Reserved judgment

EMPLOYMENT TRIBUNALS

BETWEEN

Claimant	**Respondent**
	AND
Mr N Thakrar	Ministry of Justice

RESERVED JUDGMENT OF THE EMPLOYMENT TRIBUNAL AT A PRELIMINARY HEARING

HELD AT Birmingham **ON** **11th July 2017**

EMPLOYMENT JUDGE Coaster

Representation
For the Claimant: Mr N Bidnell-Edwards, Counsel
For the Respondent: Mr A Lyons, Counsel

JUDGMENT

The judgment of the Tribunal is that:

1. The claimant is a disabled person for the purposes of the Equality Act 2010 by reason of a mental impairment.
2. The amendment to the claimant's claim to include particulars of holiday pay is allowed.

REASONS

Background

1. The claimant is a 25 year old man. He was employed by the National Probation Services as a Senior Case Administrator between 4th May 2015 and 14th July 2016. The claimant brings a claim of disability discrimination, the claimant's dismissal being the last act of alleged discrimination. The case is

defended. The respondent does not accept that the claimant is disabled for the purposes of the Equality Act 2010.

2. At a case management hearing on 1st February 2017, the matter was set down for a full hearing on 16th – 20th October 2017.

3. The preliminary issue of whether the claimant is disabled is the principal issue before me. There is additionally an application from the claimant to amend his claim to add a claim of holiday pay.

Issues

4. The issues set out in the Case Management Order of 1st February 2017 are:

(i) did/does the claimant have a physical or mental impairment?
(ii) if so did/does that/the impairment(s) have a substantial adverse effect on his ability to carry out normal day to day activities?
(iii) if so, is that effect long term?
(iv) in particular when did it start and has it lasted for at least 12 months or was the impairment likely to last at least 12 months or the rest of the claimant's life if less than 12 months. In assessing the likelihood of an effect lasting 12 months, account will be taken of the circumstances at the time of the alleged discrimination, and anything which occurs after that time will not be relevant in assessing likelihood.
(v) the relevant time for assessing whether the claimant has or had a disability.

Evidence

5. I was provided with an impact statement by the claimant and heard oral testimony from him. I was provided with an agreed bundle of 515 pages exhibited as R1. Particular reference was made to the claimant's GP medical records, the expert report of Dr Charlesworth-Jones and his additional supplementary report to the parties' questions on his expert report. Additionally a copy of the claimant's application for flexible working was exhibited as R2.

Findings of fact

6. I make my findings of fact on the basis of the material before me taking into account contemporaneous documents where they exist and the conduct of those concerned at the time. I have resolved such conflicts of evidence as arose on the balance of probabilities. I have taken into account my assessment of the credibility of witness and the consistency of his evidence with surrounding facts.

6.1 The claimant does not pursue other conditions previously pleaded including sciatica, and beta-thalassaemia trait. He additionally suffers or has suffered from irritable bowel syndrome (IBS), stomach ulcers, vitamin D deficiency and haemorrhoids.

6.2 The claimant provided an impact statement and additional oral testimony. The claimant's evidence was provided honestly and without being evasive, although at times his evidence was vague, or at least, less than positively stated. Overall I find that he told the truth and believes he is disabled.

6.3 My findings of fact relevant to the issues which have been determined are as follows.

Medical history – GP records and consultants' investigations and reports

7. The claimant has a lengthy and detailed medical history. Entries and reports relevant to the issues before me are:

(i) the claimant was prescribed medication for gastric problems for the first time about February 2011 following the unexpected loss of his cousin brother who was a very close friend. The claimant was deeply upset by his loss and states that his anxiety really began from that time. The claimant has been routinely taking prescribed medication such as omneprazole for gastric problems since that date;

(ii) the claimant was diagnosed with hypertension (high blood pressure) on 4th March 2015 and was prescribed medication for it including Ramipril and Losartan; he commenced taking Bisoprolol on 16th May 2016 which he continues to take;

(iii) the claimant was first prescribed medication for asthma (Salbutamol aka Ventolin) on 16th July 2014. In September 2015 the claimant had a primary diagnosis for his unexplained breathlessness as being possibly due to asthma. It was reported by Dr C O'Brien on 2nd October 2015 that "the considerable bronchodilator response would be in keeping with asthma, but he does not have any airflow obstruction or any air trapping." The claimant is heavily reliant on a daily basis on prescribed medication for asthma/bronchodilators such as Ventolin and Beconase since about September 2015.

