Case Number: 3305134/2018

EMPLOYMENT TRIBUNALS

Claimant		**Respondent**
Miss S Mitterhuber	**v**	**Guardian Solicitors**

Heard at: Watford **On**: 24 April 2019

Before: Employment Judge George

Appearances

For the Claimant: Mr Burrett, Counsel
For the Respondent: Mr Green, Counsel

RESERVED JUDGMENT

1. The claimant was disabled within the meaning of s.6 of the EQA between 1 September and 12 October 2017 by reason of severe chronic pain (neck and upper, middle and lower back), severe dizziness, fatigue and chronic migraine in addition to depression and anxiety.

2. The claimant's application to amend her claim is refused.

REASONS

1. The claimant was employed as a Legal Secretary by the respondent from 23 November 2015 to 12 October 2017 when she was dismissed.

2. She was involved in a road traffic accident on 12 August 2017 following which she was seen by her GP two days later and certified unfit to work. Her absence was covered by Med 3 certificates which are in the bundle of documents and covered her absence from work up to 31 August 2017; although in fact she has been certified unfit to work for subsequent periods.

3. She returned to work on 1 September and the gist of her claim is that, on her return to work, instead of working for two particular fee earners, she was required to work solely for one of them. She complains that this led to an increase in workload. Her complaint is that when she started to work exclusively for this particular fee earner, it led to her suffering abuse and harassment by the fee earner in question and she was hampered in her

work because the fee earner would not use modern technology; that meant that the claimant's job was more onerous.

4. She argues that she is a disabled person within the meaning of s.6 of the Equality Act 2010 (hereafter the EQA) and that the requirement for her to transfer departments put her to a substantial disadvantage because of the increased workload and that a reasonable adjustment would have been for her to work for the other of the two fee earners, Davendra Rampersand, exclusively.

5. Following a period of conciliation that started on 10 January 2018 and finished on 24 February 2018, the claimant presented her ET1 on 21 March 2018. The respondent defended the proceedings by an ET3 that was accepted on 6 May 2018 and the case was case managed by Employment Judge Manley at a preliminary hearing on 21 September 2018.

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6. At that preliminary hearing, Employment Judge Manley recorded that the claimant stated that her disability consisted of:

> "severe chronic pain (neck and upper, middle and lower back), severe dizziness, fatigue and chronic migraine in addition to depression and anxiety that she has had since her road traffic accident on 12 August 2017."

7. At the time, the claimant was acting in person and was attended by her daughter, who I understand to be a solicitor experienced in housing law. Employment Judge Manley recorded the sole claim to be a breach of the duty to make reasonable adjustments and the issues to be,

   7.1 whether the claimant was disabled,

   7.2 whether the respondent knew, or could reasonably have been expected to know, that she was disabled;

   7.3 whether the respondent applied a provision, criterion or practice (hereafter referred to as a PCP) of moving the claimant from the Probate Department to the Litigation Department;

   7.4 whether such a PCP placed the claimant at a substantial disadvantage in comparison with persons who are not disabled, and;

   7.5 whether the respondent had taken such steps as were reasonable for it to have to take to avoid the disadvantage. The reasonable adjustments suggested were firstly, a workplace assessment and, secondly, allowing the claimant to remain in the Probate Department.

8. After disclosure of GP and other medical records and preparation of a witness statement, in accordance with Judge Manley's order, on 26 October 2018 the respondent wrote to the tribunal to indicate that they did not concede the issue of disability.

9. The claim had been listed for a two-day full merits hearing and when it was clear that that would be insufficient, given that the issue of disability was still live, that two-day hearing was converted to a one day open preliminary hearing in order to determine the issue of disability. Therefore, the first issue for me to decide is whether the claimant was a disabled person within the meaning of s.6 of the EQA between 1 September 2017 and 12 October 2017, that being the material period for the purpose of the present claim.

10. If the claimant does not show that she is disabled within the meaning of the EQA, the claims will be dismissed because she was dismissed before she had acquired two years' continuous service and therefore has not brought an unfair dismissal claim under the Employment Rights Act 1996.

11. After the preliminary hearing was listed, on 23 April 2019, the claimant made an application to amend her claim in order to raise claims under s.15 of the EQA. When it became apparent that I was unable to determine the issue of disability in sufficient time to deliver a reasoned judgment within the time allocated, I invited submissions from the parties on the application to amend and I also listed a provisional full merits hearing for 24 and 25 February 2020.

