EMPLOYMENT TRIBUNALS

Claimant: **Mr J Baker**

Respondent: **The Chief Constable of Gwent Police**

Heard at: **Cardiff** **On: 4 June 2019**

Before: **Employment Judge Harfield (sitting alone)**

Representation:
Claimant: Mr Nigel Henry (Employment Consultant)
Respondent: Mr Jonathon Davies (Counsel)

RESERVED JUDGMENT

It is the decision of the Employment Judge sitting alone that the claimant was not a disabled person at the material time under the Equality Act 2010. The claimant's disability discrimination claim therefore cannot continue and is dismissed. The claimant's constructive unfair dismissal claim continues.

REASONS

1. This is a reserved judgment on the issue of whether the claimant was a disabled person at the material time, following a preliminary hearing on 4 June 2019.

2. I was provided with a preliminary hearing bundle (152 pages). I had a disability impact statement from the claimant [121 – 123]. I also had the benefit of live evidence from the claimant. The parties' representatives both provided disability chronologies. The representatives gave oral submissions and the claimant also relied on the submissions set out in the letter to the Tribunal at [128-129]. The respondent provided written submissions within a position statement and also handed up copies of *J v DLA Piper UK LLP* [2010] IRLR 948 and *Herry v Dudley Metropolitan Council* [2017] ICR 610.

3. I make the following findings of fact.

Findings of fact

4. The claimant was employed by the respondent as a civilian financial investigator as part of the Financial Investigation Unit.

5. In 2016 the respondent was considering redundancies in the unit. The claimant was initially part of a group of staff who jointly proposed to cut their hours in order to avoid redundancies. The claimant later withdrew from the arrangement as he decided he could not afford the reduction in pay. Exactly what happened next is a matter of factual dispute for the final hearing. However, to adopt the language of the respondent in paragraphs 9 and 7 of the Grounds of Response, it is accepted that there was an issue of morale and tension within the team following the restructure and the claimant was by April 2016 expressing concern about feeling isolated at work.

6. The claimant states, and I accept, that he first began to have symptoms by August 2016. He had a poor sleep pattern and would find himself constantly waking up at night thinking through and ruminating over the days events and the problems he was experiencing. He would take his dog for a walk and find himself crying in the street. He was grumpy and short tempered with his wife and two daughters which made him feel guilty about his behaviour. I asked the claimant if there were any activities that he used to do with his family that he no longer did, but he did not identify any, explaining that his daughters were studying for exams. The claimant's mood was miserable and despondent. He states that he found it difficult to enjoy what he was doing. I asked him if that stopped him undertaking any activities, but he was not able to identify any. Within his statement the claimant states that he found it difficult to concentrate and that he tried to mitigate this by staying out of the way of others in the team so that he could think. However, he was not able to give any examples of any activities either in work or within his home life that were affected by this stated lack of concentration other than stating that he thought it probably had more affect at home and that he may occasionally skip part of a conversation. There was no evidence before me that the claimant's performance in work was hampered at all by a lack of concentration.

7. The claimant states, and I accept, that he did not consult his GP at that time because he is a proud man and he found it very difficult to accept that there might be something wrong with his mental health or to seek help. The claimant continued to have these symptoms and in February 2017 he asked the respondent if voluntary redundancy was still available as he thought if he changed his work environment he would feel better. By 3 April 2017

the claimant was not feeling better and he asked his line manager to refer him to occupational health for counselling [131].

8. On 19 April 2017 the claimant was told that his request for redundancy had been granted. He happened to have his occupational health appointment that same day [103 – 104]. Louise Thomas, Occupational Health Advisor (who it would seem holds a Diploma in Occupational Health), recorded the claimant had symptoms of:

> "increasingly emotional, poor sleep, short temper, reduced concentration and generally has a low mood. He has managed his symptoms himself and has not sought medical advice as yet, but feels that his symptoms are having an effect on his personal life and the workplace. He is well supported at home and reports is able to undertake all aspects of his activities of daily living at this time. He has regularly exercised and utilised his allotment to relieve some of his stress but has turned his knee and is now making regular exercise difficult."

9. Ms Thomas reported:

> "In my opinion Martyn is suffering from a reactive depression due to his working situation and environment and will hopefully improve once he leaves."

