THE EMPLOYMENT TRIBUNALS

Claimant **Respondent**

Mrs K Kalia **v** **Crowe UK LLP**

Heard at: London Central **On**: 20 November & 13 December 2018

Before: Employment Judge H Clark

Representation:
Claimant: In Person on 20 November and assisted by Ms Lord from ELIPS on 13 December 2018.
Respondent: Ms A Carse - Counsel

JUDGMENT FOLLOWING OPEN PRELIMINARY HEARING

The judgment of the Tribunal is that prior to 18 October 2017 the Claimant suffered from the following disabilities:

1) **Fibromyalgia with effect from March 2015.**

2) **Vitamin B12 deficiency/pernicious anaemia with effect from the start of her employment in September 2014.**

3) **TMD with effect from April 2016.**

4) **Sciatica with effect from December 2015.**

REASONS

1 By a Claim Form presented on 3 April 2018 various claims of disability discrimination were made against the Respondent. These were all denied in a Response Form dated 9 July 2018. In light of the agreed list of issues, the most recent allegation of disability discrimination is dated 17 October 2017 (requiring the Claimant to attend the office for long hours from July 2015 to October 2017). The Claimant has been absent from work on sick leave since 18 October 2017.

2 This hearing was listed to deal consider, as a preliminary issue, whether the appellant suffered from 9 different disabilities (identified at a case management hearing on 21 September 2018) and further, as to the Respondent's state of knowledge of those disabilities. Following the provision of medical evidence, on 5 October 2018, the Respondent conceded that fibromyalgia did constitute a disability for the purposes of the Equality Act 2010 at the material time. The Respondent asserted that the remaining alleged disabilities could be dealt with at the full merits hearing, but set out its position on each one and that the preliminary hearing was not necessary. The Claimant objected to any postponement of the preliminary hearing. The Respondent wrote to the Tribunal on the 19 November explaining that the Claimant had served an additional bundle on them that day and repeated the application for a postponement. Regional Employment Judge Potter refused the Respondent's application to postpone the preliminary hearing on 19 November 2018.

3 At the outset of the hearing, the Respondent made it clear that there would be insufficient time for the Tribunal to deal with all the matters listed and that it was in evidential difficulty due to the late service of additional documents by the Claimant. No case management orders had been made in relation to the preparations for the preliminary hearing, so there was no witness statement from the Claimant specifically addressing the impact her claimed disabilities had on her life. The Claimant explained that some of documents in her additional bundle had already been disclosed and the remainder were just printouts from the internet about some of the medical conditions from which she suffers.

4 The Claimant had provided a written witness statement running to 50 pages for the Case Management Preliminary Hearing. That statement dealt with matters which were relevant to the issues in the full merits hearing as well as the preliminary issue. Ms Carse accepted that she had notice of the

contents of this witness statement and would be in a position to cross-examine on the Claimant's disabled status, but not the respondent's knowledge of her asserted disabilities. The latter would be more manageably dealt with at the full merits hearing, when all the Respondent's witnesses were available and the number of potential disabilities had been clarified. The Claimant invited the Tribunal to deal with both issues. Given the breadth of the issues, including the number of asserted disabilities, there seemed no realistic prospect of fairly determining both disabled status and the respondent's knowledge in relation to each disability in the time allocated, accordingly the Tribunal considered the former only. The question of the Respondent's knowledge of disabilities will be left to the full merits hearing.

5 A discussion was held with the Claimant as to what adjustments she might need for the preliminary hearing. She confirmed that there were no adjustments required for a one-day hearing, but for the full merits hearing she would need to electronically record the hearing rather than take notes herself. There was further discussion about these adjustments at the adjourned hearing. The Respondent objected to the suggestion that the Claimant should be permitted to record the proceedings herself. It had serious reservations about the data protection implications of the Claimant's having control over a recording. It was explained to the parties that the hearing might, in any event, be recorded by the Tribunal by the time of the full merits hearing. However, if that did not prove to be the case, the Claimant will use voice recognition software in the Tribunal to convert speech to text to enable her to have a record of the proceedings. It is anticipated that she will obtain a microphone in order that all the speech in the hearing can be captured.

6 As there were 9 different disabilities to consider, in consultation with the parties, it was agreed that they would be dealt with separately with evidence being taken and then submissions made on each disability. This would enable all the evidence and submissions to be together in relation to each separate disability, which would make the evidence easier to manage. The parties would also be able to make global submissions at the end of the evidence, if they wished to do so.

7 The disabilities on which the Claimant relies are as follows:

7.1 Pernicious anaemia/Vitamin B12 deficiency from the start of her employment.

7.2 Fibromyalgia from March 2015;

7.3 Dry eyes leading to defective vision from the start of her employment;

7.4 TMD, causing, amongst other things, bad headaches from April 2016;

7.5 Sicca symptoms from March 2015;

7.6 PVD in the left eye from the start of her employment;

7.7 Carpal tunnel syndrome/tendonitis in hands from April 2017;

7.8 Depression from April 2017;

7.9 Sciatica from December 2015;

The Law

8 The law that the Tribunal has to apply is contained in the Equality Act 2010 section 6 which defines a disability as a "*physical or mental impairment,"* which has a "*substantial and long-term adverse effect on [the Claimant's] ability to carry out normal day-to-day activities;"* The burden lies on the Claimant to prove that she is disabled.

