EMPLOYMENT TRIBUNALS

Claimant		Respondent
Mrs Lokhi Roy	v	**Leeds and York Partnership NHS Foundation Trust**

Heard at: **Leeds** **On:** **31 January 2019**

Before: **Employment Judge T R Smith, sitting alone**

Appearance:

For the Claimant: **Mrs Cakali (Solicitor acting only for the purpose of this hearing**

For the Respondent: **Mr Quickfall (Counsel)**

JUDGMENT

The claimant was not a disabled person at the material time.

REASONS

Issues.

1. The issue I was required to determine was whether the claimant was a disabled person within the meaning of section 6 of the Equality Act 2010 (EQA10") at the material time.
2. Both advocates agreed that the material time was from October 2016 until November 2017.
3. It was agreed that the condition the claimant contended constituted her impairment was a mental impairment namely "generalised anxiety disorder/stress and depression"

Evidence.

4. I had before me and agreed bundle totalling 265 pages. There was a document in the bundle at pages 148 and 149 which appeared to be some form of bar chart. The original was apparently coloured and the colouring in turn referred to a key. I pointed out to both parties that my black and white photocopy did not

show the colour marking and I could not discern what the various bars within that chart meant. I asked both advocates if they had a better copy but they did not. In the circumstances I indicated that I would not take this particular document into consideration in reaching my decision, given that I could not fully discern what it sought to convey.

5. I also reminded both advocates that I would only review those documents specifically drawn to my attention.

6. The claimant had also been ordered to prepare and file an impact statement in relation to the issue of disability. The claimant filed a document entitled "disability impact assessment" (pages 173 to 178) which was in a tabular as opposed to a narrative format. It was agreed that this document would be taken as the claimant's impact statement and evidence in chief.

7. The claimant gave oral evidence and was cross examined. No evidence was called on behalf of the respondent.

The law.

8. Disability is defined in section 6 EQA 10 in the following terms: –

"(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."

This definition is further clarified in Schedule one, Part one of the EQA 10.

9. In approaching my judgement, I have had regard to "Guidance On Matters To Be Taken Into Account In Determining Questions Relating To The Definition Of Disability (2011)" ("the Guidance").

10. I have also had at the forefront of my mind the decision in **Goodwin -v- The Patent Office 1999 IRLR 4**

11. From the case law I derive the proposition that the word impairment should be given its ordinary meaning.

12. Whilst I have regard to the fact that words such as "stress", "anxiety" or "depression" even used by GPs will not in itself amount to proof of a mental impairment, see **Morgan -v- Staffordshire University 2002 IRLR 190** that case needs to be approached with some caution as it was decided under the Disability Discrimination Act and before the rather wider wording now found in the EQA 10. That said a mere assertion by a claimant of mental impairment may not necessarily suffice.

13. The phrase day-to-day activities is not defined in the EQA 10 but I have adopted the definition found in the Guidance at paragraph D3 which reads as follows: –

"In general, day-to-day activities are things people do on a regular or daily basis, and examples include shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities. Normal day-to-day activities can include general work-related activities, and study and education related activities, such as interacting with colleagues, following instructions, using a computer,

driving, carrying out interviews, preparing documents, and keeping to a timetable or she pattern"

14. What constitutes a substantial adverse effect on normal day to day activities is something more than trivial.

15. I remind myself that I must discount the effect of medical treatment when making such an assessment. I must determine what the claimant could or could not do without medication. I have to look at what the claimant cannot do or can only do with difficulty and not what she can do, **Leonard -v- South Derbyshire Centre of commerce 2001 IRLR 19.**

16. What constitutes a long-term affect is defined in Schedule one Part two of the EQA 10 in the following terms: –

"(1) the effect of 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."

In looking at whether an impairment has a long-term affect I must take into account the likelihood of re-occurrence and the likelihood of re-occurrence means "could well happen", see **Boyle -v- SCA Packaging Ltd 2009 IRLR 746**

17. Finally, my assessment is made at the material time, and not as at the date of today's hearing.

Submissions.

18. I am grateful for the helpful and concise submissions of both advocates.

19. Other than Mrs Cakali making submissions as to this case being distinguishable from **J-v- DLA Piper LLP UKEAT/0263/09** there were no submissions on the law.

20. I mean no disrespect to either advocate by not therefore repeating their factual submissions although I assure them and the parties that I had full regard to them and, where appropriate, I have commented upon those submissions in my judgement where necessary

Findings of fact.