She referred the claimant for counselling and to some self-help resources and directed him to consult with his GP. She advised that the claimant was, in her opinion, fit for his full contractual duties.

10. On 2 May 2017 the claimant was told that redundancy was not likely to be available to him. He became very upset and reported sick. Page [134] of the bundle shows the claimant's wife speaking to HR and explaining it had taken the claimant an hour to get home from work, despite living a few minutes away, because he had been sat in the car "a broken man." The claimant states, and I accept, that this decision about redundancy caused a deterioration in his symptoms as he could no longer see a way out of his work situation. On 4 May 2017 he consulted with his GP for the first time. The entry states:

> "Stress at work Police Financial Investigator. Has worked for 38y. has been stressed ++ for a while. Been to see Occ Heal[th.] Been referred for counselling but considered fit for work. Some confusion last week was advised he could retire/made redundant and started working his month's notice but then told this week he couldn't. Really upset. Stressed. Left work and self certified. Says issues all work related although stressed this am as father currently in ambulance

> on way to NHH. Also anniversary of mum's death this week. Chat – bit tearful. Quiet. Not keen on medication Plan med3 2/52 and review. Also wishing to discuss knee but not enough time."

11. On 18 May 2017 the claimant saw his GP again. The entry says:

> "Stress at work same issues; is filing complaint; and seeking FOI info on reasons for not getting pay off now etc; P:ct med3 1m, and can request further until issues improving."

The Med 3 is at p105 and records the condition as "work related stress."

12. On 14 June 2017 the claimant lodged a grievance. On 16 June 2017 the claimant's GP reported:

> "Depressed mood still feeling low, stressed, issues at work see previous entry with JB; requested sick note, long discussion re antidepressant, do[es] not feel he is depressed to start antidepressants. – said he has been having suicidal thoughts every now and then – feels guilty for not being supportive to his daughter now with her A levels – wife is also a police officer and is supportive – tearful – said he is trying to cope by walking and running but his knee pain is preventing him from running now MSE poor eye contact, low tone voice, tea[r]ful, unkempt. Plan encouraged to try antidepressant low dose to help his sleep, counselling about SE, r/v in 4 weeks – Xray rt knee; did not examine due to time lim[i]t – issued sick note."

13. The claimant's GP prescribed him Mirtazapine, an antidepressant. The claimant only took the medication for a few days as it made him drowsy and unable to stay awake during the day and he also explained, and I accept, that he was reluctant to take antidepressants because of, in his mind, the stigma attached to mental health issues. He tried to manage his condition by instead walking miles every day, sometimes up to 7 or 8 miles a day.

14. The claimant saw Dr Hopkins, the Force Medical Advisor, on 21 June 2017 (p107 – 109). Dr Hopkins recorded:

> "Mr Baker feels that he has lost all trust in the organisation and is resentful and embittered. He also has a number of symptoms of anxiety including emotional lability and sleep loss… On the basis of the information provided to me today, Mr Baker's symptoms are entirely attributable to the current management situation. It is therefore unlikely that his health will improve without significant management action to resolve the ongoing situation. He is aware that counselling is available should he wish to access it, but without

> a change in the ongoing situation in work, it is unlikely that counselling would have a significant impact at this stage."

15. The claimant's GP on 24 July 2017 wrote:

> "Patient reviewed works for gwent police. Has been seen by occ health doctor who has advised that work related stress is unlikely to resolve unless work circumstances are changes. Work are in the process of investigating the issues raised by the patient. Has supportive wife, children awaiting exam results. Denies suicidal thoughts/plans, goes out walking every day to help relieve stress but has symptoms of depression such as low mood, sleep disturbance, tearfulness, lack of concentration. Mild anxiety sympts. Plan: fit note issued, chat about keeping active and activities to protect mental health. Rv in 4 weeks, sooner if needed."