9 Schedule 1 of the 2010 Act provides that the effect of an impairment is long-term if

(a) It has lasted for at least 12 months,

(b) It is likely to last for at least 12 months, or

(c) It is likely to last for the rest of the life of the person affected.

2(2) *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 to be treated as continuing to have that effect if that effect is likely to recur*.

The effect of medical treatment is ignored in the assessment of whether an impairment has a substantial effect on the ability of a person to carry out normal day to day activities (section 5 of Schedule 1), albeit the use of spectacles or content lenses is excluded from this provision.

10 Appendix 1 of the Equality and Human Rights Commission Code of Practice on Employment 2011 issued pursuant to the Equality Act 2010 Codes of Practice (Services, Public Functions and Associations, Employment and Equal Pay) Order 2011 SI 2011/857 provides further guidance to assist Tribunals in interpreting the law in this area. The guidance makes clear that physical or mental impairments covers sensory impairments, such as those affecting sight. "*There is no need for a person to establish a medically diagnosed cause for their impairment. What it is important to consider is the effect of the impairment, not the cause."* (paragraph 7). The Tribunal should bear in mind that some people might naturally underplay the effect of their symptoms.

11. The Code further provides that, "*A substantial adverse effect is something which is more than minor or trivial effect. The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people."* (paragraph 8). Account should be taken of where a person avoids doing something because of pain or fatigue or where someone can perform normal day to day activities, but suffer pain or fatigue when doing so. Examples of normal day to day activities are given in the guidance to include, *walking, driving, using public transport, cooking, eating, lifting, carrying everyday objects, typing, writing, going to the toilet, talking, listening to conversations or music, reading, taking part in normal social interaction or forming social relationships, nourishing and caring for one's self."*

Factual Background

12. The Claimant was employed by the Respondent and its predecessor from 1 September 2014 to work in the Employment Advisor Group. She is Association of Tax Technician qualified. The Respondent provides accountancy and tax services to a wide range of private and public sector clients. The Claimant contends that she has been required to work excessive hours by the Respondent and that her line manager has made unsubstantiated allegations against her. This has led to the Claimant's absence for work with anxiety, stress and depression.

13. Following 3 weeks' sick leave in December 2016, the Claimant stated that her fibromyalgia had affected her recovery time. The Respondent commissioned a report from the Claimant's GP, which advised that the Claimant had jaw pain, which contributed to headaches and fibromyalgia (generalised muscular aches and pains).

14. The Respondent later commissioned two Occupational Health Reports. The first was dated 6 June 2016 from Dr Padraic Ryan which noted that the Claimant had been diagnosed with "*pernicious anaemia"* in 2009 and that, "*the*

most recent medical evidence available confirms that she has fibromyalgia, vitamin B deficiency, vitamin D deficiency, and a history of cataract surgery with left vitreous detachment, which is now stable. In addition, she has recent signs and symptoms that might well be related to connective tissue disease, but this is not been confirmed. As no clear underlying medical complaint has been offered to Ms Kalia, who has been placed on symptomatic treatment and her current medication includes mild pain relief, vitamin supplementation and acid reflux reduction. Following a series of investigations in relationship to pain in her neck area, she has recently been assessed by an ENT surgeon, who confirmed that she had temporal mandibular joint disease and requires pain management. Surgical intervention is not advised. In addition to her recent diagnosis of an ENT complaint, she has mechanical back pain that has been assessed by MRI scan on at least three occasions, the most recent being in early 2016, where she was advised that she was a nonsurgical candidate and required regular exercise. I understand that her back pain has significantly improved with enhanced mobility. ….On a day-to-day basis , Ms Kalia has discomfort in her neck and lower back, her sleep pattern is disrupted, and she finds it difficult to work in an open plan office as increased levels of noise are associated with significant headaches." The report concluded that the underlying medical reasons for her attendance record included multiple medical appointments for rheumatological complaints. At the time of the report Dr Ryan considered the Claimant fit to attend work.

15. A letter from the Claimant's GP dated 16 February 2017 to the respondent explained that the Claimant suffered with temporomandibular joint pain (jaw pain) and fibromyalgia. The letter outlines that, "*the symptoms she attributes to her fibromyalgia include swelling of the hands, headaches, anxiety, muscular and joint pain, fatigue and occasionally lack of concentration. She suffers regularly from headaches which affect concentration, especially in a noisy environment, muscular and joint pains slow her down, cause fatigue and contribute toward her headaches. Her temporomandibular joint pains also contribute to headaches and difficulty/pain when twisting the neck and head. According to our records she currently has regular vitamin B12 injections, which otherwise do not usually cause any side effects. She has also had gabapentin for pain in the past and was prescribed omeprazole in December 2016."*

