EMPLOYMENT TRIBUNALS

Claimant Dr. R. Mehta

v

Respondent London Borough of Brent

Heard at: Watford **On**: 29 January 2019

Before: Employment Judge Heal

Appearances

For the Claimant: Mr. M. Green, counsel
For the Respondent: Mr. P. Lockley, counsel

RESERVED JUDGMENT

The claimant was not a person with a disability. The complaints of disability discrimination are dismissed.

REASONS

1. By a claim form presented on 5 April 2018 the claimant made complaints of unfair dismissal, disability discrimination (including failure to make reasonable adjustments and victimisation) and breach of contract by failure to give notice.

2. The claimant describes her disability or disabilities as an ankle/foot injury and anxiety and depression.

3. The respondent does not dispute that she had those conditions but does dispute that they amounted to a disability or disabilities.

4. I have had the benefit of an agreed bundle running to 144 pages. I was also given some copies of the claimant's sick notes at the outset of the hearing and I have added these to the back of my bundle.

5. I have heard oral evidence only from claimant, Dr Rupel Mehta. She gave evidence in chief means of a prepared 'Impact Statement' which I read before she was called to give evidence and then she was cross examined and re-examined in the usual way.

6. Initially the claimant had disclosed redacted copies of medical notes. I was told that unredacted copies were shown to Mr Lockley before the start of this hearing and at the outset, he confirmed that he now had no submissions to make about the redacted items.

7. I do not have the benefit of any medical or psychiatric report produced for the purposes of these proceedings. I do not know therefore what an orthopaedic or psychiatric expert would say were the answers to the questions that arise in this case.

8. Mr Green has provided me with written 'Submissions on Disability' and Mr Lockley has provided me with a written 'Respondent's Note for the Preliminary Hearing on 28 January 2019.'

9. Counsel have also provided me with copies of the following authorities:

Condappa v Newham Health Care Trust EAT/452/00
Patel v Oldham Metropolitan Borough Council [2010] IRLR 280
Anwar v Tower Hamlets College UKEAT/0091/10/RN

10. I am grateful to both Mr Green and Mr Lockley for their thorough preparation, clear submissions and good humour throughout this hearing.

11. In broad terms, the background is this: the claimant sustained an injury to her ankle at home on 17 November 2016. Initially the diagnosis was a sprained ankle. In January 2017, however, an avulsion fracture was diagnosed. Gradually, the condition of her ankle improved but not before she developed an impairment to her mental health.

12. It was clear that the claimant would be likely to need breaks during the course this hearing. Mr Green agreed to tell me when he thought the claimant would need a break.

Issues

13. At the outset of this hearing counsel outlined the issues like this:

Claimant

14. The claimant said that in relation to both disabilities it was very clear that there were substantial adverse effects. The question was at what point they became disabilities. As at the point of dismissal the claimant had been off work for over 12 months. The point of dismissal on 14 December 2017 was the last point at which discrimination was alleged.

15. At earlier points in that year, was it prospectively likely that the impairment or impairments would have a substantial adverse effect for more than 12 months? 'Likely' in this legal context does not mean more than 50% as in a balance of probabilities exercise but means 'could well happen' which may be a less than 50% chance.

16. It is not appropriate to use the knowledge available to the tribunal now as at the date of this hearing. When asking whether it was likely for an impairment to last more than 12 months the question is, what was known at the time of the alleged discrimination. This is a case in which the original diagnosis was mistaken.

17. Mr Green said it cannot be the case that the fact that something has been misdiagnosed does not affect the way we ask the question. (Mr Lockley thought that in practical terms this point was not going to matter.)

18. Mr Green drew attention to the relationship between the two disabilities. He said that the claimant's physical injury led to an impairment to mental health. His primary submission would be that each condition separately was a stand-alone disability.

19. Alternatively, relying on *Patel* he said that it was possible to look at the two effects combined to decide whether overall there was an impairment. In the further alternative, he said that if the mental health impairment was a consequence of the first, physical, impairment then I could look at the two together.