21. The claimant is employed by the respondent as a mental health worker.

22. I start with the claimant's GP records which begin on 11 May 2016. (100 to 121)

23. The first relevant entry is 21 June 2016 which recorded the claimant as being "tearful and low mood". The claimant indicated in her evidence her 16-year-old son had been diagnosed with autism/Asperger's and she was a single parent and felt overwhelmed.

24. At the consultation a PHQ and GAD form was completed. (122 and 123).

25. Care needs to be taken in the weight to be attached to such documents. For example, the GAD is described as "this easy-to-use self-administered patient questionnaire is used as a screening tool…". It consists of only seven questions with multiple-choice answers. One question is "trouble relaxing?" of which there are four possible answers to tick namely, not at all, several days, more than half the days and nearly every day. The questions refer to the previous 14 days and each answer is given a score from 1 to 3 with the "not at all" failing to score.

26. I observe the both of these forms depend solely on the evidence of the patient in answering the questions and do not involve any clinical examination by the clinician. They do not address the components of the statutory definition of disability.

27. It is proper that I say that on the GAD score that that the claimant was perceived to have severe anxiety.

28. Given the snapshot assessment using PHQ, and GAD, the fact they are totally dependent upon the honesty of the patient and does not involve a clinical examination I have given these documents little weight particularly as I found, for reasons set out later in my judgement, that the claimant was not, in all respects, open, honest or reliable in her evidence.

29. The result of the consultation on the 21 June 2016 was that the Claimant was given a sick note for one week. She was diagnosed with depression but not prescribed any form of medication which further adds to my assessment of the weight to be given to the PHQ and GAD documentation. She scored highly but her GP did not consider medication was required.

30. When the claimant next visited her GP on 30 June 2016 it was recorded that she had “no depression” but she was anxious due to family circumstances. She was prescribed Propranolol. Propranolol is a beta blocker which amongst its uses are for anxiety. She was given approximately 2.5 months supply. At the end of the prescription (that is, about, middle of August 2016) the claimant did not seek a renewal.

31. The claimant in her impact statement (paragraph 8) reported that by 20 July 2016 she was “undertaking daily activities without considerable, (sic) difficulties milder”. This is broadly consistent with the information the claimant gave to the Respondent’s occupational health department on the same day when, other than complaining of some muscular skeletal issues and reporting some stress in her personal life, she was undertaking the full extent of her role. In cross examination the claimant accepted she could undertake the full range of her duties without any adjustments for stress or anxiety. I counsel myself that merely because a person is able to do their job does not mean they may not be a disabled person.

32. Thereafter there were no relevant entries other than relating to back pain and gynaecological issues until 12 September 2016 when the claimant reported to her GP that she felt she was under a “lot of stress” and “feeling anxious”. The reason for this presentation was meetings at work. I interject here to mention the claimant was subject to a succession of meetings as regards attendance and disciplinary/grievance matters. The claimant’s GP considered the claimant was not depressed but that she felt anxious. She was given a medical certificate for three weeks which was subsequently extended for a further three weeks. The claimant was not prescribed medication although I accept the claimant’s evidence that she had been taking some herbal remedies and practising breathing exercises to reduce anxiety.

33. The claimant next attended her GP surgery on 19 December 2016 when it was recorded she was much better but got anxious and panicky before interviews in connection with her disciplinary proceedings. She was prescribed diazepam for four weeks and Propranolol but as it transpired for a subsequent entry in the GP

records (08 March 2017) did not have the need to use any of the prescribed medication. This indicates that the condition was manageable.

34. At approximately the same time, December 2016 the claimant accessed six sessions of counselling lasting approximately 50 minutes provided by the respondent. She also had access to a telephone helpline if required.

35. The claimant then attended her GP for the purposes of the GP review on 08 March 2017 where the GP diagnosed an unspecified anxiety disorder and issued a sicknote and prescribed two-month supply of Sertraline. This is a medication which can be used for panic disorders.

36. Whilst there were then further presentations by the claimant at her GP surgery, they were unconnected with her mental impairment.

37. When she was next seen by her GP on 24 May 2017, she reported improvement in anxiety and low mood. She was given a prescription of Sertraline to cover a period of just over two months. Despite that presentation on the morning of 24th of May 2017 the claimant then attended a drop-in surgery on the evening when she complained of feeling anxious. The clinician noted she was tearful and distressed but during the consultation calmed down. She was prescribed Propranolol for one month.

38. The claimant accepted that by June 2017 she had completed her medication and did not request any further prescribed medication.

39. On 27 July 2017 the respondent's occupational health department reported (133) that the claimant was undertaking all usual day to day activities with no problems and she had no problems with her concentration or ability to focus.