16. On 15 June 2017 a further Occupational Health Report from Dr Kevin Bailey, Consultant Occupational Physician, noted that the Claimant was suffering from fibromyalgia, low vitamin B12 levels and that in the past she had a frozen shoulder, whiplash, low vitamin D and a condition affecting her eyes. "*She experiences fatigue on a daily basis and this may be related not only to her fibromyalgia, but also to the low vitamin B12 levels. Her sleep has been disturbed some time. She develops headaches and a reduction in concentration and an increase in her fatigue when she is exposed to high levels of ambient noise."* Dr Bailey concluded that fibromyalgia and low vitamin B12 were her most dominant

health conditions. He also noted that one of the pain relief medications she was taking was causing her headaches. Dr Bailey recommended a discussion was had about the Claimant's workload, it reported that the Claimant would like more administrative support, including voice activated software, to work from home a further half or one day a week.

17. The Respondent had concerns about the Claimant's performance and, on 16 October 2017, the Claimant was invited to a meeting to discuss two allegations of potential dishonesty. The Claimant's explanation about one of the allegations was accepted by the Respondent, but the other matter remains outstanding. It has not been possible to conclude the disciplinary proceedings in light of the Claimant's absence from work on sick leave since 18 October 2017.

18. The Claimant has been absent from work since 18 October 2017 with variously stress, anxiety and depression. A report from her GP for the Respondent dated 12 December 2017 explained that the claimant had been seen "*on a number of occasions since February this year with regards to low mood and stress caused by her ongoing work-related issues. Overall she has suffered with anxiety for at least a year now. It is impossible to give you a definitive time period for which she will be affected by her medical ailments. They all have a variable timeframe depending on the triggers. For example, her stress/anxiety may well improve once the ongoing employment issues are resolved. Similarly symptoms of TMJ dysfunction and fibromyalgia may also improve once the stress and anxiety are better managed. However typically these conditions can sometimes affect some individuals long-term, with fluctuations in severity. Her fibromyalgia has caused her to suffer with headaches, fatigue, night sweats and musculoskeletal pains, however she manages the symptoms and does not feel that they are the reason for her inability to work currently. Indeed her anxiety, depression and work-related stress are the main reasons for not being able to work, including difficulty with reading and often rereading work, which she says leads to delays and errors as well as response time and quality of work. Her anxiety she says, leads to chest pains and an increased heart rate. She states that she becomes more nervous when she has to work with a particular colleague, which causes her significant stress. Mrs Kalia currently receives sertraline, an antidepressant, from is the only regular prescribed medication. She has also received promethaxine, which aids sleep."*

19. One of the difficulties faced by the Tribunal in determining whether each condition or set of symptoms amounted to a distinct disability as the Claimant suggests, was the nature of the expert evidence. Whilst the Claimant has adduced a plethora of medical evidence in the form of GP notes and correspondence passing between the various health professionals treating her, this evidence (understandably) does not address some of the considerations which are relevant to the Tribunal's assessment of the Claimant's disabled status.

This is particularly so in light of the need to disregard the effects of successful medication in determining whether a particular condition amounts to a disability. Further, in relation to some of the Claimant's conditions, there is an overlap between her symptoms (eg. headaches variously caused by fibromyalgia, jaw pain, as a side effect of pain relief medication and ongoing investigations of an unknown cause (which subsequently seems to have been diagnosed as migraine). Both fibromyalgia and vitamin B12 deficiency are said to cause night sweats. There is very limited medical evidence which relates specifically to the Claimant to assist the Tribunal in determining from what symptoms the Claimant would suffer if her various conditions were not treated – this is particularly the case with B12 deficiency and dry eyes, since both conditions appear to be largely controlled by medication.

20. Given the wide range of conditions from which the Claimant suffers, it would have been difficult to obtain a global medical report, which spans so many different medical disciplines. Providing reports for the Tribunal in relation to each of her conditions would also have been expensive and contributed to the delays in the litigation. The Tribunal and the parties must keep in mind the overriding objective in the Tribunal Rules to deal with issues in a proportionate manner. Establishing disability relies to some extent on medical evidence, but also a Claimant's own evidence as to the effect a condition has on their day to day activities. As the Guidance makes clear, it is the effect rather than the cause of the impairment which is relevant, however, where that effect is challenged by the Respondent, it can assist the Tribunal to understand the medical basis for a claimed set of symptoms.

21. The Respondent has highlighted the fact that the Claimant did not mention some of the conditions which she claims to amount to disabilities in the course of the Occupational Health assessments in 2016 and 2017. Further, the Claimant challenges the contents of those Occupational Health assessments, notwithstanding the fact that she was provided with them in advance of their being given to the Respondent and did not seek to correct them. Included in this is B12 deficiency. I accept as a general proposition that the Claimant is more likely to mention her more serious and in lay terms "disabling" conditions to Occupational Health. Similarly, conditions for which she has not taken time off work are likely also to be having a lower impact on her day to day activities. However, I also take into account that memory fog or forgetting things is a symptom of fibromyalgia and that conditions which are being successfully treated are less likely to be in the forefront of the Claimant's concerns during an Occupational Health assessment.