20. Mr Green's 'headline' was that this was a claimant who has been signed off work for over a year. She was not able to go to work initially without adjustments being made and from April 2017, she was not able to go to work at all.

Respondent

21. The respondent's position is that the claimant had an injury on 17 November 2016. For a number of weeks or months the evidence suggests that she could not carry out normal day-to-day activities such as household chores. Normally such an injury would be expected to heal within weeks or months but for some reason healing was slower than expected. There was a gradual healing process so that by around 6 months and certainly 12 months the impact of the foot injury was minor.

22. At some point during the 12-month period the physical impairment of the foot injury dipped below the threshold of disability. By November 2017 claimant was walking, albeit with discomfort. Mr Lockley relied on *Condappa* to note that the impact has to be substantial. One can do something with a modest degree of discomfort but not a substantial degree, that is not a substantial adverse effect on day-to-day activities.

23. Mr Lockley also relies on *Anwar* as authority that an impairment can be more than trivial but still minor. The focus therefore is not on whether it is trivial but on whether it is minor.

24. Therefore, Mr Lockley will say that the claimant cannot make out a 12-month period retrospectively and she cannot do it prospectively.

25. He says there is no evidence of any of the claimant's treating clinical staff thinking that the impairments could well last for another 6 months. He accepts that 'likely' means not 51% but 'could well happen'. This means a really significant chance and not a speculative chance.

***Facts*.**

26. I have made findings of fact on the balance of probability. (I bear in mind the distinction between the percentage chance that I must apply to findings of past fact and the different chance that I must apply to findings of likelihood in relation to the twelve-month question.)

27. I have approached the claimant's evidence with caution. At times she has described her symptoms in terms that do not show up in the contemporaneous documents: for example the word, 'agony'. In oral evidence she described a situation of pre-existing stress involving her manager which was immediately exacerbated by the injury, so as to be a mental condition more than mere frustration. That does not sit comfortably with the evidence in the Impact Statement which gives the onset of the stress and anxiety as much later. The Impact Statement describes the injury and its limiting effects as a cause of the stress and anxiety, although the GPs notes show that contemporaneously the claimant attributed the mental health issues to problems at work.

28. The claimant holds a doctorate in chemical engineering. She is therefore referred to as Dr Mehta. At all relevant times however, she worked for the London Borough of Brent, the respondent, as a Senior Performance Officer. The claimant's husband runs his own business, an accident repair centre, and works extremely long hours, 7 days a week. Dr Mehta also has two young children of an age to need waking up, helping to dress, being given breakfast and walking to school.

29. On 17 November 2016 the claimant fell awkwardly and injured her foot at home. She attended Accident and Emergency where x-rays showed no breaks or fractures. A diagnosis was made of torn ligaments and she was sent home with crutches and Co-codamol for the pain. She was advised to keep the foot elevated as much as possible to reduce swelling.

30. Although it seems highly likely and I find that the claimant did experience some stress and anxiety at the outset when she first injured her ankle (and indeed she refers to this in the grounds for claim attached to her claim form) this was not at a level to need medical intervention and did not at that stage cause a mental impairment. At that stage the impairment and the substantial adverse effect on her day-to-day activities came from the physical injury.

31. For the first few weeks after the injury the claimant was unable to bear any pressure on her foot. She found it very difficult to walk unaided and even when using crutches did not touch her foot to the ground.

32. During this initial period, there is no dispute that there was a substantial adverse effect on the claimant's normal day-to-day activities. Therefore, I do not need to make detailed findings save to note that she could not drive, stand to cook or wash dishes, perform domestic chores such as laundry or housecleaning, take her children to school, after school activities or to play with friends, exercise, use stairs or swim.

33. The claimant was unable to travel to work at her office. She lives in in Bricket Wood, near St Albans and could not either drive or manage public transport so as to travel to the respondent's offices in Brent.

34. She was therefore off work sick from 18 November 2016. Her GP signed her off work on 30 November initially until 14 December 2016 because she was '*not suitable to drive and unable to weight bear on left foot/distances'*. The GP's notes give no prognosis.

35. The claimant did not recover as expected and on 14 December 2016, her GP signed her off sick again for another month until 15 January 2017 because she could not walk long distances or drive.

