EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: S/4104573/2018

Preliminary Hearing Held at Edinburgh on 4 December 2018

Employment Judge: I McFatridge (sitting alone)

Mrs D Peoples	**Claimant** **Represented by:** **Mr Bain** **Lay representative**
HMRC	**Respondents** **Represented by:** **Ms Moscardini** **Solicitor**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The judgment of the Tribunal following a preliminary hearing is that at the relevant time the claimant was disabled in terms of s6 of the Equality Act 2010.

REASONS

1. The claimant submitted an ET1 in which she claimed she had been unfairly constructively dismissed by the respondents and that they had unlawfully discriminated against her on grounds of disability. The claimant claimed to be disabled on account of suffering from benign positional vertigo. The

respondents submitted a response in which they denied the claims. They did not accept that the claimant had been dismissed. In any event, it was their position that the claimant did not have sufficient qualifying service to bring a claim of unfair constructive dismissal. The claimant subsequently accepted this and withdrew her claim of unfair constructive dismissal. The respondents denied discrimination. They did not accept that the claimant was disabled. A Preliminary Hearing was fixed in order to determine as a preliminary point whether or not the claimant was disabled in terms of the Equality Act. At the Preliminary Hearing evidence was led on behalf of the claimant from Dr Stephen Brown the claimant's GP. The claimant gave evidence on her own behalf. A small bundle of documents was lodged on the morning of the hearing by the respondents. On the basis of the evidence and the productions I found the following essential matters relevant to the issue of disability to be proved or agreed.

Findings in Fact

2. Around 22 years ago, when the claimant was 21 or 22 she had a series of episodes where she suffered from vertigo. She became nauseous and dizzy and had headaches. She went to her GP who referred her to an ear, nose and throat specialist. Following this consultation, the claimant was diagnosed as suffering from benign positional vertigo. This is a chronic condition for which there is currently no cure. The sufferer will experience headaches and feel dizzy and nauseous in relation to head movement.

3. Since then the claimant has been aware that if she does certain things then she will start getting symptoms of vertigo.

4. Triggers for the onset of symptoms are various. If the claimant moves her head suddenly or moves her head up and down then this can trigger a feeling which the claimant is now aware can lead her to get a headache, nausea or dizziness. Generally speaking the claimant has been able to manage this by stopping doing whatever it was that was causing the symptoms. The claimant

will generally try to avoid or minimise actions which lead her to suffer symptoms. The claimant has got to recognise these symptoms over the years and was usually able to stop before the symptoms reached the stage where they caused her difficulty.

5. The claimant will avoid fairground rides which she used to like. The claimant was previously keen on motorbikes but gave this up. When she recently tried to sit on a moped she found that she was unable to do this for more than a few minutes even when it was stationery. The claimant avoids going up ladders even if they are only one or two steps. She does not clean windows or take down or put up curtains or do anything which is above her head. When going upstairs the claimant is aware that if she forgets something and then turns round when she is halfway up then this will lead to the onset of symptoms. As a result the claimant will often find herself going upstairs and then halfway up remembering something she has forgotten but still continue up to the top of the stairs, gives herself a minute or two to settle and then turns round and goes back down the stairs again.

6. The claimant always knew that she was a poor traveller and she finds travelling on an aeroplane difficult. If she goes on holiday by plane she will usually feel unwell for one or two days after each flight. When driving the claimant will try to keep to roads which are flat and do not have too many bends. When using a computer the claimant will try to avoid scrolling too much as she finds that this can bring on her symptoms. She cannot sit on a swing or a rocking or swivel chair without risking it bringing on symptoms. The claimant also has difficulty if she lies down on her right hand side or if she tries to sit talking to people who are on her right. The claimant becomes seasick on any sort of boat journey and struggles to waltz on the dancefloor or do any sort of dance that requires repeated turns. The claimant finds difficulty doing work above her head. For this reason, when she and her husband do redecorating, she will not paint ceilings. Recently she found it difficult to paint the underside of a kitchen unit as this involved her working above her head. The claimant finds supermarkets challenging as it is difficult

for her to scan shelves on either side of her without this leading to a feeling to her symptoms coming on. For this reason, the claimant will usually avoid going to large supermarkets altogether or if she does, only go up one aisle. She usually arranges for her husband to do the shopping. When shopping online the claimant will try to avoid scrolling on the computer as this also leads to an onset of symptoms. She finds difficulty wearing earphones. Generally speaking, the claimant organises her life so as to avoid any situation where she has to move her head suddenly or do anything else which might lead to vertigo. This can include such things as tracking moving objects with her eyes since eye movement can lead to vertigo symptoms.