12. What are the adverse impacts upon her ability to carry out day-to-day activities that the claimant says were both substantial and long-term? It is argued on her behalf in broad terms that she has suffered chronic neck and back pain since the 1990s and has significant history of anxiety and depression. Against that background she suffered a road traffic accident on 24 February 2012 and a second road traffic accident on 12 August 2017.

13. In this preliminary hearing I have the benefit of a bundle of documents in which were four witness statements, prepared for the claimant, to which were attached various medical reports that I will particularise further in these reasons. The first witness statement also exhibits a number of documents that are more properly relevant should the case proceed to a full liability hearing.

14. I also had the benefit of a skeleton argument prepared by Mr Burrett and the authorities bundle that he provided for the tribunal's use.

15. That claimant gave evidence and was cross examined upon her witness statement. She had confirmed the truth of them in evidence. The first statement (referred to in these reasons as Claimant 1st) is dated 18 September 2018, the second (referred to here as Claimant 2nd) is dated 9 October 2018, the third (referred to here as Claimant 3rd) is dated 22 October 2018 and the fourth (referred to here as Claimant 4th) is dated 24 April 2019.

16. Mr Green said that the respondent had only been served with the fourth witness statement (to which is attached the medical report of Mr O'Dowd) very late in the day. He personally had only seen it on the morning of the

hearing. However, he took the pragmatic view that he was not going to ask for it to be excluded and was not seeking an adjournment.

17. He also pointed out before the hearing properly commenced that his recollection was that at the preliminary hearing before EJ Manley, at which he represented the respondent, the claimant had said that it was only after the accident on 12 August that the impact upon her of her conditions had been at a substantial level and that her statement to that effect had been carefully checked by the employment judge. The claimant did appear to accept that she had said this when she was cross-examined about it and it accords with the way that the issue about disability is recorded in the case management summary as quoted above.

The law

18. A person has a disability, for the purposes of the EQA, if they have a mental or physical impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. Substantial in this context means more than trivial: s.212(1) EqA and Goodwin v The Patent Office [1991] I.R.L.R. 540. There is no sliding scale, the effect is either classified as "trivial" or "insubstantial" or not and if it is not trivial then it is substantial: Hutchinson 3G UK Ltd v Edwards UKEAT/0467/13. As it says in paragraph B1 of the Guidance on the definition of disability (2011), this requirement reflects the general understanding that disability is a limitation going beyond the normal differences which exist among people.

19. When considering whether the adverse effects on the claimant's ability to carry out day-to-day activities are substantial the following factors are taken into account (see the Guidance Section B),

    a. The time taken to carry out an activity,

    b. The way in which an activity is carried out,

    c. The cumulative effects of an impairment,

    d. How far a person can reasonably be expected to modify his or her behaviour by the use of a coping or avoidance strategy to prevent or reduce the effects of the impairment,

    e. The effects of treatment

    f. There may be indirect effects, such as that carrying out certain day-to-day activities causes pain or fatigue (See Guidance on definition of disability (2011) paragraph D22).

20. The cumulative effects of related impairments should also be taken into account (see paragraphs B6 and C2 of the Guidance).

21. What the employee is not able to do or is only able to do slowly or less easily is frequently taken into account to decide whether there is disability: Ekpe v Commissioner of Police of the Metropolis [2001] I.R.L.R. 605 @ 608 para 27. Furthermore, the EAT gave guidance on evaluating the adverse effects of an impairment in Goodwin where they said,

> "The fact that a person can carry out such activities does not mean that his ability to carry them out has not been impaired. Thus, for example, a person may be able to cook but only with the greatest difficulty. In order to constitute an adverse effect, it is not the doing of the acts which is the focus of attention but rather the ability to do (or not do) the acts. Experience shows that disabled persons often adjust their lives and circumstances to enable them to cope for themselves. "

22. The EQA provides that, where an impairment is being treated, then it is to be treated as having a substantial adverse effect if, but for the treatment, it is likely to have that effect (Sch 1 para 5(2)). However, where the effect of continuing medical treatment is to create a permanent improvement rather than a temporary improvement it is necessary to consider whether, as a consequence of the treatment, the impairment would cease to have a substantial adverse effect (See 2011 Guidance at B16 and C11). And C5 ffg.

23. Recurring effects are covered in paragraph 2(2) of Sch 1 of the EQA where it provides that if in 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.