36. The respondent referred the claimant to Occupational Health and on 13 January 2017 claimant had a telephone consultation with Grant Ciccone an Occupational Health Adviser. Mr Ciccone is a nurse, not a doctor. On the information before him, Mr Ciccone concluded that the claimant remained unfit to return to work and there was a possibility that the note would be extended for a further period of time. At this point, he believed he was looking at an ankle sprain and said that if the sprain was a 'grade 3' sprain - a complete tear of the ligament resulting in gross instability at the ankle joint and possibly requiring surgery - then the healing time may be around 3 to 6 months. Though he noted this to be a matter for the employment tribunal, he himself said that the claimant may not be considered as having a disability at this point in time.

37. An ultrasound scan on 26 January 2017 led to a diagnosis of an avulsion fracture of the claimant's foot ('*a small flake avulsion on the calcaneal margin*'). An avulsion fracture is an injury to the bone in a place where a tendon or ligament attaches to the bone. When the fracture occurs, a tendon or ligament pulls off a piece of the bone. There is a diagnostic ultrasound report dated 26 January 2017 which simply gives this diagnosis but, perhaps unsurprisingly, no prognosis.

38. The claimant passed the new diagnosis onto Mr Ciccone who added some additional information to his report. He did not at this point attempt a further prognosis but noted that the GP had extended the fit note to 26 February 2017 with the hope that physiotherapy would have started by then.

39. On 2 March 2007, the claimant had a stage 2 absence meeting with her manager. Her manager said that if claimant did not return to work by the time of the stage 3 hearing she could be dismissed. This began to make the claimant extremely anxious and stressed about what would happen to her family without her income.

40. By mid-March 2017 claimant's low mood was becoming fixed. Talking about the work situation caused her to feel upset and to cry. In order to avoid talking about the situation at work she stopped socialising. She lost her ability to control her mood, her emotions and her frustrations. She stopped cleaning, tidying and cooking. A friend found her lying on the sofa in the dark watching television in the middle of the day.

41. The claimant spoke again to Mr Ciccone on the telephone on 19 March 2017. By letter to the claimant's manager, he said that the injury had not healed as well as it

should, due to the initial misdiagnosis and the claimant continued to experience a lot of pain. The pain and discomfort caused the claimant to continue to walk with a limp. He said that most simple fractures heal well with immobilisation and non-weight-bearing activity. However, because of the misdiagnosis this did not happen for the claimant.

42. Mr Ciccone said that fractures may have good to fair outcomes, depending on the severity of the fracture, effective rehabilitation on function and the development of arthritis. He said that patients could expect recovery from most ankle fractures, depending on how severe they are, to take 4 to 8 weeks for the bones to heal completely and to several months to regain full use and range of motion of the joint. He could not give a recommendation for a provisional return to work as the claimant had gone from an acute to a chronic stage.

43. Mindful that the issue of whether the claimant had a disability was a matter for the tribunal, Mr Ciccone said that in his opinion the claimant '*may not be considered as having a disability at this point in time*.'

44. The claimant's GP, Dr Lad produced a short report for Mr Ciccone dated 24 March 2017. This described the claimant's condition as '*somewhat tricky to manage'*. He set out the history to date and said that the claimant continued to have pain and issues walking and this had been compounded by the length of time taken to make the difficult diagnosis. He added that the claimant was naturally suffering with high levels of stress and anxiety due to the ongoing nature of the situation and the knock-on effects on work. Dr Lad too did not think the claimant had a disability: he said she certainly had a degree of difficulty walking and could not drive 'right at the moment'. He said,

'*We hope with physio her symptoms improve in the next 6-8 weeks but if not may need to consider onward orthopaedic referral*.'

45. On 27 March 2017 Dr Lad prescribed the claimant Amitriptyline. For the first time his notes show a problem with low mood. However, he had referred to the claimant's stress in his letter dated 24 March: so, he must have had some prior awareness of a growing problem with the claimant's mood. He noted that the claimant was becoming '*increasing stressed low mood with ongoing difficulties at work'*. There was no suicidal ideation or intention, but sleep was a major problem. The claimant looked well, was euthymic, was well kempt, had a good rapport and good eye contact.