16. On 15 August 2017 the claimant's GP noted that he was frustrated by delays with the investigation into his complaints of bullying and harassment. The GP recorded:

> "Sleep variable, appetite ok No suicidal thoughts Again – does not wish SSRI, tried zispie few nights -felt awful. Agreed to extend med 3"

17. On 15 September 2017 the claimant's GP noted that the claimant had:

> "low mood, did not like mirtazapine as he felt sleepy, issues with work are progressing but slowly; no active suical thoughts today; adamant he does not want antidepressant or counselling. (partly due to stigma of depression). Family is supportive. Requested another sick note; agreed to give but advised may need to show more engagement with services and offers of help if symptoms persisting."

18. On 13 October 2017 the claimant's GP recorded:

> "Patient reviewed requesting a fit note as going back to work; Pt will use annual leave on first two weeks then will discuss phased return with employer . agreed to give fit note with phased return. Not completely happy with the outcome but feels he wants to go back to work. Plan issued fit note as requested for 1 month ; advised to come back for further support if required."

19. On 20 October 2017 DI Bartholomew undertook a home visit [147-148], recording that the claimant was not happy with the outcome of the fairness at work investigation, that the claimant said his condition is improving and he intends to return to work. The claimant gave DI Bartholomew a med 3

[111] which stated the claimant had a stress related problem and may be fit for a phased return to work which the claimant was to discuss with his employer. The claimant's wife expressed concerns about the claimant returning to the same office due to his feelings about members of the team and the potential for the claimant to lose his temper and do something stupid. DI Bartholomew wanted an occupational health review before a return to work was planned.

20. On 24 October 2017 DS Preston emailed DI Bartholomew expressing concern for the claimant's welfare, having spoken to the claimant on the telephone [149]. DS Preston reported that the claimant's comments made him suspect that the claimant was still unwell and that returning to work could be further detrimental to the claimant's health. DS Preston indicated that he was applying for discretionary leave to be granted to the claimant to cover the period between the Med 3 certificate and the occupational health appointment.

21. On 6 November 2017 the claimant saw Ms Thomas, the Occupational Health Advisor [113 – 115]. She stated:

> "He tells me he is still quite upset and frustrated with the recent outcomes of his grievances. He is not sleeping, his mood is quite flat and he detailed typical symptoms of stress which is starting to affect his home life now. Martyn also appeared extremely tense and embittered with the whole situation."

She advised:

> "In my opinion Martyn is not psychologically fit to return to work in any capacity at this present time. I do not feel his symptoms have improved in anyway, if anything they seem to have deteriorated…
> It is my medical opinion that Martyn is suffering from perceived work related stress that is affecting him psychologically. His symptoms are unlikely to improve without resolution to his work related factors. Coping strategies provided by Counselling and the information that I have provided may help, but ultimately a return to his previous substantive position is likely to exacerbate his symptoms…
> Psychologically he is unfit to discharge his duties effectively due to his perceived work related stress. This stress is unlikely to be resolved fully with coping strategies or medical intervention."

22. Ms Thomas arranged a review with the Force Medical Advisor on 29 November 2017. The claimant remained on discretionary leave in the meantime. Dr Hopkins reached a different view as to the claimant's fitness for work [116 – 118]. Dr Hopkins reported that the claimant was still struggling to sleep and to concentrate on anything other than his ongoing feelings of embitterment and injustice towards the Force. Dr Hopkins noted

that the claimant had not found counselling helpful which Dr Hopkins stated is often the case in those with significant symptoms of embitterment "as counselling encourages them to further ruminate on the situation about which they are embittered leading to an escalation of symptoms."

23. Dr Hopkins' opinion was that the claimant was fit for work and fit for all duties and would not anticipate any adjustments or restrictions being necessary although a phased return would be helpful. Dr Hopkins noted there was the potential for further interpersonal difficulties but that this would remain a management issue rather than a medical one and not a situation likely to be resolved by any medical intervention. Dr Hopkins ticked a box to state he considered the claimant likely to be covered by the Equality Act.

24. The claimant returned to work on 12 December 2017. He states that on his return his anxiety increased as he found out that a number of his work files had been accessed in his absence. He could see no reason for this and it increased his lack of trust in colleagues and supervisors.

25. The claimant states that following his return to work he was subjected to a series of distressing incidents in work set out at paragraph 12 of the rider to his ET1. The exact nature of these events is the subject of a factual dispute to be determined at the substantive hearing.

