EMPLOYMENT TRIBUNALS

Claimant		**Respondent**
Mr N Ratcliffe	AND	RG Partnership Limited

HEARD AT: London Central **ON:** 13 December 2018 and in Chambers 11 March 2019

BEFORE JUDGE: Employment Judge Hemmings

Representation

For Claimant: Mr J England (Counsel)

For Respondent: Mr R Lassey (Counsel)

RESERVED JUDGMENT ON A PRELIMINARY HEARING IN PUBLIC

The Judgment of the Tribunal is that from November 2016, throughout 2017, and beyond, the Claimant was a disabled person within section 6 of the Equality Act 2010.

REASONS

1. This was an open Preliminary Hearing to determine whether or not the Claimant was, at the times relevant to his claims against the Respondent, a disabled person.

2. The context of these proceedings is comprehensively recorded within the records of the Preliminary Hearing-Case Management on 3 April 2018 and the Judgment on the Public Preliminary Hearing on 25 June 2018.

3. I had before me a Bundle marked R1, helpfully prepared by the parties. Page numbers in these Reasons are references to the Bundle, unless otherwise indicated.

4. I received testimony under Oath from the Claimant, referenced to his statement at pages 18 to 27 in the Bundle.

THE ISSUES

5. The sole issue at the hearing was whether or not the Claimant was, at the times relevant to his claims against the Respondent, a disabled person as defined by section 6 of the Equality Act 2010, and therefore legally entitled to the statutory measures within the Equality Act enacted to benefit those within the workplace having the protected characteristic of disability.

6. The period relevant to these claims is the Autumn of 2016 until the Claimant's resignation on 24 October 2017.

THE LAW

7. Section 6 of the Equality Act 2010 ("the Act"), provides that:

(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.

(2) A reference to a disabled person is a reference to a person who has a disability

8. Guidance, under Section 6 (5), about matters to be taken into account in deciding any question for the purposes of Section 6(1) was issued under Statutory Instrument by the Secretary of State in 2011:

Guidance on Matters to be Taken into Account in Determining Questions relating to the Definition of Disability (2011).

9. Part 2 of Schedule 1 of the Act refers to Section 6(5) and, amongst other matters, requires by paragraph 12, that an Employment Tribunal *"… must take account of such guidance as it thinks is relevant"*

10. Part 1 of Schedule 1 of the Act sets out supplementary provisions regarding the determination of disability.

11. Paragraph 5 of Part 1 of Schedule 1 to the Act headed **Effect of medical treatment,** provides that:

(1) 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 –

(a) measures are being taken to treat or correct it, and
(b) but for that, it would be likely to have that effect

12. Subparagraph 2 provides that "Measures" include, in particular, medical treatment.

13. Schedule 1 of the Act provides that:

The effect of an impairment is long-term if-

(a) it lasted 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

14. Guidance to the Employment Tribunal from the Employment Appeal Tribunal in the case of Goodwin v The Patent Office [1999] IRLR 4 is that the focus of the Equality Act is on the things that the Claimant either cannot do or can only do with difficulty, rather than on the things that the person can do.

15. "Substantial" is defined in section 212(1) of the Act as meaning "more than minor or trivial".

16. Guidance from the Employment Appeal Tribunal regarding section 212 (1) in the case of Aderemi v London and South Eastern Railway Ltd [2013] EqLR 198 is that unless a matter can be classified as "trivial" or "insubstantial" it must be treated as "substantial".

THE FACTS

17. The Claimant is a qualified architect.

18. Between the summer of 1997 and 24 October 2017, when he resigned, the Claimant was employed within the Respondent's business, an Architectural Design organisation based in Bury, Lancashire, and operating from sites in London and Greater Manchester, employing approximately 27 staff.

19. Throughout the period material (i.e relevant and significant) to these claims the Claimant was not only an employee of the Respondent, but also an Officer of the Company as one of its Directors, also a Shareholder, and additionally the son of the majority Shareholder, Mr Terry Ratcliffe, Managing Director and Chairman.

20. The limited information made available to the Tribunal regarding the facts in this case, at this stage in the proceedings, comes from the grounds of claim in the Claim Form, the grounds of resistance in the Response Form, two statements provided by the Claimant following a preliminary hearing for case management purposes on 3 April 2018, the Claimant's testimony from the witness stand at the open Preliminary Hearing in June 2018 and this Hearing, and the documents made available to the Tribunal, including those in the file marked R1.