40. The next entry was on the 31 July 2017. It was noted the claimant was not taking any medication. She was not suffering from anxiety or depression. She complained that she was forgetful. A cognitive impairment test was undertaken by the GP which did not disclose any significant difficulties.

41. The claimant in her own impact statement for approximately this period said "things personally have been the best they had been for a long time". She described the intensity of her condition as being mild and "lowest" (paragraph 18) and all day-to-day activities were manageable.

42. On 09 October 2017 the claimant presented to her GP saying she was feeling low and demotivated and was diagnosed with low mood and signed off as unfit for work for some three weeks. That fit note was extended on 19 October 2017 for a further week and again the diagnosis was low mood.

43. On 15 November 2017 (162 to 163) the claimant presented to the respondent occupational health Department as stating her condition had significantly improved and although there were fluctuations in the symptoms, she could manage those symptoms more effectively.

44. The next entry, which is outside the material period, is dated 20 February 2018, where the GP noted that the claimant "currently sounds as though more low mood than anxiety" and diagnosed low mood.

45. At no stage during the material time was the claimant referred to a consultant psychiatrist.

46. At no stage during the material time was the claimant referred to the community mental health team.

47. At no stage during the material time was the claimant referred for CBT.

48. Other than six sessions of counselling accessed via the respondent the claimant has not had any other face-to-face counselling since December 2016.

The Claimants credibility.

49. In this case I had no report from a medical practitioner addressing the statutory definition of disability.

50. In particular I had no medical evidence as to how the claimant's impairment affected normal day-to-day activities, how the claimant was likely to function without medication and the likelihood or otherwise of re-occurrence.

51. Whilst it is not essential that such evidence is placed before a Tribunal a claimant still bears the burden of proof and without such evidence the credibility or otherwise of a claimant is of significant importance.

52. I did not find the claimant to be a wholly honest, credible and reliable witness.

53. I found the claimant was prone to making generalised statements unsupported by evidence or failing to concede points in cross examination which clearly should have been conceded. At times I found she exaggerated her evidence.

54. I am conscious this is a significant finding and it is only appropriate that I give some examples of why I reached such a conclusion. I should stress these are but examples so the claimant and respondent can understand my judgement. This not a comprehensive list.

55. The claimant contended that the physical problems referred to in her medical records were caused by her mental impairment. I cannot accept that the gynaecological matters referred to in the claimant's GP records had anything to do with a mental impairment. There was no medical evidence before me that a person suffering from anxiety was more prone to gynaecological infection than a person who did not experience such a condition as the claimant contended.

56. There was evidence in the medical records of muscular skeletal problems such as back pain. The claimant's case was that this was caused by her mental impairment. The claimant was examined by the respondent's occupational health department. In a report dated 26 May 2017 the occupational health physiotherapist concluded that the most likely reason for her neck pain related to unaccustomed exercise and the fact she was doing more typing and did not touch type and thus bent over the keyboard. The author only concluded that it was possible it was exacerbated by stress and anxiety. The Claimant would not concede the point and continued to maintain her mental impairment caused her muscular skeletal problems. In the light of the evidence this was not made out.

57. The claimant contended that her concentration was significantly adversely affected and she kept on forgetting things which impacted on day to day activities. This was an exaggeration and contradicted by the medical evidence. When the matter was examined by the respondent's occupational health department they reported on 27 July 2017 (108) that there were only two episodes of very short term and transient symptoms and enquiries via the claimant's GP noted that **"**the GP concluded that all relevant assessments which were undertaken regarding [the claimant's] reporting previous concerns with her memory and being forgetful have returned inconclusive and had been considered normal" (164)

58. The claimant in her impact statement, under the heading, “Adverse effects on day-to-day duties cannot do” referred to “hearing and sight”. When questioned the claimant could not give any cogent explanation as to how her hearing and/or sight was impacted by her mental impairment. At best she said she was forgetful and sometimes had problems with her sight in that she could not concentrate. I found the claimant exaggerated her evidence.

59. A further example, again given in the claimant impact statement of “adverse effects on day-to-day duties cannot do” was that she said she could not cook. That was not correct. Even on the claimant’s own evidence she was able to feed herself and her son. At its highest the claimant was more reliant upon convenience foods for a short period of time than cooking from scratch. It was wrong therefore for the claimant to say that she could not cook.

60. The claimant contended that her mental impairment was such that at times she could not drive. There was no medical evidence to support this and the respondent’s occupational health department in a report dated 29 of November 2017 (164) indicated that enquiries with the claimant’s GP revealed there was no medical reason why the claimant could not drive. It follows the medical evidence contradicted the claimant’s evidence.