26. The claimant states that he found his return to work very difficult and he tried to work in other police offices to maintain his own sanity and to get involved in enquiries that would take him out the office as much as possible. There is no documentary evidence before me of the claimant struggling to perform his actual duties in work in terms of, for example, struggling with particular duties because of a lack of concentration.

27. In his statement the claimant describes March 2018 as a "dreadful month." On 9 March 2018 he attended work but was feeling unwell. His diary entry at [150] records him sweating and feeling nauseous. He spoke with his wife who is a serving police officer who advised him to report sick. The email at [151] from DI Bartholomew records that the claimant's wife told him that the claimant was cold like/sweating and that "no underlying welfare issues were raised." The claimant understood that under Force policy as he was not absent for sickness reasons for the entire day this would not form part of his sickness record but it would instead be a day of work. The claimant returned to work on 12 March 2018. He did not consult his GP during that period.

28. On 14 March 2018 the claimant was told by DI Bartholomew that the claimant's absence on 9 March 2018 was to be recorded as a sick day rather than a working day or a day of annual leave. The claimant challenged this both with DI Bartholomew and with HR, in respect of which he received

a response from HR on 29 March 2018 which refused to remove the sick day record.

29. On 16 April 2018 the claimant reported sick. The claimant resigned in a letter dated 24 April 2018 in which he stated he was resigning in response to an accumulation of events, behaviour and treatment in respect of which the email from HR of 29 March 2018 was the final straw. He stated in his resignation letter that his delay in resigning was due to his illness. He states in his impact statement:

> "In April 2018, I could stand it no more; it was making me ill and I was again signed off work with "stress at work."

30. The claimant attended his GP on 24 April 2018 the entry states "stress at work ongoing issues impacting on mental health has taken legal advice and decided to resign. Asking for fit note as stress at work makes it impossible to return to work."

31. There are no other GP entries after that date relating to the claimant's mental health. The printout of GP entries at [119] shows that it was printed on 25 January 2019. The Schedule of Loss at [66] shows the claimant starting new employment from 30 April 2018.

32. The claimant told me in evidence that the symptoms of depression that he describes in paragraphs 11 to 13 of his impact statement, which include poor sleep patterns, crying, and being incredibly grumpy, morose and short tempered with his family (which made him feel upset and guilty at his own behaviour) were fairly continuous throughout the whole above period. He states that he still has symptoms of depression, including crying, to this day. In evidence the claimant agreed that he attributed the cause of his condition to his experiences in work.

The law

33. Under section 6 of the Equality Act 2010 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.
Under section 212(2) substantial means "more than minor or trivial."

34. Under paragraph 2(1) of Part 1 of Schedule 1 to the Equality Act, the effect of an impairment is long term if –

(a) it has lasted for at least 12 months,
(b) 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.

35. Under paragraph 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.

36. "Likely" in this context should be taken to mean "could well happen."

37. I was also referred to, and have taken into account, the "Guidance for matters to be taken into account in determining questions relating to the definition of disability" ["the Guidance"].

The relevant date of discrimination

38. The parties have agreed a proposed list of issues in which the respondent consented to the amendment of the claimant's claim if constrained to those agreed issues. The allegations of disability discrimination cover direct discrimination, section 15 unfavourable treatment, a failure to make reasonable adjustments and disability related harassment. The acts of discrimination complained about in respect of direct discrimination, section 15 unfavourable treatment and disability related harassment allegedly occurred on 25 January 2018, 1 February 2018, 9 March 2018, 21 March 2018, 22 March 2018, and an allegation of an ongoing failure to resolve the claimant's complaint about the treatment of his sickness absence on 9 March 2018, I presume through to the claimant's resignation. The alleged failures to make reasonable adjustments relate to broader periods of time, but the earliest that was identified by the claimant was the refusal to give the claimant voluntary redundancy on 2 May 2017.