(iv) the claimant was diagnosed with breathlessness due to respiratory muscle weakness on 7th January 2016;

(v) In June 2016 the claimant was informed by a consultant that he did not have bronchial hyper responsiveness or asthma and therefore his inhalers were unnecessary. The claimant continues to date to take asthma medication / bronchodilators;

(vi) the claimant was treated for anxiety/panic attacks with Sertraline on 14th June 2016. He continues to take Sertraline to control his symptoms.

(vii) the claimant regularly and with high frequency takes other medication prescribed by his GP including but not limited to painkillers, antibiotics for respiratory tract/chest infections, anti-histamine, steroid cream for skin conditions.

7.1 On 4th March 2015 Dr A R Maher, Consultant Cardiologist at the George Elliot Hospital NHS Trust reported to the claimant's GP that the claimant had undergone blood pressure monitoring. Dr Maher confirmed that the average readings were consistent with mild hypertension and that it would be reasonable to commence an anti-hypertensive [medication] – see paragraph [x](ii) above.

7.2 The claimant commenced employment with the National Probation Service (the respondent) on 4th May 2015 on a six month probation period which was extended on several occasions to accommodate sickness absences.

7.3 The claimant worked full time Monday to Friday. Under the respondent's flexitime policy the claimant was able to work 8am – 4pm daily. These hours enabled him to avoid the stress of driving to work at peak traffic periods.

7.4 On 1st June 2015 the clamant was reassured by Dr A R Maher, Consultant Cardiologist at George Eliot Hospital NHS Trust that the results of his lung function tests were overall reassuring although they did suggest that the claimant's lung volumes were mildly reduced.

7.5 The claimant's first period of sickness absence was between 19th October 2015 to 11th January 2016.

7.6 An Occupational Health Service report of 3rd December 2015 confirmed that the claimant was not fit to work but his condition had not been diagnosed. The report confirmed that the claimant had been to several specialists and was at that time waiting for numerous medical tests in order to aid diagnosis and inform treatment. The Occupational Health Adviser did not believe that the claimant's condition was likely to be considered a disability at that time because it had not been long term, but confirmed that the symptoms described had impacted on the claimant's mobility and function.

7.7 It was recorded that the claimant reported that his mobility was restricted due to ongoing breathlessness and that his symptoms were prohibiting restful sleep as a result.

7.8 On 17th January 2016 the respondent's Occupational Health Service provider held a telephone consultation with the claimant following his return to work on a "build up programme". The resulting report to the respondent noted that despite have been referred to two specialists for further investigation (Respiratory and Endocrinology) no diagnoses had been established and therefor the principal concern was about symptom control. The claimant

continued to report symptoms of breathlessness and generalised tiredness with swelling in the limbs.

7.9 A return to work on a phased basis over four weeks was recommended with a review at 4 weeks. The again the Occupational Health Adviser did not think the claimant's condition would be categorised as a disability because it had not been long term.

7.10 On 3rd March 2016 the claimant made a formal flexible working request on 3rd March 2016 to work four days a week, a total of 30 hours, with a proposed start date of 4th April 2016. The reason for the application was to enable the claimant to fulfil caring responsibilities for his disabled parents; to have a rest day during the week to focus on his personal health and to enable him to work more efficiently. However the claimant did not work under the proposed shorter hours as his second period of sickness absence commenced on 24th March 2016 immediately following a period of annual leave.

7.11 On 11th April 2016 the Occupational Health service undertook an assessment of the claimant. It was conducted by Dr Alan Scott. The claimant reported that he had had worsening health problems for about two years, starting with high blood pressure and chest pains. His current symptoms included breathlessness, weakness of chest muscles, swelling of limbs and dangerously high blood pressure. The report records that the claimant is under the case of several specialists.

7.12 A tumour which causes the secretion of adrenalin was suspected of being the cause of the claimant's problem. A further meeting with the consultant at the end of May was suggested pending the outcome of the investigations into whether the claimant had a tumour. Subsequently it was established there was no tumour.

