EMPLOYMENT TRIBUNALS

Claimant: Mr Jonathan McEvoy

Respondent: Survitec Group Limited

HELD AT: Liverpool **ON:** 18 July 2017

BEFORE: Employment Judge Robinson
(sitting alone)

REPRESENTATION:

Claimant: Miss L Knowles, Solicitor
Respondent: Mr P Wilson, Counsel

JUDGMENT ON PRELIMINARY HEARING

The judgment of the Tribunal is that the claimant is disabled within the meaning of section 6 of the Equality Act 2010 and can proceed to the final hearing which has already been arranged for 25, 26 and 27 September 2017.

REASONS

The Issues

1. The only issue for the Tribunal was whether the claimant was disabled within the meaning of section 6 of the Equality Act 2010.

2. I heard evidence from Mr McEvoy and his wife and submissions from both Miss Knowles and Mr Wilson.

3. I find that the claimant was disabled because of depression and stress and in coming to my conclusion I dealt with the facts of this case using the following principles: that a claimant is disabled if they have a physical or mental impairment that has a substantial and long-term adverse effect on the claimant's ability to carry out normal day-to-day activities.

4. Mr Wilson on behalf of the respondent helpfully confirmed that the respondent accepted that the claimant had a mental impairment and it was permanent and/or recurring, but the question was whether it had a substantial and long-term adverse effect on the claimant's ability to carry out normal day-to-day activities.

5. The definition of the word “substantial” is that it has an adverse effect which is more than minor or trivial.

6. “Long-term” means that it has lasted for at least 12 months, is likely to last for at least 12 months or is likely to last for the rest of the life of the claimant.

7. If an impairment ceases to have a substantial adverse effect on a person’s ability to carry out normal day-to-day activities it is treated as continuing to have that effect if that effect is likely to recur, and an impairment is treated as having a substantial adverse effect on the person’s ability to carry out normal day-to-day activities if measures are being taken to treat or correct it and but for that treatment it would be likely to have that effect.

8. I have considered the principles set out in the well-known case of **Goodwin v Patent Office [1999]** in that four different questions needed to be asked, namely:-

(1) Did the claimant have a mental or physical impairment?

(2) Did the impairment affect the claimant's ability to carry out normal day-to-day activities?

(3) Was the adverse condition substantial?

(4) Was the adverse condition long-term?

9. I must deal with these questions on a sequential basis and not altogether.

The Facts

The facts of this case are as follows:

10. The claimant worked for the respondent from April 2014 until his employment was terminated on 24 March 2016.

11. In April 2014 Mr McEvoy attended a pre-employment health assessment and left that appointment prior to the end of it. The respondent was advised that Mr McEvoy was suffering from a longstanding health issue and was receiving treatment but did not disclose the condition.

12. The claimant first became seriously depressed prior to August 2005 but in 2005 had what he considers to be a nervous breakdown. Dr Bradbury, who is the Consultant Psychiatrist who prepared a joint report for this hearing, is of the opinion that the claimant does suffer a mental impairment, a recurrent depressive disorder, ICD 10 code F33.

13. The claimant has taken citalopram over a number of years and has a repeat prescription. Sometimes he does not take his medicine. The dosage originally was only 10mg but has been raised over the years to 40mg daily with medication reviews as and when requested by his GP.

14. The claimant has tried sertraline as an alternative for a short period of time but that was ineffective, and he went back on citalopram. The claimant has had counselling, in particular in 2006 and 2007, and also Cognitive Behavioural Therapy

in 2009 or 2010. The claimant was not sure when that was. That was through his GP who put the claimant in touch with a charity called Wirral Mind. In 2011 the claimant completed an eight week session of CBT on the computer programme called "Beating the Blues".

15. In the claimant's section 6 impact statement he says that he experiences a lack of interest or enthusiasm in the following ways:-

(1) Making any form of contact with people, for example having conversations, using public transport and meeting with groups of people.

(2) Waking from sleep to get washed, dressed, cook and eat.

(3) Leaving the home to go out to the shops or work.

(4) Taking part in normal social interaction with friends and family.

(5) Spending time maintaining loving relationships with my wife and children.

(6) Reading, writing and watching TV.

(7) Fulfilling work commitments, paying household bills and doing the housework.

(8) Fulfilling hobbies, including cycling and swimming.

(9) Reasoning, concentrating and understanding.

(10) Adapting to minor changes in routine.

16. When he does not take his medication regularly he experiences an inability for self care, including washing, dressing and eating. He needs constant stimulation and encouragement from his wife to carry out those basic functions and he is sometimes unwilling and unable to leave home, wanting to sleep for unusual periods of time.

17. The claimant also suffers from the following symptoms and moods: sadness, hopelessness, worthlessness, anxiety, nausea, irritability and anger, mood swings, heart palpitations, sweating, catastrophising and paranoia.

