was able to progress from walking with crutches to using a single point cane. There was also an improvement in his right hand grip strength. Although he made progress with regards to his gait, his pain did not decrease.

He was seen three times in Sept, 2005 [Sept 1, Sept 15 and Sept 29]. He continued to have pain in his low back with radiation down his right leg. His pain interfered with his sleep. By Sept 29, 2005 he was still unable to fully weight bear on his right leg. Dr. K. Orrell ordered an MRI of his

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lumbosacral spine to see if there was anything to explain his right leg pain. This MRI was done on Nov 30,2005. It showed a mild disc bulge at the L4-5 level with left foramina! disc protrusion reaching up to the L5 nerve root. This obviously was not the cause of his right leg pain as it was on the opposite side to the disc protrusion.

I continued to see him on a regular basis in my office for follow up to his injuries. He continued to have nightmares about the accident. He would wake up through the night in a sweat, reliving the events of the accident in his dreams. Often at night he would hear a noise of a truck exhaust like he experienced with the accident.

On Feb 16,2006 I decided to replace his pain medication hydromorphone [Dilaudid] with Tylenol #3. He did find this more effective for pain relief. On March 2,2006 I prescribed Amitriptylene 10 mg to be taken one hour before bedtime. The purpose of this medication was to improve his sleep and to help reduce his pain. He took this medication for three weeks but he felt it did not help reduce his pain or improve his sleep, thus he discontinued it. By May 2006 he was attending physiotherapy twice a week. He was getting discouraged by the lack of improvement in his low back, pelvic and leg pain. He was having ongoing psychological symptoms from his accident [sleep disturbance, nightmares, depressed mood]. On May 3,2006 I prescribed Lorazepam 1.0 mg hs prn to help with his sleep. He did receive chiropractic treatment by Dr. David Dunn in May, 2006 but this did not help his pain. On June 25,2006 he was seen in my office. He had symptoms of a depressed mood, being easily frustrated with a lack of energy and ambition. I felt that he was suffering from depression secondary to his accident and possibly a post traumatic stress disorder. I prescribed Effexor XR to treat this condition. Effexor is an antidepressant that sometimes has a secondary beneficial effect of reducing pain. He took Effexor for two weeks but had to discontinue it due to a side effect of headache. On Aug 16, 2006 he described the intensity of his back, groin and leg pain as being a 9 to 9.5 on the 0 to 10 pain scale. It was obvious that he was developing a chronic pain syndrome following his pelvic fracture.

On Oct 12,2006 I increased his Lorazepam to 2 mg hs as the lower dose was ineffective. He continued to take Tylenol #3 for pain averaging 120 tablets per month. I continued to see him in my office on a monthly basis. On his Nov 14, 2006 visit Mr. Gillis reported that he was still waiting for insurance company coverage for psychological treatment by Mr. Michael Bryson [psychologist]. He also indicated that his ability to walk was greatly reduced in that he was limited in the distance. He was using a cane in his left hand when walking. His next visit was on Dec 14,2006 and Mr. Gillis informed me that he had his first appointment with Mr. Bryson for treatment was Dec 11, 2006.

Mr. Gillis was seen on a monthly basis to assess his progress and fill his prescription for Tylenol #3. He was using one hundred and twenty Tylenol #3 per month. His pain would be better managed with a longacting opioid such as codeine contin. I suggested this switch but due to the fact that it took 60 days to be reimbursed for this medication Mr. Gillis said he did not have the

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up front money to pay for this medication. In addition he would also benefit from a pain adjunct such as Gabapentin or Lyrica. Both of these medications are similarly very expensive, thus for the same reason they were not prescribed. This financial circumstance limited the medication choices. On Feb 6,2007 I replaced his Tylenol #3 with Percocet and provided him with 90 tablets for a 30 day period. He did find that Percocet was a more effective analgesic.

On his May 7,2007 visit Mr. Gillis indicated that his sessions with Mr. Michael Bryson had finished and that 'they did not help at all'. On the June 6,2007 visit I referred him to Dr. Harry Pollett who has a pain management clinic at the Northside General Hospital. On his Aug 6,2007 visit he reported that his right leg was "giving out" without warning and that he had fallen twice as a result. His examination failed to reveal any atrophy or weakness in his right leg quadriceps muscle to account for his symptoms of his leg giving out.

On his visits on Sept 6 and Oct 4,2007 he expressed symptoms of irritability, reduced energy and ambition, feeling sad and worthless. He continued to have nightmares about the accident and he thought about death a lot. I diagnosed him with a depression secondary to his chronic pain, with a likely underlying post traumatic stress disorder [PTSD]. I provided him with samples of the medication CipraleX to treat this depression. A dose of 10 mg od was started on Nov 5,2007.

On his follow up visits he reported that he was sleeping better since on the CipraleX. His use of Percocet increased to 120 tablets per month by Jan, 2008. On Jan 7,2008 he reported that he was worrying less which was attributed to the CipraleX. His appointment with Dr. H. Pollett was on March 27,2008. While on the CipraleX he continued to take Lorazepam 2 mg hs. Attempts to become more physically active in the hopes of helping to reduce his pain failed ,as he reported an increase in his pain when he tries to walk. He had his sacroiliac joints injected with Triamcinolone and Marcaine by Dr. Pollett but this did not help reduce his pain at all even temporarily.