22. During her long-term absence from work, the Claimant has undergone a number of medical investigations and has been diagnosed with carpal tunnel syndrome, tendinitis and migraine. She is also being treated by a physiotherapist

for upper neck pain with referred neuro pain down both arms, which is suspected to be caused by a C5/C6 disc prolapse. There is no doubt that the Claimant's various health challenges have cumulatively had a substantial adverse effect on her day to day activities, both in terms of her mobility and ability to concentrate on tasks such as reading and writing. The question for this Tribunal is whether some of the Claimant's individual conditions have such an effect as she contends. The Claimant's asserted disabilities are considered in turn:

Fibromyalgia

23. The Respondent accepts that this condition amounts to a disability for the purposes of the Equality Act 2010. The Claimant explained in her Claim Form that this results in night sweats, muscular pains and pains in her bones, swollen hands, headaches which affect her concentration and means she cannot tolerate noise and more generally, memory fog. The latter means that the Claimant is prone to forget names, dates and chronologies. The condition also causes chronic fatigue, chest pains, difficulty in sleeping, numbness and tingling in her hands, arms, feet and legs and irritable bowel syndrome. The Claimant's GP confirmed in his report that fibromyalgia "*causes generalised muscular aches and pains"* and was *a* long-term condition which caused headaches which affect concentration, muscular aches and pains, causes fatigue and contribute toward headaches.

Pernicious Anaemia/B12 deficiency

24. The Claimant explained in her evidence that her diagnosis of "pernicious anaemia" means that she cannot absorb vitamin B12. She has adduced evidence (in the form of her GP records), demonstrating that she was diagnosed with this condition on 19 August 2008. In any event, it is agreed that she informed the Respondent about her vitamin B12 deficiency at the start of her employment in September 2014. The GP's report dated 16 February 2017, confirmed that the Claimant has regular vitamin B12 injections which otherwise "*do not usually cause any side effects".* The medical evidence does not suggest that the Claimant has symptoms arising from her B12 deficiency, but as she has B12 injections every 3 months, it may simply be that this is because the injections supress such symptoms. The symptoms which caused the Claimant to seek the diagnosis, were dizziness and night sweats, which improved after the injections started. However, night sweats are also said to be a symptom of fibromyalgia.

25. In determining whether a vitamin B12 deficiency amounts to a disability, I have to disregard the injections the Claimant receives. There is no medical evidence confirming what symptoms the Claimant would suffer without treatment (and, therefore, what effect it would have on the Claimant's day to day activities). The only evidence there is comes from the Claimant. Given the complexity of the

Claimant's medical conditions and the overlap between symptoms, this is less than satisfactory, given the Claimant is not medically qualified. If the Claimant did not have these injections, she says she would get progressively more tired, breathless, dizzy, tired and would not be able to climb stairs. She says she would die within 2 or 3 years.

26. Although there is no medical evidence specifically addressing the issue, the Claimant has provided evidence from the Pernicious Anaemia Society which lists the common physical symptoms of the condition, which include the following symptoms which the Claimant suggests she has: tiredness/lethargy, waking up tired, shortage of breath, unaccountable sudden diarrhoea, swollen tongue, and feeling "foggy." The Respondent suggests that the Claimant has not been diagnosed with Pernicious Anaemia. However, the leaflet provided explains that, "*pernicious anaemia is not caused by a malfunction of blood but a faulty digestive process that leads to a lack of B12 that results in a problem with red blood cells in a patient's blood. If the gastric panetal cells do not produce the intrinsic factor, then the B12 cannot be absorbed and the red blood cells will not be able to do their job properly*." This explanation is consistent with that given by the Claimant in her evidence and with her regular receipt of vitamin B12 injections. Further, the first Occupational Health Report from Blossoms Health Care dated 6 June 2016 refers to her diagnosis of "pernicious anaemia" in 2009. Were this diagnosis doubtful, I would have expected the author, Dr Ryan, to have queried it in his report. In the circumstances, I am satisfied that the Claimant's vitamin B12 deficiency is liable to cause some of the symptoms listed in the Pernicious Anaemia Society leaflet.

27. The Respondent points to the fact that the Occupational Health letter of 6 June 2016 does not record any symptoms arising from Vitamin B12 deficiency and the Claimant accepts that there is an overlap between the symptoms of fibromyalgia and those of B12 deficiency. As the latter is effectively managed by regular B12 injections, on a day to day basis it is not necessarily symptomatic. Given the effect of the condition has to be judged without medication, the fact that the Claimant did not mention her B12 deficiency to Occupational Health is of limited probative value. There would have been no particular need for the Claimant to describe symptoms of a condition she has which are, by and large, controlled by medication and, as she pointed out, has learned to live with.