61. The claimant attributed the fact she got a speeding fine whilst driving to her mental impairment and said this was example of how it affected the day-to-day activities because she would never normally speed. I did not find that convincing and regarded it as pure speculation.

62. The claimant contended she could not shop but when I asked who was doing her shopping for her, she then relented and suggested that she her own shopping but sometimes with difficulty. Again, I found this to be an example of the claimant exaggerating her evidence.

63. During her evidence the claimant referred to having delusional thoughts but there is no cogent medical evidence that this was a significant symptom that she presented to her medical advisers

64. .As I have already noted the claimant in her impact statement (paragraph 8) reported that by 20 July 2016 she was “undertaking daily activities without considerable, (sic) difficulties milder” yet when she was cross examined on this point said her impact statement was wrong. Either the claimant was not telling the truth when cross examined and the impact statement was correct or if she is right that the impact statement was not correct on this point and I am entitled to conclude there may be other assertions in the impact statement which are also incorrect.

65. For all the above reasons I did not find the claimant to be an honest and reliable witness

Discussion.

66. I am satisfied at the material time the claimant has been suffering from some form of mental impairment consistent with generalised anxiety disorder/stress and depression.

67. Such an impairment does not need to be clinically recognised.

68. There is sufficient evidence in the GP records, occupational health records and the claimant’s evidence (to the extent that I accept it) to support that finding.

69. The issue in this case, in my judgement, is whether the effects of that impairment were sufficient to satisfy the statutory definition of disability.

70. Whilst I remind myself that the threshold for a condition having a substantial effect on normal day-to-day activities is low, more than trivial, I am not satisfied that the claimant has demonstrated on the balance of probabilities a substantial adverse effect on normal day-to-day activities. Having looked at the guidance and the day-to-day activities as described the claimant I am not satisfied that performing those activities has been substantially affected by her mental impairment. She has been able to function and I do not accept she has not been able to undertake household tasks. It might be that on occasions she has not fulfilled those tasks to her own very high standards or on some occasions using convenience food. I regret to say due to my findings in relation to the claimant's credibility I did not find her account of what he could do or could only do with difficulty by way normal day-to-day activities to be a reliable indicator and in the absence of other evidence cannot accept the same.

71. I have noted in the Guidance those sections dealing with adverse effects on the ability to carry out normal day-to-day activities, D11 to D 19 and the appendix. I noted this is not a prescriptive or exhaustive list. When one looks at the Guidance and compares it with my findings of fact and in particular my concerns as to the claimant evidence, I find this case falls outside the statutory definition of disability. Ms Cakali accepted the claimant could function during the material time but not at her previous level. That is not the test as it would mean that a person who had very high standards but had to compromise them would on her argument satisfy the statutory definition. That is not right. All that has to be determined is whether the claimant ability to undertake normal day to day activities due to her mental impairment has a substantial and adverse long-term effect.

72. I have been careful to remind myself that it may well have been the claimant could do normal day-to-day activities because of the medication she was receiving, at least during part of the material time. I must discount the effect of that medication. Again, the difficulty I face is I have no reliable evidence as to how the claimant would function without her medication. I only have the claimant's word that she could not function without it and again due to my finding as to her credibility do not accept the same.

73. I have to consider whether the claimant's condition has a long-term effect. Mr Quickfall argued there had been a number of discrete episodes of anxiety or depression triggered by life events that would affect any person. In particular the diagnosis of the claimant's son with autism/Asperger's and then the very natural reaction to grievance and disciplinary proceedings causing the claimant to feel anxious. This is a case which is more akin to the second example given in section C 6 of the Guidance he argued.

74. However, I am satisfied the claimant condition has a long-term effect. I have considered whether this is an underlying condition with a fluctuating effect. Having carefully analysed the evidence I have found it is. I do not accept that there have been a number of discrete and self-episodes. The claimant is a person with a particular vulnerability. As she said in her evidence "I have always been anxious about my health, think I have got cancer or something else" This is a person who due to that personality trait will always have a pessimistic outlook on health which in turn is likely to trigger her anxiety. Whilst I note the

claimant has a coping strategy such as breathing which she can reasonably be expected to follow it has not proven successful. It has broken down in the past and that is a factor I must take into account in assessing the likelihood of recurrence. In any event I find the claimant has suffered from her claimed mental impairment for at least 12 months.

75. To conclude whilst I find that the claimant does have a mental impairment and it does have a long-term effect, she has not satisfied me that the impairment has a substantial effect on her ability to carry out normal day-to-day activities and therefore I must dismiss her claim.

Employment Judge T R Smith

Date: 13 February 2019