21. The Claimant alleges, as background context, that he has raised serious concerns with the Chairman periodically since 2004 about a range of matters, including extreme work pressures, and an intimidating working environment, an autocratic leadership style, poor communications, and uncaring attitude to project resource-management, and succession issues.

22. The Claimant alleges that the Respondent's treatment of him "was largely or wholly responsible for causing" his illness during 2017/2018.

23. On 20 April 2017 the Claimant's GP issued a Med 3 Fitness Statement certifying that the Claimant was unfit to work for a fortnight because of "low mood" and immediately referred the Claimant to Dr Andrew Parker, Consultant Psychiatrist. That medical certificate was extended for a further four weeks on 4 May 2017 by a further Fitness Statement in which the Claimant's medical condition was referred to as Depression, an internationally recognised clinical illness with disabling characteristics, the Claimant having been seen the day before by Dr Parker who unhesitatingly (according to his letter of 10 May 2018, at pages 47 to 49), following a full psychiatric assessment, made a diagnosis of depression in the *"moderate to severe ICD-10 F32.2 range*".

24. The Claimant did not work between 20 April 2017 and 24 October 2017 on which date he met with the Respondent's Chairman, his father, and resigned from his employment, tendering one month's notice expiring on 25 November 2017 during which the Claimant was again covered by a Med 3 Fitness Statement as he had throughout the period from 30 April 2017.

25. The Claimant's account of the disabling impact of his medical condition is set out briefly in his Claim Form and comprehensively within his statement prepared for this Hearing, headed "Claimant's Disability Impact Statement", which is at pages 18 to 27.

26. Commonly, in disability discrimination claims, the primary source of evidence for the Tribunal in respect of the impact of a disabling medical condition will be the Claimants themselves and the Claimants' medical advisers, those medical advisers reporting from their medical records their patients' own account of their condition and its impact on them, as well as providing to the Tribunal an expert opinion on diagnosis, prognosis and the normal and probable patient-impact of such diagnosis. Claimants' accounts of their disabling conditions, and the medical evidence they place before the Tribunal require, like all evidence, assessment and ultimate determination by the Tribunal in terms of its value and the weight to attach to it.

27. The following findings of fact have been reached in respect of the Claimant's account, reflecting the probabilities about the Claimant's description of his experiences from October 2016 through to his resignation in October 2017, in terms of credibility and reliability, in the light of meticulous cross-examination by Counsel for the Respondent on every available basis for challenging the confidence the Tribunal should have in the Claimant's account.

28. The Tribunal records its observation of the Claimant, during cross-examination, displaying an evident respect for the hearing-process, concern to understand each question and to provide a considered response, and in spite of judicial interventions from the Tribunal (notwithstanding the facility for re-examination) inviting the Claimant to elaborate on simple Yes and No answers where the Claimant gave the Tribunal the impression that he was contemplating elaborating on his answer through a "*Yes but….*" or a "*No but*…." reply, a noticeably respectful, but not necessarily beneficial, reluctance to disagree with cross-examining Counsel.

29. Moving on from the Claimant's account to medical evidence a record of the Claimant's GP consultations from 1967 until October 2018 is at pages 30 to 44.

30. That Record includes a consultation on 20 April 2017 and notes *Generalised anxiety disorder* and *Depressed mood* and on 4 May 2017 notes *Depressive episode. Depressive disorder.*

31. A record summarising test results between 2010 and 2018, recent medication and active or significant clinical problems is at pages 45 to 46. That Summary includes the following:

    1 May 2018 - "*H/O: depression*" [H/O = history of]

32. The Consultant Psychiatrist's report dated 10 May 2018 records that the Claimant was referred by his GP to Dr Parker on 20 April 2017 and is graphic in its description of how the Claimant presented, clinically, at his first consultation with Dr Parker on 3 May 2017.

33. It appears from Dr Parker's report, Point 2 of the report at page 48 in the Bundle, that the Claimant's GP letter of 20 April 2017, referring the Claimant to Dr Parker, opines the "approximate time of onset as October 2016".

34. Dr Parker's Report has been considered and assessed by the Tribunal comprehensively. The Tribunal notes in particular the following individual extracts:

I completed a full psychiatric assessments and you also had a comprehensive set of blood test.

You gave very clear and convincing history of the onset of classical symptoms of a depressive illness commencing approximately October 2016. This began as marked fatigue, loss of interest in most things, including work, and a lack of capacity for feeling. This was clearly a qualitative change from your usual self. You were initially slow to recognise the symptoms and to seek help. Your condition progressed, however, developing further symptoms, and further functional impairment.