Submissions

39. The respondent disputes that the claimant had at the relevant time a mental impairment. The respondent relies on *J v DLA Piper* (above) in which Mr Justice Underhill stated at paragraph 42:

> "The first point concerns the legitimacy in principle of the kind of distinction made by the tribunal, as summarised at para 33(3) above, between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to them as symptoms of low mood and anxiety. The first state of affairs is a mental illness – or, if you prefer, a mental condition – which is conveniently referred to as 'clinical depression' and is unquestionably an impairment within the meaning of the Act. The second is not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problems at work) or – if the jargon may be forgiven –

> 'adverse life events'. We dare say that the value or validity of that distinction could be questioned at the level of deep theory; and even if it is accepted in principle the borderline between the two states of affairs is bound often to be very blurred in practice. But we are equally clear that it reflects a distinction which is routinely made by clinicians – it is implicit or explicit in the evidence of each of Dr Brener, Dr MacLeod and Dr Gill in this case – and which should in principle be recognised for the purposes of the Act. We accept that it may be a difficult distinction to apply in a particular case; and the difficulty can be exacerbated by the looseness with which some medical professionals, and most pay people, use terms such as 'depression' ('clinical' or otherwise), 'anxiety' and 'stress'. Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If, as we recommend at para 40(2) above, a tribunal starts by considering the adverse effect issue and finds that the claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for 12 months or more, it would in most cases be likely to conclude that he or she was indeed suffering 'clinical depression' rather than simply a reaction to adverse circumstances: it is a common sense observation that such reactions are not normally long lived."

40. This passage was cited with approval by the Employment Appeal Tribunal in *Herry* (above). In which Judge David Richardson said:

> "55 …We would add one comment to it, directed in particular to diagnoses of "stress". In adding this comment we do not underestimate the extent to which work-related issues can result in real mental impairment for many individuals, especially those who are susceptible to anxiety and depression.
>
> 56 Although reactions to adverse circumstances are indeed not normally long-lived, experience shows that there is a class of case where a reaction to circumstances perceived as adverse can become entrenched; where the person concerned will not give way or compromise over an issue at work, and refuses to return to work, yet in other respects suffers no or little apparent adverse effect on normal day-to-day activities. A doctor may be more likely to refer to the presentation of such an entrenched position as stress than as anxiety or depression. An employment tribunal is not bound to mind that there is a mental impairment in such a case. Unhappiness with a decision or a colleague, a tendency to nurse grievances, or a refusal to compromise (if these or similar findings are made by an employment tribunal) are not of themselves mental impairments:

> they may simply reflect a person's character or personality. Any medical evidence in support of a diagnosis of mental impairment must of course be considered by an employment tribunal with great care; so must any evidence of adverse effect over and above an unwillingness to return to work until an issue is resolved to the employee's satisfaction; but in the end the question whether there is a mental impairment is one for the employment tribunal to assess."

41. The respondent submits that the claimant's mental state is an expression of his feelings about his work environment and that, in effect, the claimant is nursing a grievance (whether justified or not). It is submitted that such a state of mind does not constitute a mental impairment. The respondent further argues that, in any event, any impairment is not substantial and there is no evidence that it would fulfil the temporal aspect of the test for disability.

42. The claimant submits that it is clear that he did have an impairment and that the cause of the impairment is not probative as what matters is the effect that an impairment has on the individual's ability to carry out normal day to day activities (paragraphs A3 and A4 of the Guidance). The claimant relies on the impact on day to day life set out within his impact statement noting that he first sought a referral to occupational health in March 2017 (as above, the date in fact appears to be 3 April 2017) feeling that his day to day life was already by then being substantially affected and that he consulted his GP in May 2017 after he felt incapable of continuing at work due to mental impairment.

43. The claimant further submits that there is a long term adverse effect. Mr Henry refers to the claimant's absence from work from 4 May 2017 until his phased return to work on 13 October 2017 (I presume that is intended to be December 2017 as the claimant himself states in his pleaded case and his impact statement that he did not return until the December). The claimant's written submissions state that on 9 December 2017 the claimant was again unable to work and went home ill. I can find, however, no record of this sickness absence in the evidence before me (there is for 9 March 2018). The claimant submits that from December 2017 to April 2018 the claimant changed his working pattern to avoid his usual place of work when in March 2018 he found himself severely impaired and was too unwell to work from 16 April 2018 onwards. It is stated that the claimant is still suffering the effects of his depression today. It is submitted:

> "There is no previous history of depression or psychological impairment, the evidence clearly shows that if not continual, there is an intermitted recurrence of the same underlying condition that has lasted from at least April 2017 to at least November 2018, and is still continuing."