46. On 6 April 2017 the claimant met with Grant Ciccone for a review occupational health assessment. She travelled there and back by taxi. Mr Ciccone recorded the slow healing process and also the claimant's low mood. She had been getting tearful and anxious especially when receiving communications from her manager. She was mobilising with the aid of a crutch; her movements were slow and considered and she was experiencing pain and discomfort on mobilising. She had been prescribed strong analgesia to help manage the pain.

47. Mr Ciccone said in his report to the claimant's manager that an avulsion fracture usually takes 6 to 8 weeks to heal however if it failed to heal sufficiently then surgery may be an option. In such a case the healing time may take up to 12 weeks. Surgery

was not being considered in the claimant's case and he was unable to provide a 'timeframe'. He said that the claimant was currently unable to drive her manual geared car. Again, while properly reminding himself that the question of disability was a matter for the tribunal, he said that the claimant '*may not be considered as having a disability at this point in time*.'

48. The claimant continued to be signed off work and the statement of fitness dated 25 April 2017 for the first time notes that the conditions include, *'anxiety/stress related problem'.*

49. As it turned out, Amitriptyline gave the claimant a stuffy or foggy head. She subsequently returned to her GP on 22 May 2017 who prescribed Citalopram. This was the first point at which the GP diagnosed an anxiety state. He recorded, '*mood and anxiety still not great*.' As before, he recorded that the claimant looked well, was euthymic, well kempt, had a good rapport and eye contact with no thought disorder and no suicidal intention. He issued a further statement of fitness for work saying that the claimant was not fit for work until 30 June 2017 because of fracture and ongoing pain/mobility and her anxiety/low mood.

50. Citalopram made the claimant feel a little bit better but she was still, '*in a very dark place.'*

51. On 20 June 2017, a podiatrist reported to the claimant's GP that the claimant had pain on the antero lateral aspect of left ankle and 2nd to 5th toes. He thought the sinus tarsi were the '*culprit*' but could offer nothing relieve pain in these areas. His report gives no prognosis.

52. By July 2017 the claimant was walking more, and without her crutches, although still with a limp. From the summer of 2017 to her dismissal, the claimant took paracetamol and ibuprofen. She tried to avoid ibuprofen because of the risk of adverse effects on her stomach. So, she said she took ibuprofen when the pain was really bad but otherwise if the pain was bad when she woke up she would take paracetamol. Whether she needed to take any more might depend on what she was doing that day.

53. The claimant has described to me a situation in the summer of 2017 in which it would take her 15 minutes to walk what would otherwise be a five-minute walk to school. She says that when she arrived at school she was in agony. However, when I read her GP's notes and the other medical evidence the word 'agony' does not appear, nor does any word consistent with agony. By this stage in the development of the conditions it is her mental health situation which appears in more detail in the GPs notes. The claimant's impact statement too does not describe the situation in the terms she used in oral evidence.

54. The claimant saw Mr Zaw a consultant orthopaedic surgeon specialising in foot and ankle surgery, on 24 July 2017. In a letter to the claimant's GP dated 27 July Mr Zaw reported ongoing problems with pain over the anterolateral ankle and around the base of the fifth metatarsal. Recent x-rays showed no evidence of residual non-union. The ankle and the remainder of the midfoot joints appeared normal. On examination there was tenderness around the anterior talofibular ligament region ('ATFL'). There was some sensitivity around the main branch of the superficial peroneal nerve. There

was some radiation of pain towards the third and fourth toes which occasionally had reduced movement and a crunching sensation. There was tenderness along the proximal third metatarsal around its base and proximal shaft.

55. Mr Zaw's letter gives no prognosis.

56. The claimant was discharged from physiotherapy on 11 August 2017 having made '*some improvement*'. It was the physiotherapist who had referred the claimant to podiatry services for assessment because the non-resolution of her symptoms. The physiotherapist says,

'*we discussed treatment to close at this current point in time due to the on-going employer issues that were causing [the claimant] a significant amount of stress and we agreed to a further referral (if required) once they had resolved*.'