7.13 Following a review with Dr Saravanan on 23rd May 2016 it was reported to the claimant's GP that there was not cause to label the claimant's hypertension as secondary hypertension.

7.14 Dr Scott assessed the claimant again on 23rd June 2016. Dr Scott described in his report to the respondent the continuing symptoms of fatigue, weakness, breathlessness, shaking, swollen legs and very high blood pressure. Dr Scott stated, that although the claimant had been found to have asthma, there was no diagnosis which explained all his symptoms and tests would be ongoing for another three months or so.

7.15 Dr Scott also records that in April 2016 the claimant had been found to have dysfunctional breathing and had developed random panic attacks.

7.15 Dr Scott could not state whether the Equality Act would apply to the claimant's conditions as there had still been no unifying diagnosis and a year had not yet passed.

7.16 The claimant remained absent from work until a capability hearing was held by the respondent on 14th July 2016 following which the claimant was dismissed.

7.17 On 26th August 2016 the claimant was informed by Professor Morgan following a cardio-pulmonary exercise test that the claimant's physiology was normal but with "premature termination due to de-conditioning".

7.18 Professor Morgan confirmed that the claimant's sleep study was normal.

7.19 Professor Morgan recommended CBT, rather than Sertraline, for the claimant's anxiety and also that he should seek out a supervised physical training opportunity to assist with his breathing.

7.20 Professor Morgan did not arrange to see the claimant again on a regular basis and stated *"hopefully things will improve with training and lifestyle adjustment".*

7.21 The claimant was advised on 10th January 2017 by Dr P Saravanan, consultant Physician and Associate Clinical Professor at the George Elliott Hospital NHS Trust that his average blood pressure monitoring results had improved. Dr Saravanan reassured the claimant that the episodes of high blood pressure are short-lived and should not really cause any long term issues. Dr Saravanan therefore suggested that the claimant undertook blood pressure monitoring himself on an average of once a month to keep an eye on his blood pressure that way.

Impact statement

8. The claimant claims that he is disabled by his various conditions. The claimant relies principally on three conditions:- the condition of severe hypertension which is managed with a high doses of beta-blockers. He explains that an intense period of stress and anxiety can increase the risk of suffering from heart failure, heart attacks, stroke, panic attacks and swollen legs.

8.1 The claimant's second principal impairment relates to asthma and dysfunctional breathing pattern which is caused by Respiratory Muscle Weakness. He explains that it causes lack of sleep as the claimant's sleeping pattern is disrupted and he becomes tired quickly, suffering from dizziness, fainting and shortness of breath.

8.2 Third, the claimant suffers from anxiety.

8.3 The claimant has poor appetite caused by his anxiety and suffers as a result from mood swings. He has fluctuating weight. He lacks energy on a daily basis. He is unable to walk long distances because of pain and becoming breathless very quickly due to his breathing difficulties. He suffers from swollen limbs, chest pains due to the weakness of his chest muscles. Not going out very far has had a negative effect of his self confidence and independence. He needs to be accompanied by a family member.

8.4 The claimant is afraid to drive long distances because of his legs and, because of his health issues, that something might flair up. He does not go the gym and his breathing difficulties prevent him from swimming.

8.5 The claimant takes the following medication:

- Co-codamol/Zappain 30/500mg and 8/500 tablets for severe pain
- Omeprazole 20 mg capsules
- Diazepam 2mg tables – a controlled drug for severe pain when required
- Bisoprolol tables for high blood pressure and prevention of heart failure currently at 10mg.
- Prednisolone 30mg tables for infections when needed
- Paracetamol 1000mg tables for pain
- Beconase Aqueous Nasal Spray 50mcg for sinuses and breathing
- Sertraline 50mg tablets for anxiety, panic attacks and lack of sleep
- Clarithromycin 50mg tablets for respiratory tract infections when required
- Epaderm cream for skin/itching due to stress
- Loratadine 10mg for skin/itching due to stress
- Loperamide 2mg for IBS
- Ventolin inhaler for breathing difficulties
- Lorazepam tablets for anxiety and panic attacks.

8.6 The medications taken by the claimant have adverse side effects, causing drowsiness, inflammation, IBS, swollen limbs, particularly the legs, pain, itching, lethargy, weakness, low and negative mood despite taking antidepressants.