Findings

Adverse effects on day to day activities

44. In *J v DLA Piper* Mr Justice Underhill stated that in cases where there may be a dispute about the existence of an impairment it will make sense to start by making findings about whether the claimant's ability to carry out normal day to day activities is adversely affected (on a long term basis), and to consider the question of impairment in the light of those findings.

45. As set out above, I accept that by August 2016 the claimant was displaying symptoms of disrupted sleep, bouts of crying (particularly when walking the family dog), grumpiness and short temperedness with his family, a lack of enjoyment in activities, feeling miserable and dreading work. Having considered all the documents before me, the claimant's impact statement, his evidence at the hearing, and the Guidance, I am, however, unable to conclude that there was at this time a substantial adverse effect on the claimant's ability to carry out normal day to day activities.

46. I must concentrate on what the claimant could not do, rather that what he could. I also bear in mind that substantial should be taken to mean more than a minor or trivial effect. I also take into account the Guidance makes clear that at paragraph B5 that the effect can be on more than one activity, which taken together can result in an overall substantial adverse effect. The example given in the Guidance is:

> "A man with depression experiences a range of symptoms that include a loss of energy and motivation that makes even the simplest of tasks or decisions seem quite difficult. He finds it difficult to get up in the morning, get washed and dressed, and prepare breakfast. He is forgetful and cannot plan ahead. As a result he has often run out of food before he thinks of going shopping again. Households tasks are frequently left undone, or take much longer to complete than normal. Together, the effects amount to the impairment having a substantial effect on carrying out normal day to day activities."

47. The symptoms that the claimant here describes, however, are not of themselves normal day to day activities that have been adversely affected. As set out above, he was unable to give any examples of participation in family or home or social daily activities or hobbies that were disrupted due to his mood or behaviour. The claimant talked about having difficulties concentrating although he said to me in evidence that was more in his home life with skipping parts of conversations sometimes. He talked about trying to work with other people he found more supportive and that he was trying hard to do his day job. He was otherwise unable to give me any examples of any lack of concentration having an adverse impact on an actual activity

of daily life whether in work or outside of work and he works in a role that will require fairly significant concentration at times. As I have said, there is no evidence before me as to the quality of the claimant's work suffering due to a lack of concentration. I accept that avoiding individuals or having significant difficulty taking part in normal social interaction or forming social relationships can be a normal day to day activity. However, there is no evidence to suggest that the claimant was having such difficulties whether in work or in his private life outside of the particular group of colleagues that he had an issue with. I do not consider that an inability to interact normally with a particular group of individuals in work is a normal day to day activity. Taking all of this in the round I therefore do not consider that it amounts to a substantial adverse effect on normal day to day activities at this point in time.

48. I do accept that at that time the claimant had genuine symptoms including difficulties sleeping, tearfulness, low mood, and being short tempered. I also accept that this could amount to a mental impairment arising out of the claimant's reaction to work events rather than simply being a reflection of the claimant's personality or character responding to adverse workplace experiences. However, as stated I do not find there to be a substantial adverse effect on normal day to day activities at this point in time.

49. I find that the claimant's mental impairment continued at around that same level (and therefore not at the threshold of having a substantial adverse effect on day to day activities) and that continuation prompted him to seek medical attention in April 2017. Ms Thomas considered at that time the claimant was suffering from a reactive depression but also reported that the claimant was able to undertake all aspects of his activities of daily living and was fit for his full contractual duties. That supports my conclusion that the claimant did have had a genuine mental impairment but not one that was having a substantial adverse effect on normal day to day activities.

50. I find that there was a deterioration in the claimant's health from 2 May 2017 onwards once he was told that voluntary redundancy was unlikely to happen. His GP described him as having poor eye contact, a low tone voice and being tearful and unkempt. The claimant was reporting occasional suicidal thoughts. I find that at this time the claimant became unable to concentrate or control his mood sufficiently to perform the normal activities associated with day to day working life. The claimant was out walking daily sometimes 7 to 8 miles a day to try to clear his mind and exhaust himself so that he could sleep, this would have been to such an extent that I accept he would not have been fully engaging in other aspects of home life. I accept that at this time the claimant's mental impairment did have a substantial adverse effect on normal day to day activities. I do not consider that the claimant's failure to take antidepressant medication for any

sustained period is indicative of him not having a mental impairment or there not been a substantial adverse effect on normal day to day activities.