57. The claimant was able to go on holiday with her family in August 2017, although she says she dreaded it and was not in the mood to go.

58. The claimant attended eight sessions of cognitive behavioural therapy ('CBT') between August 2017 and January 2018. The claimant was discharged in January 2018 because there had been no change in her symptoms. Nicky Hope of the Wellbeing Service thought that this may have been the result of the claimant's ongoing issues at work blocking the effects of the treatment.

59. The claimant's GP had signed her off work again from 30 June 2017 to 10 September 2017 citing a foot fracture and ongoing pain and mobility issues as well as anxiety and low mood.

60. On 11 September 2017 the claimant again saw her GP, suffering from pain in her foot and with mobility issues. She was now walking unaided but with a limp because she could not put too much pressure on her foot.

61. Dr Rafferty (who appears to be Mr Zaw's registrar) saw the claimant on 9 October 2017. An MRI scan showed no evidence of any fracture and no evidence of any hidden bony flake. There was a very small effusion within the ankle and a small amount of effusion in the lateral gutter. There might have been some abnormal signal in the ATFL but the rest of the ligaments were all intact. On examination, the ankle was completely stable. There was a good range of movement.

62. Dr Rafferty thought the claimant had damaged her ATFL and noted this was taking some time. The report concludes,

'*I have discharged her from our care, would be happy to see her again have not resolved over the next six months and she is still concerned*.'

63. By the time the claimant saw her GP on 7 November 2017 she was doing all of her usual activities again, apart from intensive exercise. Pressure or impact on her foot was still painful and every so often her ankle would give way causing pain. The GP signed her off sick again until 7 January 2018 because of foot pain secondary to fracture and anxiety and low mood.

64. On 29 November 2017 the GP prescribed 56 tablets of citalopram one to be taken each day.

65. The claimant was dismissed with effect on 14 December 2017. The claimant says that this knocked her pride and dignity and made her wish to hide away from people more.

66. Assuming the claimant took one citalopram each day, these would have run out in January 2018. When the claimant saw her GP on 19 March 2018 for a medication review she told the GP that her medication had run out; she thought she would be fine but was now probably going through an employment tribunal. 56 tablets of citalopram were therefore prescribed again.

67. When the claimant next saw her GP on 19 June she said she had run out of citalopram 2 weeks previously.

Law

68. A person has a disability if she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on her ability to carry out normal day-to-day activities: section 6 Equality Act 2010.

69. Paragraph 2 of schedule 1 to the 2010 Act says:

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.

70. Paragraph 5 of schedule 1 says that an impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if measures are being taken to treat or correct it and but for that it would be likely to have that effect. ‘Measures’ includes in particular medical treatment.

71. The Guidance on the definition of disability (2011) at C2 says that the cumulative effect of related impairments should be taken into account when determining whether the person has experienced a long-term effect for the purposes of meeting the definition of a disabled person. The substantial adverse effect of an impairment which has developed from, or is likely to develop from, another impairment should be taken into account when determining whether the effect has lasted, or is likely to last at least 12 months, all the rest of the life of the person affected.

72. Assessing the likelihood of an effect lasting for 12 months, account should be taken of the circumstances at the time the alleged discrimination took place. Anything which occurs after that time will not be relevant in assessing this likelihood. Account should also be taken both the typical length of such an effect on an individual and any relevant factors specific to this individual (for example, general state of health or age).

73. There is no exhaustive list of normal day-to-day activities. In general, day-to-day activities are things that people do on a regular or daily basis. Examples are given at D3 of the Guidance and in the Appendix to the Guidance. In deciding whether an activity is a normal day-to-day activity, account should be taken of how far it is carried out by people on a daily or frequent basis. In this context, 'normal' should be given its ordinary, everyday meaning.

74. The Equality Act 2010 is not concerned with *any* adverse effect but with a *substantial* adverse effect. Where a person is able to and does carry out normal day-to-day activities in pain or with difficulty this may amount to a substantial adverse effect but it will not necessarily do so (*Condappa* paragraph 47).