Expert report – Dr Charlesworth-Jones

9. Dr Charlesworth-Jones is a member of the Royal College of General Practitioners. He is a member of the Faculty of Occupational Health; holds dual qualifications in law and medicine, specialising in clinical negligence and personal injury law; he holds full registration with the General Medical Council, he is a general practitioner, an occupational health doctor and the author of personal injury, clinical negligence and occupational health reports which are used in civil litigation.

9.1 Dr Charlesworth-Jones was provided with joint instructions from the parties' representatives. He also had access to the claimant's GP's medical records and various consultants' reports.

9.2 The questions put to Dr Charlesworth-Jones can be summarised as follows:

(i) whether on 11th January 2016 (return to work date) and on 16th July 2016 (dismissal date) the claimant was suffering from a mental or physical impairment within the meaning of the Equality Act 2010 and what was the effect of medication (if any) being taken on those dates ;
(ii) what (if any) of the claimant's conditions had changed between 11th January and 16th July 2016;
(iii) from what date would the claimant have been able to return to work;
(iv) what condition(s) was the claimant suffering from at the date of the medical assessment (on 25th May 2017), its/their effect and the prognosis; and
(v) whether adjustments claimed by the claimant would have been of assistance.

Severe hypertension

9.3 Dr Charlesworth-Jones referred to the correspondence of a consultant cardiologist, Dr Maher who had investigated the claimant's condition. Dr Maher recorded at 4th March 2015, that in his opinion the claimant's condition was consistent with mild hypertension. However the claimnat's GP notes record between 18th August 2015 and 21st July 2016 blood pressure readings which were "normal".

9.4 Dr Charlesworth –Jones states at page 7 of his report that based on the readings in March 2016 it had not been clinically appropriate for the claimant's GP to have signed him off as unfit for work on the basis of hypertension.

9.5 Dr Charlesworth-Jones observed that the report of Consultant, Dr P Saravanan dated 10th January 2017 confirmed that the claimant's episodes of high blood pressure are short lived and should not really cause any long term issues. Dr Saravanan recommended that the claimant monitored his blood pressure on an average of once a month.

9.6 Dr Charlesworth Jones was of the opinion that the hypertension diagnosed did not constitute an impairment because even in March 2015, it was diagnosed as being "*mild*".

Asthma, Respiratory muscle weakness and Dysfunctional breathing syndrome

9.7 Dr Charlesworth summarised the investigations undertaken by several physicians into the claimant's cardiac and pulmonary conditions. Dr C O'Brien, Consultant Respiratory Physician stated on 2nd October 2015: *"the considerable bronchodilator response would be in keeping with asthma, but [the claimant] does not have any airflow obstruction or trapping."*

9.8 The claimant was referred to Dr Min, Consultant Physician and was assessed by him on 7th January 2016. Dr Min records in his letter of 11th January 2016 to the claimant's GP: "*no ventilator or cardiac limitation. Respiratory muscle measurements significantly reduced – peak inspiratory strength 23% of predicted peak expiratory strength 19% of predicted."* This outcome resulted in a referral to Professor Morgan who assessed the claimant on 29th April 2016, 14th June 2016 and 26th August 2016.

9.9 Dr Charlesworth-Jones noted on page 8 of his report that Professor Morgan, Consultant Physician/Honorary Professor of Respiratory Medicine at the University Hospitals of Leicester, NHS Trust, had stated in his letter to the claimant's GP on 29th April 2016: *"Also whatever the underlying cause of his breathlessness I think he has significant dysfunctional breathing syndrome".*

9.10 On 14th June 2016, following a second assessment, Professor Morgan, wrote to the claimant's GP stating: *"interestingly his PC20 and sputum induction do not suggest that he has bronchial hyper responsiveness or asthma and therefore his inhalers are unnecessary."*

9.11 Dr Charlesworth-Jones concluded therefore that a diagnosis of asthma after this date is not supported by the medical evidence.