24. The effect of an impairment is "long-term" if it has lasted for at least 12 months or is likely to last for at least 12 months (Sch 1 para 2(1) – which also applies where the effect is likely to last for the rest of the life of the person affected). Likely means "could well happen": SCA Packaging Ltd v Boyle [2009] I.R.L.R. 54. What the tribunal has to assess is the likely duration of the effect judged at the time the allegedly discriminatory act took place. In the present case, therefore, I need to consider whether in the period from the claimant's return to work on 1 September 2017 and her dismissal on 12 October 2017, the effect or effects of the impairment relied on (see paragraph 6 above) had lasted or were likely to last for at least 12 months. Likely has the same meaning when considering the effects of treatment and seeking to answer the question whether, but for the treatment, the impairment is likely to have a substantial adverse effect.

25. When considering the effect of a mental impairment such as depression the most frequently cited case is J v DLA Piper [2005] I.R.L.R. 608 EAT. Paragraphs 40 & 42 of the judgment of Underhill LJ read,

> "40: Accordingly in our view the correct approach is as follows:

> (1) It remains good practice in every case for a tribunal to state conclusions separately on the questions of impairment and of adverse effect (and, in the case of adverse effect, the questions of substantiality and long-term effect arising under it) as recommended in *Goodwin*.
>
> (2) However, in reaching those conclusions the tribunal should not proceed by rigid consecutive stages. Specifically, in cases where there may be a dispute about the existence of an impairment it will make sense, for the reasons given in paragraph 38 above, 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.

…

> 42: The first point concerns the legitimacy in principle of the kind of distinction made by the tribunal, as summarised at paragraph 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 – […] - 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 laypeople, use such terms 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 paragraph 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 commonsense observation that such reactions are not normally long-lived."

26. Should it prove necessary for the tribunal to consider the application, it will need to consider the factors set out in Selkent Bus Co v Moore [1996] ICR 843–844. The first relates to the nature of the application itself, ie whether it is minor or substantial. The second concerns the time limits: where the claimant proposes to include a new claim by way of amendment, the tribunal must have regard to the relevant time limits and, if the claim is out of time, to consider whether the time should be extended under the appropriate statutory provision. This, however, is 'only a factor, albeit an important and potentially decisive one', in the exercise of the overall discretion whether or not to grant leave to amend. Third, it must have regard to the timing and manner of the application. Although delay in itself should not be the sole reason for refusing an application (see also para [314] below), the tribunal should nevertheless consider why it was not made earlier and why it is now being made. 'The paramount considerations are the relative injustice and hardship involved in refusing or granting an

amendment. Questions of delay, as a result of adjournments, and additional costs, particularly if they are unlikely to be recovered by the successful party, are relevant in reaching a decision'. (Mummery J in Selkent Bus Co.)

Findings of fact

27. The claimant had a road traffic accident (hereafter a RTA) on 24 February 2012 in which she sustained whiplash injury (Claimant 1st – paragraph 5) and psychological trauma. She clearly made a personal injury claim in relation to that accident and a report by John K O'Dowd, a Consultant Spinal Surgeon, who examined the claimant on 2 September 2014 for the purposes of that litigation is exhibited to Claimant 4th. The following relevant medical history is taken from that report.

28. Mr O'Dowd contrasted the claimant's description of her medical history with her documentary medical records. For example, he said in paragraph 6 that the claimant told him that she had previously had occasional episodes of neck pain which she described as "*normal neck ache*" but that that had never led to medical treatment or time off work and was not disabling. She had no recollection of previous back problems. However, the previous medical records that he catalogues in paragraphs 12 to 19, include a referral for x-rays for cervical and thoracic spine in 1991, and a reference to her visiting her GP in October 1996 complaining of "*painful neck constant – 5 years. Neck movement full*".

29. In July 1997 she was seen in a Rheumatology Department describing a five to six-year history of neck and right arm pain. And paragraph 17 of the O'Dowd report records a note in her GP's records, dated 6 November 2009, that she had visited complaining of neck pain which was described as "*chronic long-term often severe and aggravated by the stresses in her life*". A Consultant Rheumatologist who was seen on 6 April 2010 wrote that "*the claimant has had neck pain "for the last 20 years*"". Also of relevance is that Mr O'Dowd found a General Practice entry on 22 February 2012 related to migraine and it appears that the claimant had told her GP on that occasion that she had suffered from migraines for years but that over the last few months she had them three or four days a week.