75. It is possible to conclude that the effect of an impairment is more than trivial and yet still minor as opposed to substantial (*Anwar* paragraph 24).

76. In asking whether an impairment is likely to last or has lasted at least 12 months fine distinctions between one medical condition and its development into another are to be avoided. The effect of an illness or condition likely to develop, or which has developed, from another illness or condition forms part of the assessment of whether the effect of the original impairment is likely to last or has lasted at least 12 months (*Patel* paragraph 15.)

Analysis

77. Taking the foot injury on its own I do not consider that that impairment alone amounts to a disability. The claimant plainly did suffer from a substantial adverse effect on her ability to carry out day-to-day activities starting on 17 November 2016. I consider that I have to look at the situation as it actually was, not as the ankle sprain it was originally thought to be. The actual situation was an undiagnosed fracture which was first thought to be a sprain and therefore not treated as a fracture.

78. As at January 2017 Mr Ciccone wrongly thought that he was looking at an ankle sprain for which healing, if it was grade 3 sprain, would take between three and six months. As at that point, the substantial adverse effect 'could well' last until May 2017.

79. By March 2017 however, Mr Ciccone had the accurate diagnosis. In that light, he expected it to take 4 to 8 weeks for bones to heal and several (I think *further*) months to regain full use and range of motion of the joint. On a generous basis, it 'could well' have taken to mid-January for the bones to heal and it 'could well' have taken a further six months the claimant to regain full use and range of motion. The timescale then is 8 months, which remains less than 12 months.

80. This approach however leaves out the problem of the undiagnosed fracture. I do not have any medical evidence about how long an additional period that feature would add to the 'likely' period of recovery given that the claimant was originally given the wrong treatment. I do not myself have the medical expertise to answer that and I have no expert's report. What I have is Dr Lad's report saying that the problem has been compounded by the length of time taken to make the difficult diagnosis. However,

knowing the problem of the undiagnosed fracture, he *hoped* that with physiotherapy the symptoms would improve in the next 6 to 8 weeks from 24 March 2017. That would take until the end of May (so 6.5 months from the injury). Just because Dr Lad *hoped* for improvement by this point not mean that the symptoms *could well* not have lasted longer. Conversely, I do not have any medical evidence to show that the substantial adverse effect could well have lasted very much longer.

81. What in fact took place might be some evidence (albeit imperfect) of the likely duration of the substantial adverse effect. In fact, although the claimant's progress was very much slower than the various specialists hoped and no doubt expected, the fact is by July (eight months after the injury) the claimant was walking without crutches albeit with a limp. The medical evidence from 24 July and 9 October is consistent with the injury resolving and leaving the claimant with minor problems. By November (12 months after the injury) she had resumed her usual activities apart from intensive exercise. I do not consider intensive exercise to be a normal day-to-day activity, having regard to the examples at D3 of the Guidance and in the Appendix to the Guidance.

82. I have to consider the position as it would have been without treatment. Without a specialist expert report to give evidence on the subject I have to do the best I can on the evidence I do have. The claimant was prescribed Co-codamol and Naproxen initially, but I do not see these prescriptions being repeated. By the summer of 2017 the claimant was taking occasional ibuprofen if the pain was bad and paracetamol if she woke up in pain or otherwise needed it. I find that without these fairly mild medications, the claimant would have been in some pain, but not agony, and still able to carry out her normal day-to-day activities without serious pain or discomfort. Had the position been more extreme than this, I would have expected her to be expressing herself in stronger terms to Mr Ciconne, her GP and specialists, and also to be prescribed stronger pain relief.

83. So, on all the evidence and looking at the ankle on its own, I do not consider that a substantial adverse effect on normal day-to-day activities in fact lasted 12 months, or, viewed at the time when the alleged discrimination took place, that it was likely to last more than 12 months where likely means, 'could well' last more than 12 months.

84. I turn to the mental health impairment. I note that at no point do the GP's notes diagnose depression: the record is of 'low mood' and anxiety states, with mention of stress. On my findings of fact, by mid-March 2017 but not much before, the low mood which became an anxiety state had become something that had a substantial adverse effect on the claimant's day to day activities. The claimant was not sleeping, she had lost control of her emotions and had stopped doing household chores.