9.12 On his 14th June 2016 Professor Morgan also recorded in his letter to the claimant's GP that the claimant's "*breathing is not limited by either heart or lung problems".*

9.13 On 26th August 2016 following a cardiopulmonary exercise test, Professor Morgan wrote: *"the cardiopulmonary test was a sub maximal [performance with high heart rate and ventilator reserves….This picture suggests normal physiology but premature termination due predominantly to deconditioning…I have reassured him about this physiology and not arranged to see him on a regular basis."* In summary Professor Morgan recommend that the claimant underwent a course of CBT and the de-conditioning of his respiratory muscles could be managed with physiotherapy.

Anxiety, stress and panic attacks

9.14 There were multiple references in the medical notes and consultants' correspondence to these symptoms. Dr Charles-worth Jones noted that in Professor Morgan's letter of 29th April 2016 and reference to his recommendation

Other conditions

9.15 Although Dr Charlesworth-Jones dealt with the conditions of Beta Thalassaemia trait, vitamin deficiency, IBS, stomach ulcers and sciatica in his report, I do not refer to them any further as the claimant declared that he did not pursue them.

Dr Charlesworth Jones' opinion - summary

11th January 2016

9.16 With reference to his substantive report and subsequent further answers to the parties' representatives' questions, Dr Charlesworth-Jones' opinion is that on 11th January 2016 the status of the claimant's various conditions were:

(i) hypertension - although it was unlikely to be severe;
(ii) asthma - although being treated for asthma with inhalers, that diagnosis was later disproven;
(iii) dysfunctional breathing syndrome – was not diagnosed at that time and was subjective;
(iv) respiratory muscle weakness – it existed but was not fully diagnosed at that time;
(v) anxiety, stress and panic attacks existed, were subjective with no treatment provided at the time.

9.17 Dr Charlesworth-Jones found on balance that it was unlikely at that time that the claimant's various conditions resulted in an adverse effect on the claimant's ability to carry out normal day to day activities. The medical records made no reference to loss of day to day function. The reason for continued absence according to the GP records was not a loss of ability to work or undertake day to day activities but for investigations for a possible adrenal gland tumour (phaeochromocytoma) which was not found.

9.18 Dr Charlesworth- Jones found that the medical records did not support impairment at 11th January 2016 on the basis of dysfunctional breathing or respiratory muscle weakness although there is multiple references to this condition existing before the material time, there was no record of symptom progression.

9.19 Dr Charlesworth-Jones was of the view that anxiety would be the cause of the claimant's panic attacks and that it was the only condition which medical evidence supported as being an impairment causing a substantial adverse effect on day to day activities. Dr Charlesworth-Jones states:

> *"Ultimately the diagnosis of dysfunctional breathing syndrome was made by exclusion and testimony to the subjective nature of this conditions. [The claimant] was recommended CBT by Professor Morgan – a psychological therapy. The medical records suggest a subjective perception of breathlessness and probably sub-optimal breathing effort; this was suggested after all the anatomical and physiological tests provided to be normal. On balance this is more like to be representative of anxiety and wider psychological problems. The effects as [the claimant] felt them were likely at*

the time of 11th January 2016 to be more than trivial and therefore qualified as being substantial."

9.20 Dr Charlesworth-Jones noted that the subjective breathing symptoms had already been on going for 1 – 2 years by the time that the claimant consulted Professor Morgan in on 29th April 2016.

9.21 He notes that hypertension was a continually present condition with the likelihood that it would be lifelong although the effects could be mitigated with medication. Dr Charlesworth Jones did not find that the claimant's hypertension caused a substantial adverse effect on day to day activities. The GP record of 1st December 2015 referred to "for last 3 – 4 years have been having some health problems" and goes on to list various symptoms all of which have been investigated with no significant pathology having been identified.

14th July 2016

9.22 At 14th July 2016 Dr Charlesworth-Jones was of the opinion that the claimant suffered from anxiety. He states that the claimant's anxiety had existed for a period over a year prior to 11th January 2016 and anxiety levels had worsened by 14th July 2016 although phaeochromocytoma had been ruled out in early June 2016, asthma had also been ruled out in June 2016; and blood pressure readings had been well within normal limits, but readings were likely to be raised due to anxiety as opposed to an intrinsic pathological cause.