51. I find that by October 2017 there had been some improvement in the claimant's condition. He was seeking a return to work which was supported by his GP and Dr Hopkins. I bear in mind that as at 6 November 2017 Ms Thomas was stating that the claimant was not fit to return to work and that she felt his symptoms had deteriorated. However, on the other hand the claimant had told DI Bartholomew that his condition was improving and he intended to return to work and the claimant's GP and then Dr Hopkins supported a return to work which did then happen in December 2017. Further, whilst I take account of Ms Thomas' views as a medical practitioner, it is also relevant to acknowledge that it was Ms Thomas who referred the claimant on to Dr Hopkins for a more specialist view.

52. I therefore find that by December 2017 the claimant's condition improved such that he still had a mental impairment but that it no longer had a substantial adverse effect on normal day to day activities. Again, I accept that the claimant continued to have difficulties with sleeping, feeling upset, anxious, low mood, feelings of distrust and bitterness. But again these do not by themselves amount to normal day to day activities that have been adversely affected. There is no evidence before me that the claimant struggled to function with ordinary work activities on his return. Dr Hopkins advised that the claimant was fit for work and all duties without any adjustments being required. Again, the claimant talked about having difficulties concentrating, and how he attempted to mitigate that by not engaging with the team and seeking work elsewhere. But there remained no examples or evidence of the lack of concentration having an adverse impact on his performance of activities associated with daily life. I accept that the claimant also avoided interacting with those in the team he had difficulties with. However, again is no evidence to suggest that the claimant was having such difficulties outside of the group of colleagues that he had an issue with. As above, I do not consider that difficulties engaging or interacting with a particular group of work colleagues within a particular workplace setting is itself a normal day to day activity. Taking everything in the round I therefore do not consider that at this time, from 12 December 2017 onwards, the claimant's condition had a substantial adverse effect on his normal day to day activities. It is notable in that regard that the claimant was not having ongoing appointments with his GP or indeed with occupational health.

53. The claimant had a brief period of sickness in March 2018 but that appears to have been a cold related absence. Certainly, the claimant did not consult his GP about any psychological ill health at that time and the note prepared by DI Bartholomew following his discussion with the claimant's wife noted that no underlying welfare issues were raised. The claimant says that there

was a deterioration in his health in March and April 2018 after the series of incidents he identifies in the rider to his tribunal claim culminating in him reporting sick on 16 April 2018. However, he did not see his GP until 24 April (the date of his resignation) and did not request a referral back to occupational health. The claimant then did not ever see his GP again about his psychological health and he was able to take up new employment on 30 April 2018 [66]. The claimant's GP on 24 April did not record any particular symptoms or impact on day to day activities other than the claimant was saying that stress at work makes it not possible to return to work. There was no fresh offer of antidepressants or other treatment by the claimant's GP. Whilst I therefore accept that the claimant was continuing to have some symptoms at that time, including difficulty sleeping, low mood, tearfulness, short temperedness and the avoidance of his colleagues at work to the extent he again considered he could not be in his particular place of work and reported sick, I do not consider that this as a whole demonstrates that there was a substantial adverse effect on his ability to carry out normal day to day activities at that point in time.

Long term substantial adverse effect

54. It follows from the above that as at 2 May 2017, when the voluntary redundancy refusal was communicated to the claimant, whilst the claimant had been suffering from a mental impairment since August 2016 he was not at that time a disabled person as there had not, by that time, been a substantial adverse effect on normal day to day activities. I have found that any substantial adverse effect on normal day to day activities arose *after* that decision was communicated to the claimant.

55. To the extent that the claimant may argue that there were acts of discrimination in the period 2 May 2017 (after the deterioration in the claimant's condition) to 12 December 2017 I do not consider that he would meet the definition of disability at that material time. In respect of the substantial adverse effect on normal day to day activities after the 2 May 2017, I have found that substantial adverse effect had ceased by the time of the claimant's return to work on 12 December 2017. The period of substantial adverse effect therefore lasted approximately 7 and a half months. The claimant therefore did not have a mental impairment that had a substantial adverse effect on his ability to carry out normal day to day activities for a 12 month period.