28. Although there is an overlap between the apparent symptoms of B12 deficiency and fibromyalgia (which led to the delay in diagnosing the latter), I am satisfied if the Claimant did not receive her injections of B12 every 3 months, she would suffer from a level of fatigue, which would have a more than minor or trivial effect on most of her day to day activities, including her mobility and ability to concentrate. As such, it constitutes a disability for the purposes of the 2010 Act

and has done so throughout the Claimant's employment by the Respondent. Whilst no finding is made as to the life limiting nature of the condition, I have no difficulty in accepting that there would be serious consequences for the Claimant's health were her regular vitamin B12 injections to stop.

Dry Eyes

29. The Claimant says she has suffered from dry eyes since she was 18. Whilst she accepts that she has never taken any time of work due to dry eyes, absence from work is of limited relevance in assessing substantial adverse effect. She asserts that her colleagues would have seen her putting in eye drops at work. The Occupational Health reports do not record symptoms of dry eyes, although the Claimant planned to mention them. In evidence she suggested that she was not given enough time with the Occupational Health doctor to enable her to fully explain all the health conditions from which she suffers. However, in cross-examination the Claimant accepted that her first Occupational Health examination (in 2016) lasted around an hour and that she had received copies of both reports before they were released to her employer. It is, therefore, reasonable to infer that if there was a serious omission from either report, the Claimant would have raised it either with the Occupational Health provider or the Respondent. The Claimant is a sophisticated and educated litigant, who would have been able to challenge material errors or omissions in the Occupational Health report, if not at the time, certainly having been given an opportunity to see the report in advance of its provision to the Respondent.

30. Although the Claimant has had prescriptions in the past for dry eyes, it was cheaper to buy products which relieved symptoms commercially, so this is what the Claimant does. I accept the Claimant's evidence that she has lived with dry eyes since she was 18 and the condition is, therefore, a long term one. The Claimant described the symptoms of dry eyes as a feeling of dryness, grittiness or soreness which gets worse throughout the day. She says it can cause a burning feeling and red eyes and her eyelids are prone to stick together at night causing pain. If the lubrication is not used, the Claimant says her vision goes blurred and she gets tired and has headaches. However, there is no medical or ophthalmic evidence as to how the Claimant's vision would be affected by dry eyes if the over the counter medication was not used.

31. Given the very limited medical evidence beyond the fact that the Claimant suffers from dry eyes and administers eye drops to combat this, I cannot be satisfied that the effect of the untreated condition would have a substantial long term adverse effect on the Claimant's vision. Having a feeling or soreness or grittiness is clearly unpleasant, but I must be satisfied that there is a substantial adverse effect on the Claimant's ability, for instance, to read or see obstacles

when she is moving. Whilst it is appreciated that the application of eye drops will cause a temporary blurring of vision, such medical information as has been provided by the Claimant concerning her eyesight described her vision after eye surgery to her left eye on 20 April 2018 as "good". Whilst it is appreciated that this was in the context of her eye surgery, such a statement is not consistent with the Claimant's having regularly blurred vision due to dry eyes as she claims.

PVD

32. The Claimant was diagnosed with PVD (posterior vitreous detachment) in her left eye in 2014 when she attended King Edward V11 hospital casualty department, having experienced seeing floaters (a letter of Mr Jasvir Singh Grewal dated 21 July 2018 confirms this). The condition is explained in a leaflet produced by the Claimant by the Royal Berkshire Hospital – the vitreous jelly in the eye turns to liquid, which means it can move away from the retina and floaters or flashing lights can be caused. In April 2018 the Claimant had a retinal detachment repair at Windsor Hospital and a letter from her consultant ophthalmologist, Mr Grewal, dated 21 July 2018 noted that she had "good vision" following this procedure. He also suggested that photophobia in her left eye might be a result of her left pupil being slightly larger than her right one.

33. The literature produced by the Claimant described PVD as "*very common and although irritating, it is not a serious condition*." Two out of three people over the age of 60 get PVD and *"in the majority, this does not cause any serious problems. In a small minority there can be a retinal tear/detached retina which can be treated with laser surgery.*" The Respondent submits that there is no medical evidence which expressly identifies that the Claimant's retinal detachment was caused by PVD. Whilst this is the case, the fact that the literature provided to the Claimant identified retinal tear or detachment as a possible consequence of PVD lends support to a connection. Whilst a retinal detachment is clearly a serious condition, it is demonstrably treatable with surgery and is temporary in nature.

34. Whilst I accept there might remain some risk of another retinal tear or detachment (as the literature identifies) and this is an understandable concern for the Claimant, the long term condition of PVD is suffered by the majority of the older population. It is described in the literature as common, irritating but not serious. The medical evidence suggests that the Claimant's vision was "good" following her laser surgery. Against this background, I am not satisfied that PVD has a substantial long-term adverse effect on the Claimant's ability to perform activities such as reading or other activities for which sight is needed (such as walking). This condition sits more comfortably as a "limitation which does not go beyond the normal differences in ability which might exist among people" as contemplated in the Guidance.