9.23 The GP record on 21st July 2016 notes that the claimant had had no panic attack since starting Sertraline on 14th June 2016 to which Dr Charlesworth-Jones comments that the current dose of Sertraline is one quarter of the maximum prescribed dose and that he considered the level of dose to be suboptimal.

9.24 The claimant's multiple GP consultations between 11th January and 14th July 2016 refer to anxiety symptoms as well as drawing a hypothetical link between physical symptoms and anxiety. Dr Charlesworth-Jones was of the view that the insomnia, loss of appetite, mood swings, loss of energy were consistent with an anxiety condition.

9.25 There was a tension in Dr Charlesworth-Jones' report and subsequent supplemental answers in that he states that anxiety had existed for over a year prior to 11th January 2016 yet the only reference on which this he bases this statement, is in his supplementary responses and is a GP record entry at 29.10.15 *"worried about the burning stomach pains"* and at 12.11.15 "*worrying that something wrong"* . In response to supplemental questions from the claimant's representative Dr Charlesworth-Jones stated that prior to 11th January 2016 there is a record of anxiety but not that this was causing the claimant a substantial adverse effect on day to day activities for a period over a year prior to

11th January 2016. Dr Charlesworth-Jones states that there was no associated loss of day to day function recorded in the notes because of anxiety.

9.26 Dr Charlesworth-Jones then goes on to say that there is evidence that there are either anxiety symptoms or treatment of anxiety (in the form of Sertraline) cumulatively lasting more than a year from 5th February 2016 although he comments, the medical records of substantial adverse effect does not cover a year from this date.

9.27 In answers to supplemental questions Dr Charlesworth-Jones says that from the GP consultation dated 21st July 2016 Sertraline was essential in preventing panic attacks and that without this medication there could well have been more recorded problems relating to anxiety had it not been prescribed. He confirmed that the other conditions of hypertension, asthma, dysfunctional breathing, respiratory muscle weakness would not in his opinion have likely had a substantial adverse effect even without medication.

Submissions

10. I was provided with written submissions by Mr Bidnell-Edwards and I heard oral submissions from both representatives. I have read and retained a full note of the oral submission on the tribunal file. I have taken the submissions into account in my conclusions.

Relevant law

11. Disability is defined in S6 Equality Act 2010. The Equality Act 2010 Guidance issued by the Office for Disability Issues of HM Government in 2011 (the Guidance) sets out in Part 2 matters to be taken into account in determining questions relating to the definition of disability with particular reference at Section B to the meaning of 'substantial adverse effect'; at section C to the meaning of long term effects; and at section D the meaning of normal day to day activities.

Conclusions

12. I have read the lengthy GP medical records. It is clear that the claimant has a history of worrying about a large number of health issues of concerns, over the last three to four years. His fears and symptoms have been investigated and his symptoms treated.

12.1 The claimant currently continues to take asthma medication when he has been informed by a specialist that he does not have asthma. The claimant deflects the responsibility for continuing to take asthma medication when he does not have asthma according to medical specialists, by explaining that he is advised to do so by his physiotherapist and his GP continues to prescribe it. I do not find that the claimant has the physical impairment of asthma and I accept Dr Charlesworth-Jones's opinion that the condition of anxiety is having an effect on the claimant's perception of his breathing difficulties. .

12.2 The claimant's shortness of breath and associated dysfunctional breathing syndrome was diagnosed by exclusion of other possible diagnoses in about June 2016. He has been advised and reassured that there is no abnormality in his heart and lungs. He has been advised to take a psychotherapy treatment (CBT) and physiotherapy to strengthen his breathing capacity. The claimant has not undertaken a course of CBT. The claimant's shortness of breath is described by him as having a substantial impact on his ability to carry out day to day functions. I find that based on the evidence the claimant's shortness of breath is affected by and heightened by his state of anxiety and also that it is not a permanent or long term condition. The remedy for it is in the claimant's own hands if he wishes to do anything to resolve the situation – Professor Morgan provided advice to the claimant and did not require to see him again. I do not find that the claimant's shortness of breath is a physical impairment amounting to a disability within the meaning of the Equality Act 2010. I find that it is closely associated with his condition of anxiety.