When I saw you on 3 May 2017 you appeared very tired and weary with large bags under your eyes and spoke with a hoarse voice. You were tense and there was a mild degree of slowness in your speech. Objectively, you appeared very depressed and lacking in capacity for pleasure. You described yourself as "empty and lost".

In addition, you reported poor concentration, low energy, low motivation, slight weight loss and fleeting suicidal thoughts. Sleep has been very poor with early-morning wakening (a classic symptoms of depressive illness). In the week prior to seeing you, you reported attaining only 3 to 5 hours of sleep per night, waking with negative ruminations.

I had no hesitation in making a diagnosis of ***depressive episode in the moderate to severe range (ICD-10 F 32.2)*** *[text highlighted by Dr Parker] at our first meeting, based on the combination of the history you gave me, as well as my clinical observations*

Subsequent meetings reinforced the appropriateness of this diagnosis, as for several further months you continued to be markedly depressed as observed by me in clinic as well as your self-report. At one point your score on the Beck depression inventory was 33 (in the severe range).

In my opinion, you had clearly developed a depressive illness rather than simply some depressive symptoms, or simply stress-related symptoms.

Some of the indicators that this was an illness and thus markedly different to normal biological functioning are the following features: complete loss of capacity for pleasure (anhedonia), definite early morning wakening, a mild degree of psychomotor retardation (slowness), as well as the persistence and pervasiveness of these symptoms over many months.

Your condition led to clear functional impairment directly because of the symptoms of depression.

You reported that your concentration, in particular, had become "rubbish" although you acknowledged long-standing problems with attention. I interviewed your wife on 10 May 2017, and she told me that you had become increasingly distracted, that you are not getting things done. Between May and July 2017 you continued to appear very depressed and I would have expected this to cause impairment in your ability to work and normal day-to-day activities to a moderate degree.

At our meeting on 7 June 2017 you told me that your mood had improved after commencing treatment but has become much lower again in the context of further difficulties with your father concerning work. On that day you scored 33 on the Beck depression inventory, (a commonly used validated tool for assessing the severity of depressive symptoms). A score of 33 indicates symptoms in the severe range.

*I do think that you were suffering from mental impairment, namely**, depressive episode in at least the moderate to severe range, sometimes severe (ICD-10 F 32.2),** and that this had begun around October 2016 and had been persistent since then, although I first examined you on 3 May 2017.*

From the approximate time of onset, as reported in the GP letter, 12 months later, on 11. October 2017, I reported you as being, "close to remission", but you continued on antidepressant medication at that time, namely Escitalopram 20mg per day, as well as Modafinil 50 mg per day for augmentation. Escitalopram was at the highest licenced dose. Had the Escitalopram been removed there would have been a very high chance that you would have relapsed back into depression quickly, as your improvement was very recent. Thus you were not in full recovery in October 2017.

35. The Tribunal's judgment on the facts takes into account the following, non-exhaustive, concessions made by the Claimant under cross-examination:

    (1) That the Claimant was not sure precisely about the timing of the onset of his mental health problems in the autumn of 2016, and that it might have been slightly after October 2016.

    (2) That in an email dated 22 November 2017 from the Claimant to the Respondent he did not refer to being depressed before April 2017.

    (3) That the Claimant objected to, and challenged, his father for expressing the opinion that the Claimant had "*suffered from depression for a number of years*" page 53.

    (4) That the Claimant had acknowledged that he had long-standing problems with attention, Dr Parker's report at page 2, such that he could not claim that his attention shortcomings were attributable to his illness.

    (5) That the Claimant was well enough on 11 July 2017 to register an internet domain name - page 54.

36. The Tribunal is satisfied on the evidence that from around October 2016, or slightly later, the Claimant's mental health deteriorated to the point where he was clinically depressed, his illness progressively eroding his ability to function normally and to carry out normal day-to-day activities.

37. From the onset of the depressive illness the Claimant exhibited classic symptoms of depression including insomnia, withdrawal from social interaction, irritability, an inability to enjoy anything, and disturbing ruminations. The Claimant lost interest in his fitness-exercise regime (frequent jogging), attending live music events, and socialising with friends, including diminished interest in interacting with his wife. The Claimant withdrew reclusively into himself and substantially ceased to engage in those normal lifestyle activities either because he could not do them at all given his mood and frame of mind or could only engage in them with difficulty.