7. Over the years from diagnosis until 2017 the claimant's vertigo did not cause her any absences from work. The claimant had a very good work record with minimal absences. None of these were related to her vertigo. Although she was not absent from work the Claimant continued to suffer from her impairment and the severity of her symptoms varied from time to time. On many occasions she would find herself suffering to the extent that she could do nothing other than lie down and keep her head as still as possible. Usually she did not require to attend her GP as a result of these flare ups but occasionally she did. On these occasions she would be prescribed medication which she would take for a time until the symptoms abated. The claimant saw herself as a fairly stoic person who wanted to get on with her life and would not let her symptoms get in the way of her leading her life. She developed the skill of recognising the onset of symptoms at an early stage and discontinuing whatever she thought might be causing the symptoms until they went away. She would often attend work whilst suffering from these early stage symptoms and sometimes when she came home she would have to immediately lie down for a while in order to ameliorate them. The claimant has been with her current GP, Dr Brown, for 12 years and during that period she did not consult him at all about her vertigo until 2017.

8. One of the recognised features of benign positional vertigo is that if a patient is exposed to external stimuli which bring on symptoms then this can result

in a flare up of the condition that will continue for some considerable time even after the stimuli has been removed. During such a flare up the sufferer is completely disabled and requires to keep their head absolutely still in order to avoid blinding headaches, nausea and dizziness. Usually the patient will be unable to do anything apart from lie in a darkened room remaining as still as possible until the flare up goes away. On occasions a sufferer will not be able to move other than by crawling along the floor as this is the only way they can keep their head sufficiently still.

9. The medical advice from DVLA is that persons who suffer from the claimant's impairment are not permitted to drive Heavy Goods Vehicles or public service vehicles. They are permitted to drive private cars unless they are actually suffering from a bout of dizziness. They are forbidden to drive at all if they are suffering from symptoms of dizziness.

10. The condition can be treated by drugs and or exercise. The effectiveness of these treatments is variable. Sometimes they work, sometimes they do not.

11. The claimant commenced employment with the respondents in or about July 2016. By December 2016/January 2017 the claimant began to notice that her symptoms of vertigo were appearing more often. She felt this might be attributed to her working environment. The claimant required to use two screens. This caused her to require to move her eyes between one and the other and this caused her to get symptoms which she recognised as potentially leading on to an attack of vertigo. She also required to sit on a swivel chair. She also required to use headphones. The claimant was aware that wearing headphones is something which is difficult for people with her condition as the earphones can change the pressure on the ears which are extremely sensitive to this. The claimant went to see her GP. As had happened previously the claimant was prescribed drugs to take for her vertigo. One of these was an anti-vertigo drug (Beta-histine) the other was an anti-emetic (Cinarazin).

12. A few days later the claimant suffered a sudden flare up of her vertigo symptoms whilst driving home from work. She required to stop the car several times. When she got home she experienced severe symptoms of headache, nausea and dizziness. She required to lie still in bed in a darkened room. She was unable to do anything for two days.

13. In accordance with the respondents' absence management policy the claimant was contacted on each of the two days of her absence by her manager. Her manager completed keeping in touch notes recording this conversation which were lodged (pages 26, 27). He noted that this was the claimant's first absence since she had started with R 11 months previously.

14. The claimant returned to work after two days' absence and a return to work meeting took place with her manager. This lasted around five minutes. The claimant's manager completed a return to work form on 7 June which was lodged (pages 28-29). The claimant noted that it was over five years since her last episode. She said that normally an episode was over quite quickly but on this instance it had lasted several days. The claimant confirmed she had another appointment with her doctor. It was agreed that the respondents' manager would make a referral to the respondents' Occupational Health service.

15. The claimant had a telephone assessment with an Occupational Health nurse on 12 June. Following this the respondents' Occupational Health providers sent a report to the respondents. This was lodged (page 30-31). Essentially they stated that they had commenced the process of writing to her GP for further information and that on receipt of this report the claimant would have a further Occupational Health telephone assessment. The Occupational Health report notes at page 30

> "Following this most recent flare up she acknowledges some improvements in her symptoms with prescribed medication. To date however this has not fully resolved her symptoms, she reports ongoing

symptoms of being lightheaded and dizzy and limits head movements to prevent flare up of symptoms."

16. The claimant's GP duly provided a report to the respondents' Occupational Health providers and following a subsequent telephone conversation with the claimant they submitted a further report to the respondents on 18 July 2017. This was lodged (pages 32-33). Under current health situation it was noted

"Further medical evidence was requested from my colleague and this has been received. The GP report confirms that (the claimant) was reviewed by ENT several years ago for symptoms of vertigo all investigations carried out at that time showed no abnormality and she was provided with advice on how best to manage her symptoms. (The claimant) has experienced acute episodes of symptoms since then which were self-managed. She reports increasing symptoms of vertigo including dizziness/balance issues amongst other symptoms over the past few weeks. She has re-attended her GP and been prescribed medication aimed at alleviating her symptoms and I have advised her to re-attend her GP to discuss further specialist review. She reports that symptoms are aggravated by excessive head/eye movement and stress. She reports increased stress at present triggered by personal and work related issues. …."