12.3 I accept the evidence of Dr Charlesworth-Jones based on the medical specialists reports that the claimant's hypertension is mild. As recently as January 2017 the claimant was reassured by his consultant that his hypertension condition was unlikely to cause any long term problems. I do not find that the claimant's hypertension is a physical impairment amounting a disability for the purposes of the Equality Act 2010. It is a lifelong condition and has been present before the current issue with the respondent. The periods of increased hypertension are directly related to the claimant's state of anxiety.

12.4 I do not accept that individually the claimant's physical conditions amount to a disability. I accept the medical evidence that the claimant's condition in reality is one of anxiety which I find is a mental impairment and the claimant's complaints of shortness of breath, asthma, dysfunctional breathing syndrome are as a result of his subjective perceptions that he has conditions and that those perceptions are as a result of anxiety.

12.5 Anxiety was not been identified by the claimant's GP as a medical condition which requires some psychological intervention and the claimant has rejected the suggestion that he requires psychological intervention because he believes there is a stigma attached to a psychological condition.

12.6 There is a reference in the GP record on 17th February 2015 of a stress related problem, with ongoing stress at work and being bullied by a manager at work.

12.7 There is then no further reference to anxiety or stress in the GP record despite almost 30 visits to his GP between 17th February 2015 and 29th October 2015. On 29th October 2015 the GP records state *"worried about the burning*

stomach pains" and 12th November 2015 *"worrying that something is wrong as still feels weak".*

12.8 There is no further reference to stress or anxiety until 5th February 2016. On 29th April 2016 Professor Morgan records that *"on examination there was some suggestion of anxiety"* although he goes on to say that "*heart sounds were normal and [the claimant's] chest was clear".* Panic attacks are recorded as starting in mid June 2016 after the claimant received in May 2016 an indication from the respondent that he is at risk of dismissal.

12.9 The claimant said in cross examination that he had been anxious since his cousin brother who was his best friend, had unexpectedly died in 2011. He explained that his health issues had started from that date. The claimant did not accept that there is no indication in his health records of stress or anxiety until 5th February 2016. He believed he would have said to his GP and/or the occupational health doctors that he was anxious/suffering from anxiety, but also accepted that they would have made a record of him saying it, which they did not.

12.10 I have considered whether the claimant's state or condition of anxiety commenced earlier, and has existed for three to four years. I have considered it a possibility given the claimant's lengthy medical records covering a significant number of different health issues, whether real or perceived. However, it is possible to be anxious about health without it being disabling and preventing functioning adequately on a day to day basis performing the normal day to day tasks of living. The claimant was still driving to work in January – March 2016, a journey of about an hour each way. There is no record of him being unable to dress himself or to take responsibility for his diet or own personal hygiene.

12.11 The claimant believes that his various health conditions, his concerns for his disabled parents, his application for flexible working in early March 2016 were all manifestations of his anxiety and that there was no need for him to actually use the word "anxiety" to describe his condition. Had the claimant being suffering from such heightened anxiety that it amounted to having a substantial adverse effect performing day to day tasks, I think it highly unlikely that the claimant's GP, and all of his medical specialist consultants and the occupational health doctors who assessed him would have systematically failed to record the claimant informing them accordingly. I do not believe that they have failed to diagnose that he suffering from anxiety. The various doctors that the claimant saw over a period of some three years up his absence from work in October 2015 would observe anxiety as an issue and would have record it as such if the claimant had presented as anxious or stressed.

12.12 On the basis of the documentary evidence the earliest date at which the claimant could be said to be showing signs of anxiety is in October/November 2015 after being signed off sick from work. This is referred to by Dr

Charlesworth-Jones. The claimant is prescribed an antidepressant for the first time on 5th February 2016 when the GP notes record that the GP had a long discussion with the claimant. The notes state: *"feeling out of breath, using his inhalers more, getting pain in his lt arm/hand, getting puffiness of hands and legs, dry skin, bowels – says has to run to the toilet after eating anything…… has got appointment with neuromuscular consultant in april, resp in april, endo in march – thinks too far. OE pulse 70/min, chest clear, spo2 98%, CVS/NAD, dry skin, factor of anxiety, not sleeping well, will try amitriptyline, also to book for B12 injections."* I take judicial notice that spo2 98% and a pulse rate of 70/min are normal. I note that the claimant is by 5th February worried that the various appointments with consultants for investigation in March and April 2016 are too far away for his comfort.