38. Equally, and in consequence of his illness, the Claimant also lost interest in undertaking and completing the normal day-to-day activity of undertaking tasks in and around his home, and although the Claimant's attention span and concentration had never been a particular personal strength, he lost the ability to concentrate on simple day-to-day activities such as reading a newspaper or watching television.

39. The Tribunal is also satisfied that towards the end of 2016 the Claimant entered a state in which he suffered (and that suffering intensified over an extended period of time in excess of a year, impacting on the Claimant's ability to undertake normal day-to-day activities throughout that overall period) with nervous anxiety, uncontrollable worrying, irritability, insomnia, fearfulness, disinterestedness, hopelessness and despair (culminating in suicidal thoughts and consequent consideration of hospitalisation by his psychiatrist), with those symptoms managed through therapy sessions with his psychiatrist and medication, and ultimately, but slowly and progressively, alleviated through therapeutic measures and medication over an extended period of time into 2018.

40. Dr Parker's report refers to an expectation on his part of the Claimant's medical condition impacting on the Claimant's "*normal day-to-day activities to a moderate degree*". That professional opinion, available to assist the Tribunal's decision (it being a judicial, not medical, decision whether or not a Claimant meets the criteria of a disabled person within s.6 of the Act), is one of an adverse impact which is more than minor or trivial.

41. The Tribunal also observes that although Dr Parker corresponded with the Claimant's GP on 11 October 2017 (referred to in Dr Parker's Report) as "close to remission" this was within the context of the Claimant continuing on his daily antidepressant medication, Escitalopram at 20mg, the highest licensed daily dose a Doctor can lawfully prescribe, supplemented by Modafinil at 50mg daily. Dr Parker expresses the opinion to the Claimant in Dr Parker's Report, unsurprisingly it appears to the Tribunal, that "*had the Escitalopram been removed there would have been a very high chance that you would have relapsed back into depression quickly, as your improvement was very recent. Thus you were not in full recovery in October 2017*"

42. <u>CONCLUSIONS</u>

(1) The Claimant had a mental impairment, clinical depression, from around October/November 2016, throughout 2017 and beyond, a period exceeding a year. At the time of the Claimant's first consultation and examination by Dr Parker on 3 May 2017 the Claimant was diagnosed as having been clinically depressed since the autumn of 2016, some six months or so before, and as at May 2017 the Claimant's medical impairment was likely to last for at least 12 months overall, namely a further six months or more.

(2) The Tribunal places its attention firmly on the effects, the impact and consequences, of the Claimant's symptoms rather than the symptoms themselves. The Claimant's medical condition affected the Claimant's ability to carry out his normal day-to-day activities as recorded in the findings of fact above.

(3) That effect was adverse. It affected the Claimant detrimentally by reducing materially the quality of his life and sense of well-being.

(4) That effect was substantial in that it was more than minor, insubstantial or trivial.

(5) That effect was long term, exceeding 12 months, notwithstanding the ameliorating effect by the autumn of 2017 of the Claimant's medication, the Tribunal having applied paragraph 5 of Part 1 of Schedule 1 to the Act which, by law, requires the Claimant's clinical depression to be treated by the Tribunal as having a substantial adverse effect on

his ability to carry out normal day-to-day activities if, without the medical treatment, it would be likely to have that effect.

(6) The Judgment of the Tribunal is that from November 2016, throughout 2017, and beyond, the Claimant was a disabled person within section 6 of the Equality Act 2010.

(7) A final Preliminary Hearing for case management purposes will be listed to set the date for the Final Hearing and to make appropriate Case Management Orders and Directions. As both parties are now legally represented that Hearing will be conducted by telephone.

(8) Further, as both parties are now legally represented alternative dispute-resolution options will, undoubtedly, have been considered. As the Tribunal has observed at the earlier hearings a complex dispute is further complicated by the multiple relationships involved, the Claimant having been both an employee and an officer of the Respondent, a family business, with continuing connections through his shareholding and the indissoluble father-son relationship with the Respondent's Chairman. There are many means of resolving a dispute satisfactorily without a Final Hearing, one of which is Judicial Mediation, an option which will be on the agenda for the Case Management Hearing.

Employment Judge Hemmings

Date 25 March 2019

JUDGMENT AND REASONS SENT TO THE PARTIES ON

30 May 2019

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FOR THE TRIBUNAL OFFICE