56. I also do not consider that it can be said that at any particular point of time during that period 2 May to 12 December 2017 the substantial adverse effect was likely (in the sense of "could well happen") to last for at least 12 months. The claimant's situation has to be considered as it stood at the relevant time and not with the benefit of knowing with hindsight what actually happened next. However, the claimant's deterioration in May 2017 was as

a result of the reversal of the decision on voluntary redundancy and I do not find there is sufficient evidence to show that the substantial adverse effect on normal day to day activities that followed was likely to last for at least 12 months as opposed to being a temporary reaction to that particular circumstance. Med 3 certificates were not issued for more than 4 weeks at a time and there is nothing in particular in the GP entries that indicates a long term poor prognosis. The claimant had a period of sick leave where he was unwell and adapting to the fact that he would not be able to take redundancy and would have to return to work but by the October 2017 onwards he was improving and working towards a return to work. The fact that it could be anticipated the claimant may have ongoing difficulties in work if his relationship difficulties with the colleagues in question remained which would not, by itself, amount to a likelihood of continued substantial adverse effect on normal day to day activities because, as already stated, I do not consider that such communication and integration difficulties relating to a particular group of people in work constitutes a substantial adverse effect on normal day to day activities.

57. Following the claimant's return work, I have found that the substantial adverse effect on normal day to day activities ceased even though the claimant had some ongoing symptoms. At the time of the alleged acts of discrimination in 2018 the claimant therefore again was not a disabled person and had not been a disabled person in the past.

Recurring condition

58. The claimant relies on the concept of a recurring condition. As set out above, however, I do not find that the substantial adverse effect on normal day to day activities did recur after the claimant's return to work in December 2017. I also do not find that the substantial adverse effect on normal day to day activities was likely to recur. Again, I accept the claimant, if he remained in the work environment in question, was likely to have ongoing difficulties with the colleagues in question which would cause, at times, some symptoms. However, I do not find there is sufficient evidence to show that this would amount to a likely future substantial adverse effect on normal day to day activities bearing in mind that the claimant, apart from the period May to December 2017 (when he was dealing with the aftermath of the withdrawn voluntary redundancy) 2017 had been functioning, including in work, without symptoms at a level that they had a substantial adverse effect on his normal day to day activities.

59. I have already dealt with the contradictions between the report of Ms Thomas of 6 November 2017 and the other evidence from around the time of the claimant's improvement and return to work. There is therefore not sufficient evidence before me to show that it was likely that the claimant would deteriorate again and the substantial adverse effect recur. Dr Hopkins, who

it would seem is a more senior occupational health practitioner to Ms Thomas was, in effect, encouraging the claimant to return, and indicated that the claimant would be fit to return to all duties without adjustments. Dr Hopkins did identify there was the potential for further interpersonal difficulties to arise if the management situation went unaddressed but that this was a management issue not a medical one. Again, I do not consider that this is sufficient to demonstrate that substantial adverse effects on normal day to day activities were likely to recur. The fact that Dr Hopkins ticked a box to say the claimant was likely to be covered by the Equality Act without explaining why, and bearing in mind the wider contents of Dr Hopkins' report likewise does not convince me that the claimant's condition met the requirements of a recurring condition or that he otherwise was a disabled person within the meaning of the Equality Act.

Conclusion

60. In conclusion, whilst the claimant had a mental impairment, it only had a substantial adverse effect on the claimant's ability to carry out normal day to day activities in the period 2 May 2017 to 12 December 2017. There was therefore no long term adverse effect at any of the relevant dates and the claimant has also not established that the substantial adverse effect was likely to recur within the meaning of the Act as I have not been satisfied on the evidence that the effects were likely to recur beyond 12 months after the first occurrence.

_____

Employment Judge Harfield
Dated: 18 June 2019

JUDGMENT SENT TO THE PARTIES ON

……18 June 2019……..

.....
FOR THE SECRETARY OF EMPLOYMENT TRIBUNALS