12.13 On 4th March 2016 another reference is made to "stress" in the GP notes which state that the GP had a long discussion with the claimant and advised him on *"breathing exercises, clam down, relaxation exercises,. reassured…* and prescribed 10 mg of amitryptiline.

12.14 I find that the degree to which the claimant's anxiety became recognised by the medical profession was about the time that it started to have a substantial adverse effect on the claimant's ability to do day to day tasks and that this was in early 2016, and not before January 2016. On 8th January 2016 the claimant is recorded in his GP notes as wanting to return to work. He did return to work on a phased basis on 11th January 2016. He was then signed off on 24th March.

12.15 By 5th February 2016 it is clear from the GP notes, that the claimant's anxiety had reached a stage where it became more than him being merely a "worrier" about his health, which he has in the past acknowledged, and became a mental impairment of anxiety and that this has an effect on his other conditions of IBS, shortness of breath, a dry skin condition, puffiness of limbs.

12.16 I find that the claimant's anxiety did not reach the level of being a disability, a mental impairment, until about 5th February 2016 and the GP notes confirm this. I find that the claimant's level of anxiety is continuing.

12.17 By June 2016 the claimant was suffering from panic attacks and he was prescribed Sertraline in June 2016 which has controlled the panic attacks.

12.18 I find that the claimant's anxiety does have a substantial adverse effect on his ability to carry out normal day to day activities.

12.19 The condition of anxiety is clearly long term as it has lasted more than 12 months.

Holiday pay

13. The claimant had ticked the ET1 to indicate that he wished to claim holiday pay. No further particulars were provided and the matter was not raised by the claimant at the case management preliminary hearing on 1st February 2017. It was not been referred to in the further and better particulars served on the respondent following the case management order of 1s February 2017.

13.1 There was no explanation why the arears of holiday pay had not been flagged up earlier, but it was now the claimant's wish to amend the particulars of claim to include five days holiday pay. The claimed loss of some £349 had been included in the schedule of loss served on the respondent.

13.2 The respondent objected to the late application to amend the claim to include holiday pay. The respondent did not accept that the box ticked at 8.1 on the ET1 meant that the holiday pay claim had already been pleaded and was therefore not a new head of claim. The respondent submitted that it was far too late to be making the application – it was a new head of claim. Responding to it would incur the respondent in additional management time and cost in obtaining the evidence relating to the holiday pay.

13.3 Reference was made in submissions to Harvey and the analysis set out by Mummery LJ in **Selkent .**

13.4 I have considered the guidance provided in Harvey based on Selkent. This is not a claim which is an entirely factual new allegation changing the basis of the existing claim. It is not the correction of a clerical or typing error, nor is it a substitution or addition of another label for facts already pleaded.

13.5 It is an application to add the factual details to an existing allegation – a claim for holiday pay. Holiday pay is ticked in box 8.1. It is plain to see. The respondent has been on notice of it since the ET1 was served. The respondent was under a duty to pay arrears of holiday pay, if any, on termination of employment. It appears that both parties lost sight of the need for particulars of the claim for holiday pay in the grounds of complaint and grounds of resistance, with the focus of both parties being solely on the lengthy disability issues. This was an error at the very least on the part of the claimant's solicitors.

13.6 An application should not be refused because it has been made late. There are no time limits in the Tribunal rules for the making of amendments. They can be made at any time. Delay in making the application invokes the exercise of the Tribunal's discretion having regard to the guidance given by higher authorities on the exercise of that discretion. A paramount consideration is the relative injustice and hardship involved in refusing or granting the requested amendment.

13.7 I find that this is an application to add further detail to a head of claim already indicated in the ET1. The cost and inconvenience to the respondent is

minimal in providing a copy of the claimant's computerised holiday and salary record which will be a definitive response to whether the claimant is or is not owed holiday pay arrears. Considering the balance of injustice to the parties, I find that a refusal of the application to add the particulars of five days holiday pay would be unreasonably harsh on the claimant and, if it is owed, a windfall albeit a very small one, to the respondent. The amendment to include holiday pay particulars is allowed.

Signed by _____ on 26th July 2017

Employment Judge Coaster

Judgment sent to Parties on

27 July 2017

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