Temporomandibular Disorder (TMD)

35. The Claimant was diagnosed with TMD in April 2016 and says this condition gives her jaw pain, ear ache, difficulty in concentrating, headaches and ringing noises. The cause of the condition is a misalignment of the jaw, which leads to teeth grinding at night, which is then symptomatic in the day time. The Occupational Health report dated 6 June 2016 makes reference to this diagnosis and the resultant need for pain management. The Claimant wears a mouth guard to stop her grinding her teeth at night which was fitted in July 2017 and this has helped to alleviate the symptoms. The Claimant explained in her evidence that the headaches caused by TMD are different in nature from those which are caused by her vitamin B12 deficiency or prescribed medication (both of which have also given her headaches). The TMD headaches are in both her head and jaw and would last for a few days. Paracetamol would not be sufficient to stem them.

36. The medical evidence from the Claimant's GP dated 16 February 2017 confirms that TMD is a long-term condition, which contributed to the Claimant's headaches and difficulty/pain when twisting her neck and head. The condition is also referred to in the later report dated 12 December 2017 (as TMJ), suggesting that the symptoms might improve once the Claimant's stress and anxiety are better managed, but, "*typically these conditions can sometimes affect some individuals long term, with fluctuations in severity.*" I am, therefore, satisfied that the Claimant has suffered from TMD since 2016. Her symptoms have been alleviated to some extent by the wearing of a night guard at night, to prevent her grinding her teeth. That treatment should be disregarded in considering whether TMD amounts to a disability for the purposes of the 2010 Act. The primary symptom, as confirmed by the Claimant's GP is headaches and pain when twisting her neck and head. The Claimant suffers from headaches for a variety of reasons (and has more recently been diagnosed with migraines, which have partly been caused by analgesic over use). It may not be possible to isolate the cause of each and every one of the Claimant's headaches, but she is undoubtedly prone to them and I accept her evidence that generally she is aware from the site of the headache, whether it is caused by TMD. I accept that headaches of a duration and intensity which cannot be alleviated by pain relief are likely to substantially affect the Cliamant's ability to concentrate on work-related tasks such as reading and processing information. As such, I am satisfied that untreated TMD amounts to a disability for the purposes of the 2010 Act.

Sicca Symptoms

37. The Claimant explained that Sicca is a lack of fluids in the body (apart from

blood), ie. dry eyes, dry sinuses and problems with saliva glands. The Respondent accepts (from having done its own internet research) that "Sicca Syndrome" is an auto-immune disease known as Sjogren syndrome. This has been ruled out in relation to the Claimant. The medical evidence concerning "sicca symptoms" takes the form of letters from a Consultant Rheumatologist, Dr Simona Gindea dated 14 May 2015 and 17 July 2015. In the first, Dr Gindea diagnoses: "*Sicca symptoms – most likely benign sialadenitis and dacryoadenitis; less likely related to connective tissue disease."* This followed a radiological scan of the Claimant's salivary glands on 15 April 2015. The other diagnoses in the letter were for Vitamin B12 deficiency, history of low vitamin D, whiplash injury in 2006 and left frozen shoulder. Specifically, in relation to sicca symptoms the investigations had excluded connective tissue disease, but noted "*She is having submandibular swelling and pain and dry eyes since she was a teenager, worse during night, early morning."* The second letter confirmed that "*conclusion is that Mrs Kalia is having most likely benign sialadenitis and dacryoadenitis. She is having episodes of submandibular swelling and pain "on and off". An ultrasound of salivary glands done on 25th June was normal."* In October 2015, Dr Adler wrote to the Claimant's GP outlining the Claimant's various complex symptoms, including a "*very dry mouth and requires water to swallow food."* Further, "*She recently saw Dr Gindea who extensively investigated her for an underlying connective tissue disorder and really has found absolutely no evidence of it. This includes an ultrasound of the neck which showed no inflammation of any salivary glands."* He then proceeded to recommend an MRI scan in relation to pain in her left lower back and buttock area radiating towards the hip.

38. The Claimant originally suggested in her evidence that she does not suffer from "primary sicca", but from "secondary sicca" and that her dry eyes are sicca symptoms and she has her salivary glands checked annually to ensure they are not cancerous. She confirmed that she does not have Sjogren syndrome. On further questioning, it transpired that the Claimant has not been diagnosed with "secondary Sicca", but this was simply a term she had picked up from a rheumatologist. The symptoms with which the Claimant was concerned were a dry mouth, dry nasal passage and dry eyes. She explained that the benign sialadenitis relates to her salivary glands and dacryonadenitis to tear ducts.

39. The Claimant added in oral evidence that she had reduced fluid in her muscles, which were a "sicca symptom". Whilst the Tribunal accepts that the Claimant suffers from muscular pain due to fibromyalgia, the medical evidence does not support a separate and distinct condition arising from a lack of fluid in her muscles unrelated to fibromyalgia.