85. At no point is there any contemporaneous prognosis for the mental health condition. I have no expert evidence to inform me about what, prospectively, could well have been the prognosis when viewed at the time of the alleged discrimination. It is clear from the claimant's impact statement that her mental health remained poor through April and May and even June of 2017. By November (in relation to her foot) she says that she was doing all her usual activities again, but this must also mean that her mental state was allowing her to do all her usual activities again. In January 2018 after 8 sessions of CBT it appears that the claimant's symptoms were unchanged, but

these symptoms are not described in the document of 29 January 2018, and nor are the effects on day to day activities.

86. As at the time the alleged discrimination must have ended (14 December 2017) the mental health impairment had not lasted for more than 12 months: it had started in about mid-March, so had lasted 9 months, at least at some level. I have no psychiatric evidence to tell me whether it was likely to (could well) last for more than 12 months as viewed between March and December 2014. There is evidence from the claimant that it had improved as at November 2017. That the claimant's symptoms were unchanged by CBT does not tell me what effect those symptoms had on her day to day activities. Whatever symptoms continued, they did not have a substantial effect on the claimant's ability to carry out her day to day activities. I notice that in early 2018 she had left off taking citalopram and had thought she could do without it. It was the anticipation of tribunal proceedings that made her resume medication. This is evidence too that in fact the symptoms were minor by January 2018.

87. The evidence is that the treatment had relatively little effect. Amitriptyline gave her a stuffy head. The claimant said that Citalopram had little effect when her symptoms were bad: she was still in a very dark place. So, I consider that the effect on her day to day activities is as I have found it to be, and would be like that even without the treatment. CBT appears to have no effect either.

88. Therefore, I consider that even if I were to aggregate the two conditions, they did not (retrospectively) have a substantial adverse effect on the claimant's day to day activities for 12 months. The claimant has not proved that, when viewed prospectively as at the time of the alleged discrimination, either impairment was 'likely' to have a substantial adverse effect on her day to day activities for more than 12 months.

89. If I am wrong about any part of that, after a careful examination of the GP's notes I do not consider that the two conditions were sufficiently related to be able to aggregate their effects. As I read the notes I see that the claimant's complaints about her mood (where linked to anything) are directly linked to her concerns at work: she was not saying to her GP that her low mood was because of her physical impairment, but because of ongoing difficulties at work and a grievance about her colleague. The letter from the Wellbeing Service dated 29 January 2018 appears to confirm this. The claimant also told me that there was some pre-existing problem at work which had caused her stress. I prefer the contemporaneous medical evidence of the cause of the mental impairment. I find that the mental impairment was related to the problems at work, and was only related to the foot injury as a part of a more distant chain of causation. If Latin is permissible, the fracture was the causa sine qua non, but not the causa causans. 'But for' the fracture, the claimant would not have had the same problems at work which appear to have been the immediate cause of the mental health impairment. However, the fracture did not itself cause the mental health impairment.

90. I find that these are two separate impairments, one has not developed out of the other, and they should be considered separately for the purposes of whether the 'impairment' was long term. Had I found that the mental health impairment had developed out of and because of the fracture and its physical aftermath, I would have found otherwise on this point: in that situation the two conditions would be related and the fact that one is physical and one is mental seems to me to be irrelevant.

91. Dealing with Mr Green's original 'headline' point: it is true that the claimant was signed off work for more than 12 months. On these facts, I do not take a medical certificate, without more, as evidence that there was a substantial adverse effect on day to day activities for the period of time covered. The Act does not provide that a person has a disability if she has statements of unfitness to work from her GP for a 12 month period. I have to make findings on whether on all the evidence the impairment had the relevant effect.

92. For those reasons I find that the claimant was not a person with a disability and I dismiss the complaints of disability discrimination.

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Employment Judge Heal

Date: ……31.01.2019………………..

Sent to the parties on: ..31.01.2019....

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For the Tribunal Office