17. The claimant was off again at the end of July for five days. The claimant woke up during the night with migraine like symptoms. She considered that she might also have some kind of viral infection however she experienced all of the symptoms of vertigo. She had headaches and was nauseous and dizzy. Once again she was unable to do anything apart from lie down and try to keep her head as still as possible.

18. The claimant returned to work. Her GP referred her back to an ENT specialist and she had an appointment with them in or about October. They gave her an A4 sheet detailing various exercises which she could carry out in order to

alleviate her symptoms. Generally the exercises involved placing one's head deliberately in a situation which one knows will induce vertigo with a view to desensitising oneself. The exercises are unpleasant to carry out and the claimant has difficulty doing this. The claimant continued to take the medication which she had been prescribed by her GP. In addition the claimant found that she suffered from ongoing headaches and took Paracetamol for this.

19. At around the beginning of December the claimant realised that she had been having headaches more or less constantly for a period of time since June and decided to keep a record of the symptoms simply to see whether they were in fact continuous. The claimant found that they were. The claimant was expecting to get invited to another Occupational Health consultation following her referral to ENT but this never happened.

20. The claimant was again absent from work in January 2018. The reason for her absence was that the claimant caught a viral infection (described by her as "a bug") that was going around and affected a very large number of people in the respondents' organisation including a number of the colleagues with whom she worked closely. The claimant was off for two days. The claimant's position was that the reason for this absence was primarily the "bug" but that it also led to an exacerbation of her symptoms.

21. The claimant resigned her employment on 2 February 2018.

22. The claimant has now commenced other employment. This employment does not involve her looking at dual screens, sitting on a swivel chair or using headphones. It is also employment where she is able to self-manage to the extent that if she feels that a particular task is likely to lead to difficulties with her vertigo she can stop doing it for a time. Following this the claimant has not had any significant flare ups. She is still aware that she requires to take care to avoid situations which might lead to her suffering vertigo. She still

avoids all of the things which she has avoided for the last 20 years. She has discontinued using the drugs and has not required to go back to her GP.

Observations on the Evidence

23. I accepted that the claimant and Dr Brown were both honest witnesses who were trying to assist the Tribunal as best they could. The claimant's medical notes had not been lodged nor had a copy of the letter which Dr Brown had sent to the respondents' Occupational Health providers in July. For this reason, Dr Brown's evidence was based on his recollection. He was able to give clear evidence as to the general nature of the claimant's condition but was unable to give particularly precise evidence in relation to detail of how the claimant was affected. I entirely accepted his evidence that during a period of flare up a sufferer of this illness is completely incapacitated. I also accepted his evidence that the drugs can help in some cases but not in others. For this reason I did not feel this was a case where I could make a finding that but for the drugs the claimant's condition would be worse. I also accepted his evidence that in his view the dual screens were a particularly likely reason for the claimant's symptoms becoming exacerbated. There was a concern that this particular item does not appear to have been mentioned by the Occupational Health providers. I entirely accepted the Claimant's evidence regarding the things which she tries to avoid in her life in order to avoid the onset of a flare up in her symptoms. I accepted that she was in no way trying to exaggerate her symptoms. I also accepted that for much of the time she has been able to manage her lifestyle so as to minimise the number of flare ups which occurred but that when they have occurred they have been completely incapacitating. Her detailed evidence regarding the effect of her impairment on herself was entirely consistent with the more general evidence given by Dr Brown regarding the usual symptoms of this condition.

Issues

24. The sole issue which I was required to determine was whether or not the claimant was a disabled person in terms of Section 6 of the Equality Act. At one point the respondents' representative raised the issue of knowledge of disability but it was clear to me that this was a matter which was outwith the scope of the Preliminary Hearing which had been fixed. The Preliminary Hearing was solely to determine the issue of whether or not the claimant was disabled.

Discussion and Decision

25. Both parties made submissions and rather than repeat these I will refer to them where appropriate below.

26. The definition of disability is contained in Section 6 of the Equality Act 2010. This states:

> (1) A person (P) has a disability if –
>
> (a) P has a physical or mental impairment, and
>
> (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities."

27. The burden of proof is on the claimant to demonstrate that she was disabled at the relevant time. Assistance is given to Tribunals in determining the question of whether or not a person is disabled by schedule 1 of the equality act and also by published guidance on matters to be taken into account in determining questions relating to the definition of disability. The current version of this is dated April 2012 and was brought into force by the Equality Act 2010 (Guidance on the Definition of Disability) Appointed Day Order 2011 (SI 2011/1159).