40. The Claimant's evidence was confusing about what she describes as the disability of sicca symptoms. The medical evidence (without expert interpretation) has not clarified the position. There is no doubt that the Claimant suffers from dry

eyes (dealt with above) and complains of a dry mouth (which causes her to need to drink with food) and sometimes of swollen salivary glands. These symptoms were investigated in 2015, but the summaries of her medical conditions provided by her GP to the Respondent on 16 February 2017 and 12 December 2007 makes no mention of on-going "sicca symptoms". The Occupational Health report refers to "a condition affecting her eyes", which I infer is dry eyes, but there is no reference to a dry mouth or swollen salivary glands. Whilst I bear in mind that the focus must be on the effect not the cause of symptoms, the Claimant deals with the adverse effect of a dry mouth by drinking water with food. This does not, in my judgment, amount to a substantial adverse effect on her ability to eat.

41. Whilst I appreciate that the Claimant might have forgotten to mention these symptoms in her Occupational Health examinations in 2016 and 2017 for reasons connected to her memory difficulties arising from fibromyalgia, the fact that sicca symptoms were not highlighted by the Claimant's GP reports, taken together with the inconclusive medical evidence, means that I am not satisfied that the Claimant suffers from a distinct disability of "sicca symptoms" which have had a substantial and long-term effect on her day to day activities. If it is the case that some or all of these symptoms relate to fibromyalgia, it is open to the Claimant to obtain medical evidence to that effect (in the event that the symptoms are separately relevant to her individual discrimination claims).

Sciatica

42. The Claimant suggests that she has suffered from sciatica since September 2015, when she first noticed a pain at the base of her spine going through the back of her left leg with some numbness in her left foot. The pain affects her mobility. In November 2015 she had an MRI scan and had a follow up consultation with Dr Matthew Adler to interpret her scan. Dr Adler wrote to the Claimant's GP on 21 December 2015 explaining that "*The MRI of the SI joints was normal but she does have a degenerate L5/S1 disc. There was no definite root compression. I have referred her to Apple Physiotherapy for some core strengthening exercises and physiotherapy. I hope the symptoms settle but if they do not, I would ask one of my spinal colleagues to decide whether or not she would benefit from an L5 root block."* Although the letter itself does not appear to offer a diagnosis of "sciatica", in correspondence with the Respondent's Solicitor dated 1 November 2018, the Claimant says she was informed by Dr Adler that she has pressure on the sciatic nerve. In her oral evidence, the Claimant says she still has pain and numbness down her left leg and she is planning to go back for physiotherapy and pain management in relation to it. The Claimant has made an application for a blue badge and has included the condition "sciatica" on her application.

43. In a letter from Dr Daniel Fishman, Consultant Rheumatologist dated 15

September 2018, a diagnosis of sciatica was confirmed. The letter provided, "*[the Claimant] has a number of pain-related symptoms including cervical degeneration, prolapsed intervertebral disc and sciatica, tinnitus and TMJ disfunction."* Whilst it is unfortunate that Dr Adler's initial report does not use the word "sciatica", the subsequent evidence, taken to together with the Claimant's recollection of what she was told by Dr Adler, suggests that such a diagnosis was made. There is no particular benefit to the Claimant in mislabelling her back pain "sciatica" as opposed to "mechanical back pain" or a "degenerate disc". In general terms I am satisfied that the Claimant was diagnosed with sciatica or a related back condition which substantially affected her mobility in December 2015.

44. Sciatica was not a condition which was mentioned in either Occupational Health report, although the June 2016 report made reference to "mechanical back pain", which had significantly improved with enhanced mobility. This was in the context of the Claimant's having had three scans, the most recent of which was interpreted by Dr Adler, who diagnosed sciatica (at least verbally). The Claimant cannot remember if she mentioned sciatica at either Occupational Health examination and submits that the Occupational Health Doctors had limited time with her, so that no negative inferences should be drawn from the fact that sciatica was not covered in either report. The Claimant has undoubtedly suffered numerous health challenges over recent years and the range and variety of medical investigations she has undergone would make it difficult for even a reasonably thorough Occupational Health assessment to cover all them. This is particularly so having regard to the Claimant's conceded disability, which is accepted to affect her memory. However, the 2016 assessment took place within 7 months of the MRI scan and treatment for the Claimant's back pain and the condition was clearly discussed and a conclusion reached that the pain had significantly improved. As at June 2016 sciatica/back pain, therefore, does not appear have had a significant impact on the Claimant's day to day activities as her physiotherapy/increased mobility had relieved the symptoms.

45. The Claimant invited the Tribunal to view an MRI scan which had been taken of her back in November 2015 to demonstrate where her spine is squashed. The Tribunal explained that it did not have the expertise to interpret a scan. The Claimant clearly suffered from a painful back problem in late 2015 which affected her mobility in a substantial way, however, the medical evidence expressed a hope that the symptoms would "settle" and, if not, an L5 root block would be advised. This procedure has not proved necessary and the Occupational Health Assessment in June 2016 suggests that there had been an improvement in the symptoms at that stage. However, the Claimant's own evidence and the recent letter of Dr Fishman outlined above, suggests that her back pain has since returned with some force. Whilst I am not satisfied that the Claimant's sciatica/back pain has consistently had a substantial adverse effect on her day to

day activities since 2015, it appears to be recurring in nature and, therefore, satisfies the test in Schedule 1, paragraph 2(2).