18. The lead up to the claimant's dismissal on 24 March 2016 is not something that I need to dwell on in this judgment, but prior to that dismissal the claimant had been sent by the respondent to an Occupational Health expert. He saw that physician on 8 March 2016. That report suggested that it would be prudent for the respondent to consider that the claimant came under the disability provisions of the Equality Act 2010. The recommendation made by the Occupational Health physician was that there should be a short phased return to work.

19. The relevant medical history is as follows. In 2005 the claimant was under pressure both with regard to a new job he had just taken up, the family were building an extension to their home and there were two young children both under five years of age at the time. The claimant started to smash up the patio outside with a sledgehammer and was taken to A & E and during that time he was withdrawn, aggressive and difficult to live with for some weeks. His sleep was poor and he did

not want to get out of bed. His appetite was also poor and his mood was negative. That 2005 episode seems to have been a watershed in relation to Mr McEvoy's health and since then, as his wife has put it, he is a changed person.

20. Dr Bradbury went through a full history with the claimant and also after meeting the claimant obtained the GP notes and in her report has dealt with many of the entries in the report and given her view. She noted in her report that on 22 February 2016 the GP referred the claimant to psychology/counselling [sic] in the following terms:-

> "Has a long history of depression and various mental health troubles…He does have periodical social difficulties that have led him to experience problems at work…He fails to pick up social cues in a situation and also has trouble empathising, which has given him some relationship problems with his wife…He has been on citalopram for a considerable period of time because of depression and he is now on a higher dose, 40mg daily. He is coping ok but wishes to have some psychological therapy to look at the issues above and see if he can be helped with some of this and maybe throw some more light on whether he does indeed have autistic spectrum disorder…I have explained that possibly some of this is his personality rather than it actually being a condition that we could give him a label for and he accepts and understands this…"

21. The conclusion of Dr Bradbury, having spoken to Mr and Mrs McEvoy at their home, was that the claimant suffered from a depressive episode that was of moderate severity in 2005, but following that his mood has fluctuated dependant on life circumstances. Dr Bradbury goes on to say that in her experience patients can continue to function at work when their depressive symptoms are mild but the majority would need time off work once their symptoms become of moderate severity, thus "I have concluded that at all other times, any depressive symptoms/episodes have had a mild effect on his ability to function on a day-to-day basis".

22. Dr Bradbury also went on to say that in her opinion there were also personality factors that were important which made the claimant vulnerable to depressive episodes including poor self esteem, poor emotional intelligence and interpersonal skills leading to angry outbursts as described in he report.

23. It is at that point in her report that she pins down the mental impairment as a recurrent depressive disorder ICD 10 code F33 which she says "by definition is a condition with a fluctuating course".

24. Dr Bradbury concludes that the claimant has suffered from such an impairment since approximately 2005 and his symptoms are low mood, sleep abnormality, self neglect, poor motivation, energy and interest with attendant negative cognitions, anxiety and social withdrawal.

25. Dr Bradbury makes the point that there is a danger in psychiatry that a psychiatric disorder can be inferred simply from the presence of emotional distress or unusual behaviour. She goes on to say:

> "This is a mistake both from a medico-legal and from a straightforward clinical perspective. In order to define some sensible boundaries between

understandable distress on the one hand and clinical significance on the other it is usual to look for evidence of the following when trying to gauge the clinical significance or not of presenting psychiatric symptoms."

26. The three issues she then suggests are needed to be looked at are:-

(1) Evidence of complaint being documented in the medical records by a health professional.

(2) Treatment intervention being considered necessary on clinical grounds.

(3) Evidence of impairment in social or occupational functioning.

27. Dr Bradbury suggests that the evidence of impairment and social or occupational function is historical as at the time she met Mr McEvoy he was considered to be well and functioning. She confirmed that the history she received was consistent with the identification of a mental impairment and she goes on to say that:

"Apart from finding him on examination to be someone who clearly has significant emotional problems as described in my answer to (a), there was no current evidence of active depressive illness."

28. Dr Bradbury therefore had to rely on the GP's records and Mr McEvoy's impact statement. She compared the records to those symptoms that Mr McEvoy was complaining of in his stsatement, including low mood, poor sleep, self neglect, poor motivation, energy and interest with attendant negative cognitions, anxiety and social withdrawal which the claimant reported prevented him from performing even the simplest of tasks of self care, from participating in any family relationships from any household tasks and from going to work.

29. Dr Bradbury accepted that that was corroborated to the extent that his GP records confirmed that for a short period in 2005, and she goes on to say that the evidence would imply that even at its worst during the period when Mr McEvoy was off sick as a result of depression he was still able to fulfil the majority of day-to-day tasks. She then suggests that because of the conflict in evidence between GP records and what Mr McEvoy was saying it was for the Tribunal to decide "which is the more accurate portrayal of Mr McEvoy's inability to carry out day-to-day tasks as a result of his mental impairment". She also commented that it would be highly unusual for someone to be able to function adequately for any length of time at work but not at home.