A more detailed assessment was performed on his May 27,2008 and June 6, 2008 visits as to how his injuries caused interference with his day to day functioning. He described that he "can't do nothing". For example he used to enjoy ice fishing and trout fishing in the spring which he cannot do now. Also he enjoyed using an ATV or pleasure boat for recreation but he could no longer do these activities. After riding in his car for 25-30 minutes he develops an increase in his pain thus limiting the distance he can travel. He is in pain "all the time"with standing, sitting or walking making the pain worse. With light household chores such as using the vacuum or doing laundry his pain increases significantly. He cannot carry the grocery bags into his home after shopping. When at the grocery store he is limited in his ability to bend and squat to get items off the lower shelves. He is also disappointed in that he is limited in what he can do with his grandchildren [ages 3, 5 &6]. For example he cannot play with them or lift them due to his injuries from his accident.

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His pain was described as being there all the time. He is never pain free. His Percocet takes "the edge off the pain". The pain is located on his low back and radiates to the lower thoracic spine in the midline. It also radiates to his buttock and down both legs to his feet. There is a squeezing quality to his pain. As a result of his injuries he had become depressed with no interest in his hobbies or life in general. He admitted that he wasn't taking very good care of himself, in order to pick something off the floor he cannot bend but must squat. For showering he uses a shower chair and has difficulty getting in and out of the tub. His ability to vacuum is limited to 5 minutes. Laundry must be done in small loads and he cannot wash dishes due to his inability to stand for any length of time. His walking distance was limited to a few blocks. He also reported that he was doing some minor carpentry work prior to his accident but he can no longer do this.

With regards to the emotional effects of his accident, his symptoms included being moody, irritable and cranky. He lost interest in his various hobbies. His symptoms worsened in the spring of 2008 and as a result he was not taking as good care of himself from a hygiene standpoint and with regards to his other medical conditions. He was not eating properly and skipping meals. He was spending a lot of his day just staring out the window. His sleep is interrupted with difficulty getting back to sleep. He also used to enjoy reading but has no interest in this anymore. His diagnoses are a major depression and post traumatic stress disorder. Unfortunately, I was unable to provide him with samples of Ciprallex on a regular basis which resulted in less than ideal treatment. I was also providing supportive psychotherapy treatment on his visits. On his June 26, 2008 visit I provided him with a toll free number for the Provincial Family Benefits Program which would likely provide him with Pharmacare coverage.

When Mr. Gillis was next seen by me on July 10, 2008 he informed me that he had an appointment with Dr. H. Pollett at his pain clinic on August 6, 2008. He continued to require four Percocet tablets a day to help reduce his low back and pelvic pain. I continued to see him in my office on a monthly basis. His symptoms of depression did not improve. He could not afford the antidepressant medication Ciprallex and he had not received any Pharmacare coverage for his medication. On his visit of Oct 22, 2009 he informed me that the treatment that he had received from Dr. Pollett had not helped so far.

When I saw Mr. Gillis on Oct 22, 2008 he informed me that his daughter said she would pay for his antidepressant medication. He continued to feel unwell from a mental health standpoint. I started him on the medication Effexor XR on that date to help with his depressive symptoms. Due to their persistence and for assistance in determining whether his symptoms were due to a major depression or a post traumatic stress disorder, I decided to refer him to a psychiatrist, Dr. Brian Foley. The starting dose of Effexor XR was 37.5 mg od for one week then increase to 75 mg od. When I saw him on Nov 21, 2008 he indicated that he had noticed some improvement with Effexor in that he was now less irritable and that he didn't dwell on the accident as much. I decided to increase the dose of Effexor XR to 150 mg od; however, when this dose was increased he developed side effects and it had to be discontinued.

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He was seen by Dr. Brian Foley on Dec 8,2008 and he diagnosed him with Post Traumatic Stress Disorder [PTSD] mild to moderate severity and a major depressive disorder. Dr. Foley started treatment with psychotherapy on Jan 29,2008. He prescribed Trazadone in a dose of 25 to 50 mg at bedtime to help with sleep. On April 4,2009 Dr. Foley started Mr. Gillis on Cipralex 10 mg od to replace the Effexor. Mr. Gillis continued to not have any drug coverage so Dr. Foley provided him with samples. Since starting the Cipralex and Trazadone there has been some improvement in his sleep. He continues to have recurrent thoughts about the accident. My last visit with Mr. Gillis was on May 20,2009. He reported that he tried to walk without his cane but this did not work out as he had increased pain. Dr. Foley last saw Mr. Gillis on May 5,2009. He is being maintained on Cipralex 10 mg od. There has been some improvement in his mood in that he isn't brooding as much and had fewer nightmares. He still felt very nervous if he was passed by a truck while driving in a car as this brought flashbacks of the accident to him.

hi conclusion, Mr. Gillis was involved in a car pedestrian accident on June 12,2005. He sustained injuries which included a fracture of his right 5th metatarsal, a fracture of the superior ramus of the right pubic bone that extended into the acetabulum, a fractured left 6th rib and soft tissue injuries to his low back. As a result of the nature of this accident in that Mr. Gillis felt that he was purposely injured rather than it being an accident, he has developed major psychological symptoms which include nightmares, sleep disturbance, anxiety and a depressed mood. He frequently has intrusive thoughts and recall of the traumatic incident. He has been diagnosed as having a Post Traumatic Stress Disorder with a Major Depression and he has required psychiatric care for this.

As a result of his physical injuries to his low back and pelvis he has developed a chronic pain state. This has significantly impaired his ability to perform a lot of his daily activities. As previously outlined he has a marked reduced ability to perform household activities of daily living, personal care and other activities of daily living such as grocery shopping. He has become very limited in the distance he can walk even with the use of a cane [two blocks]. He now cannot perform recreational activities such as fishing and using an all terrain vehicle that he enjoyed prior to the accident. He is limited in the distance he can drive. Prior to his accident he worked part time doing carpentry and as a taxi dispatcher. These are employment activities he can no longer perform.

Yours truly

P.Poulos M.D.