Depression

46. The Claimant was first diagnosed with depression following her absence from work in October 2017, although her GP's letter dated 12 December 2017 suggests that the Claimant first reported symptoms of low mood and stress in February 2017. With the benefit of hindsight, the Claimant considers she was suffering from depression from April 2017. Although she says she felt suicidal, she did not speak to her GP about this, but mentioned it to a colleague. She explained that she did not tell her GP as she never saw the same Doctor and did not want to admit there was a problem. She did not mention her low mood in the second Occupational Health assessment in June 2017, but first raised it with her GP on 16 or 17 September 2017. Throughout September, 2017 the Claimant reports suffering from headaches, chronic fatigue and had nightmares about her workload. On 18 October 2017 the Claimant visited her GP and was signed off with work related stress.

47. The GP's letter dated 12 December 2017 states, "*overall, [the Claimant] has suffered with anxiety for at least a year now*". The main reason for the Claimant's long-term absence from work has been "*anxiety, depression and work-related stress.*" I accept the Claimant's oral evidence to the effect that she has been prescribed the anti-depressant sertraline since mid-November 2017, although the prescription is dated 30 November 2017. In December 2017, the Claimant's GP suggested her depression would be likely to continue for the next few months, but could be 1 – 2 years. I accept that the Claimant is still absent from work by reason of depression (alongside other conditions). The Respondent conceded that the Claimant's 3 December 2018 fit note refers to "anxiety with depression" amongst other things as the reason for her unfitness to work from 30 November 2018 to 28 February 2019. It has therefore, turned out to be a long-term condition as the GP suggested it might and one which has been sufficiently serious to render her unfit to work.

48. The prescription of sertraline in mid-November indicates that the Claimant's GP has taken a more serious view of her symptoms. Depression was added to "work-related stress" on the fit note and appears to be a firm diagnosis from then on. The Claimant describes her symptoms of depression as not wanting to talk to people or leave her home and having nightmares about her work. Such symptoms quite clearly have a substantial impact on her day to day activities given she is inhibited from human interaction, whether socially, at work or to perform tasks which require her to leave her home and talk to strangers (such as shopping).

49. The Claimant invites me to find that she has been disabled by reason of depression since April 2017, notwithstanding the fact that she was not diagnosed with the condition until November 2017. It is acknowledged that there are a number of good reasons why patients do not seek medical help for mental illness (and there may well be such reasons in this case as the Claimant outlined), however, the Tribunal does not have medical expertise and it would be going beyond the bounds of judicial notice or the assessment of surrounding evidence to conclude the Claimant suffered from undiagnosed depression from April 2017. There is medical evidence that she was suffering from anxiety and low mood in early 2017. Anxiety and stress are conditions which go hand in hand with depression, but they are distinct diagnoses. The fact that the Claimant reported "low mood" to her GP might suggest the beginning of symptoms of depression, but not to such an extent that a diagnosis was made, that treatment was deemed necessary or the Claimant's ability to work was compromised. In these circumstances, I am not satisfied that the Claimant was suffering from depressive symptoms which had a substantial adverse effect on her day to day activities in early 2017.

50. Whilst the Claimant asserts she reported feeling suicidal at work in June or July 2017 and on 20 September 2017, at the time she thought that this was due to medication she was taking. Whilst not wishing to minimise the seriousness of the Claimant's assertion, the Tribunal is not qualified to assess the medical significance of it in the context of a diagnosis of depression, particularly against the background of the Claimant's dissatisfaction with her working conditions and the apparently difficult working relationship she had with one of her colleagues. Accordingly, whilst the Claimant might well now qualify as a disabled person by reason of her depressive illness, when she was still attending work in early October 2017, she did not.

Carpal Tunnel Syndrome/Tendonitis

51. The Claimant was diagnosed with carpal tunnel syndrome in both her wrists by Dr Rick Seah in March 2018. His report of 14 March 2018 refers and indicates she received a cortisone injection in relation to her right wrist. Although the Claimant says she raised question of wrist pain with her GP in December 2016, she was advised that this was caused by fibromyalgia. The Claimant is clearly of the view that she was suffering from carpal tunnel syndrome in 2016 and it affected her ability to lift files in the work place. She says the shooting pains are different from the constant ache of fibromyalgia and that the wrist is not a fibromyalgia point. Her GP in December 2016 clearly disagreed with her. I consider it unlikely that the Claimant would not have given a proper description of the type or site of the pain she was suffering in 2016 to her GP, such that her GP misattributed the Claimant's symptoms to fibromyalgia in 2016. I cannot, therefore, be satisfied that the Claimant was suffering from undiagnosed carpal

tunnel syndrome/tendonitis in 2016 or 2017, until she was prompted to seek a referral from her GP for a private appointment in early 2018. As the last act of discrimination alleged by the Claimant in these proceedings occurred in October 2017, it is not necessary for the Tribunal to determine whether the Claimant is currently disabled by reason of carpal tunnel syndrome.

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Employment Judge Clark

Dated: 7 January 2019

Judgment and Reasons sent to the parties on:

9 January 2019

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For the Tribunal Office