28. With regard to the issue of long term the Act states that for the purpose of deciding whether a person is disabled the long term effect of an impairment is one which has lasted at least 12 months or where the total period for which it lasts from the time of the first onset is likely to be at least 12 months or which is likely to last for the rest of the life of the person affected. In terms of Section 2(2) of Schedule 1 of the Act if an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day-to-day activity it is as to be treated as continuing to have that effect if that effect is likely to recur. In the present case the claimant's condition is one which fluctuates. There are special provisions at section C5-C11 of the guidance which are relevant in deciding whether the claimant's condition is long term.

29. Section C6 of the guidance provides as an example a person with arthritis where the person experiences substantial adverse effects for a few weeks after the first occurrence and then has a period of remission. If the substantial adverse effects are likely to recur then they would likely be regarded as long term.

30. It appears to me that the claimant's situation is analogous to this and that the effects of her condition were found to have a substantial effect on her ability to carry out day-to-day activities then they would be regarded as long term.

31. Both parties in their submissions concentrated on the question as to whether or not the effect of the claimant's impairment on her day-to-day activities was indeed substantial.

32. In this case the claimant has a recognised diagnosis. Although Dr Brown's evidence was somewhat unspecific as regards to the effects on the claimant I considered his evidence was useful in showing the type of effects which are typical for this condition. I accepted his evidence that during a flare up someone suffering from this condition is almost completely incapacitated. His evidence was that sometimes the only way that person can move without risking moving their head in such a way as to cause nausea is to literally crawl

along the floor. Dr Brown was not able to say that the claimant was in this situation but in any event all he could have done was repeat what the claimant had told him. The claimant's own evidence however was that during periods of flare up then this was exactly how she was.

33. Much of the claimant's evidence was fairly unhelpful to her in that I did not consider the fact that she no longer rides a motorbike or goes on fairground rides or is able to paint ceilings to be indicative of an inability to carry out normal day-to-day activities. If these were the sole effects of her impairment then she would not be regarded as disabled.

34. My take on the claimant's evidence however was that she suffers from a condition which is long term in that it is likely to recur. Much of the time the symptoms are minor and can be controlled by avoiding situations which are likely to exacerbate them. Some of the control measures do impinge onto areas which are normal day-to-day activities such as shopping but during the periods when the claimant is not having a flare up the effect is fairly minimal. It appears to me that the claimant's situation is very much akin to that of a person who suffers from migraines. Much of the time they will be able to carry on perfectly normally. Over time as they get to know their condition they will start to recognise things which are likely to trigger an attack and they will avoid them by for example not eating trigger foods such as cheese. They are not rendered disabled by the fact that they avoid eating cheese. On the other hand what may render them disabled is the fact that from time to time they will suffer a period of complete incapacity where they are unable to carry out any day-to-day activities because all they can do is lie at home in bed in a darkened room. It is also similar to the example of someone suffering from Menieres disease mentioned in section C7 of the guidance. For much of the time the effect of the claimant's impairment may not meet the threshold of being substantial however from time to time she will have flare ups which most definitely do meet the threshold of having a substantial adverse effect on her ability to carry out day-to-day activities. I considered on the basis of the evidence that that is the case here.

35. I accepted the claimant's evidence that when she does have an attack she is unable to do anything. There is a total inability to carry out day-to-day activities. This is a substantial adverse effect. It also appeared to me to be absolutely clear that this is something which is likely to recur and given that the claimant has had the condition for over 20 years I considered it to be established that in terms of the Act the substantial adverse effect was long term.

36. In addition to those periods of incapacity I had no doubt that in her everyday life the claimant is conscious of her impairment and takes active steps to avoid the unpleasant consequences which occur when she has a flare up. During these 'non flare up' periods the effects of her impairment on her ability to carry out day-to-day activities may vary from things which are a genuine difficulty and could be considered substantial adverse effects to some which are much more trivial. In my view however that is not the important point. The important point is that the claimant from time to time will suffer from periods of complete incapacity and on the basis of the evidence this is something which is likely to recur. In my view the claimant has met the burden of proof on her in this case and has established that she is disabled in terms of the Equality Act.

Case Management

37. The parties were agreed that in the event that I found that the claimant was disabled then a further Preliminary Hearing would require to take place in order to discuss case management. This should be scheduled as soon as possible.

Anonymisation

38. Although the matter was not raised by either party I considered that since this judgment involves discussion of sensitive medical topics it would be

appropriate for the names of the parties to be anonymised. The claimant shall be referred to as C and the respondents as R.

Employment Judge: McFatridge
Judgment Date: 06 December 2018
Entered into the Register: 11 December 2018
And Copied to Parties