30. Dr Bradbury however confirms that should the Tribunal accept that the claimant's impairment when active and without medication impacts on his day-to-day activities as described by Mr McEvoy at interview and from his impact statement then in her opinion the impairment was at least of moderate severity. She confirms later on in her report that without antidepressants for Mr McEvoy's illness that he quickly relapses into a depressive illness that significantly affects his ability to carry out normal day-to-day activities. The caveat on that comment by her is the phrase that she inserts in that commentary "by his evidence".

31. Dr Bradbury's analysis at the end of her report is this:

> "Mr McEvoy has a recurrent condition, albeit there is little evidence to suggest that any one episode, where the effects have been substantial, lasted more than 12 months. He has had this condition since 2005 and it was certainly present during the relevant period, albeit in remission as a result of regular medication and a period of relative stable [sic] in his circumstances."

32. Outside of the report by Dr Bradbury the claimant has on a number of occasions been assessed and given what is known as a PHQ9 score. Any score of 20 and above is deemed to be severe. On 12 March 2009 the claimant's score was 21 and on 1 April 2011 his score was 22. This questionnaire is apparently used as a screening tool to monitor the severity of depression.

Conclusion

33. Applying the principles I set out at the head of this judgment to those facts I concluded that Dr Bradbury's report was of some help to me but did not answer all the questions I needed to answer with regard to this legal issue. I accepted that her report suggests some scepticism because of the disparity between his medical records and the claimant's own account of his symptoms. I noted in particular the doctor's comment that it was highly unusual for someone to be able to function at work but not at home. But ultimately she recognised the claimant had a mental impairment and was on drugs to counter the effects of that impairment. The issue for me therefore came down to the effect on day to day activities and what I made of the claimant and his wife's evidence in that regard. Dr Bradbury uses the word "mild" to describe the effect on the condition the claimant has on his day to day activities (paragraph 30). However I noted the claimant's PHQ9 score (paragraph 32) and his and his wife's testimony regarding the effect on his day to day activities and how the drug he takes ameliorates the position.

34. I came to the conclusion that both Mr and Mrs McEvoy were honest historians.

35. The issues leading up to the incident in 2005 and the incident itself has had a profound effect both on Mr McEvoy and on his family, and Mr McEvoy to put it bluntly has not been a well man since.

36. I accepted the claimant's evidence that he has been taking citalopram virtually all the time since 2005 save for a short period using sertraline, but that he on occasions has tried to stop taking medication. I accept that I was not able to pinpoint exactly how long a period of time that Mr McEvoy was not on some medication. When he said he was off it for a short period of time that could mean two or three weeks or two or three months. I concluded from the evidence of both him and his wife that when he came off medication his depressive illness took hold once more. His symptoms were then noteworthy, and at that point his wife would persuade him to go back onto the medication.

37. I also accept that the claimant has had Cognitive Behavioural Therapy and that he has seen his GP on a regular basis, although not all the time, about his depression.

38. I also accept Mr McEvoy's evidence that he did not always go to see his doctor when things got too much for him. His own personality often did not allow him

to feel comfortable opening up to the medical professionals. It was only when things became particularly bad that his wife was able to persuade him to go and see his doctor.

39. Therefore I do not see any difficulty in understanding why there were gaps in the medical records where the claimant did not see his GP nor in the divergence between what the GP was saying about the claimant and what Mr McEvoy says about his condition.

40. I also believe the support of his wife has been a real positive for Mr McEvoy in the last 10-12 years or so.

41. I find that without the medication the claimant would be in danger of a relapse towards a serious depressive illness. I have considered the guidance on the definition of disability and in particular B4, the cumulative effects of an impairment, B12 and what follows the effects of treatment, and C5 recurring and fluctuating effects.

42. I considered in particular B12 which says:

> "The Act provides that where an impairment is subject to treatment or correction the impairment is to be treated as having a substantial adverse effect if but for the treatment or correction the impairment is likely to have that effect."

43. In this context the word "likely" should be interpreted as meaning "could well happen".

44. Medical treatment in this context also includes counselling therapies and treatment with drugs.

45. Overall I concluded that the claimant was disabled within the meaning of section 6 of the Equality Act 2010 in that he has a recurrent depressive disorder as found by Dr Bradbury. The 2005 episode was serious. The claimant has been on drugs to counter the effects of depression and stress upon him. If he comes off those drugs he is likely to have a serious relapse and the claimant would not be able to carry out a range of day to day activities. With the support of his wife he copes but she knows he needs either, at those points, to get to see his GP or go back immediately to take drugs or both. Without his citalopram the claimant would find his ability to carry out day to day activities substantially adversely effected and consequently he can proceed with his claim.

04-08-17

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Employment Judge Robinson

JUDGMENT AND REASONS SENT TO THE PARTIES ON

7 August 2017

FOR THE TRIBUNAL OFFICE