30. The history recorded by Mr O'Dowd following the February 2012 RTA, is that the claimant had back pain the day after the collision (paragraph 22 of the report) and had physiotherapy in April or May 2012 which she found to be very painful. Paragraphs 22 to 28 of the report seemed to have been provided by the claimant's history. Paragraphs 29 to 39 seemed to have been provided by the medical records. I note that Mr O'Dowd says in his paragraph 66, that the claimant comes across as a "*reliable historian*" and also says "*I believe her description to date of restrictions on occupational, recreational and domestic activities as reasonable and these are of the result of the indexed accident*".

31. In broad terms, the claimant's history of her symptoms following the February 2012 accident, as recorded by Mr O'Dowd, are that specialist

physiotherapy from October to December 2013 seemed to have reduced her levels of pain (paragraph 23 of the report) but that she had a very acute flare up in December 2013. She referred to that in oral evidence before me and paragraph 36 of Mr O'Dowd's report substantiates that evidence.

32. The medical records referred to by Mr O'Dowd, dating between the February 2012 RTA and the December 2013 flare up, indicate that the claimant had right sided low back pain, when assessed by Physioworld in April 2012, but that the neck pain had resolved. The records appear to confirm that that physiotherapy did not produce very much improvement over four weeks or so and a recommended MRI scan took place on 16 October 2012. She was referred for physiotherapy again by her GP in June 2013 and the referred refers to:

> "recurrent bouts of neck and occipital pain triggering recurrent migraine headaches, standing with neck inflection or movements restricted. Very tender trapeze would benefit from physiotherapy."

33. The Physiotherapy Assessment Sheet at this time shows "*Significant right sided low back pain and paid across the back of the neck*" (Paragraph 35 of the report).

34. At the time of the assessment by Mr O'Dowd the claimant described current symptoms which Mr O'Dowd regarded as being "*a flare up in her cervical spine and lumber spine condition*". (See paragraph 62). In that paragraph it appears to me that Mr O'Dowd is making a judgment that the neck pain reported to him at the time of the examination was a flare up of a pre-existing and already symptomatic condition and not caused by the road traffic accident for which he had been instructed. Although he does record that there is a difference between the claimant's recount to him of continuous pain and the contemporaneous medical records that does not prevent his conclusion (paragraph 66) that the claimant is a reliable historian. It is the basis of his conclusion that the neck pain is not caused by the February 2012 road traffic accident. He does not doubt that the pain exists.

35. Furthermore, he reaches conclusion in paragraph 63 and 64 that the February 2012 accident produced a flare-up in a pre-existing cervical spine condition which lasted for six or seven weeks and a more significant flare-up in her underlying degenerative low back pain which persisted through until 2013. The claimant clearly had a substantial flare-up in December 2013 because Mr O'Dowd recorded seeing the Accident and Emergency Records associated with that.

36. My conclusion is that Mr O'Dowd's report supports a finding that, as at 2 September 2014 when he saw her, the claimant had a pre-existing cervical spine condition and an underlying degenerative low back pain problem for which she had received sporadic treatment as set out in his analysis of the medical records. The road traffic accident had precipitated a flare-up in those conditions. In respect of the flare-up of the underlying degenerative low back pain problem, that had persisted through until 2013. Although he

did not conclude that the road traffic accident had caused the December 2013 flare-up, that causal relationship is not something that I need to be concerned about. What I need to consider is whether the December 2013 incident was a flare-up in an existing condition and that does appear to be evidenced by Mr O'Dowd's report.

37. When considering the current treatment requirements Mr O'Dowd gives the opinion that the claimant is developing a "more significant chronic persistent pain state" although that is not related to the February 2012 road traffic accident. He recommends further specialist reports in paragraph 70 where he says:

> "I believe that Ms Mitterhuber is developing a chronic persistent pain condition refractory to various treatments. I believe that its causation should be assessed by a chronic pain expert. In addition, she has significant previous history of anxiety and depression, has a significant intercurrent history of depression and I believe that this should be assessed by a Psychiatrist."

38. There is also a review of relevant medical records in the report of Mr Malik, a Consultant Orthopaedic Surgeon, that is dated 8 July 2018 and appended at SM2 to Claimant 2nd. That report has been prepared on the instruction of solicitors representing the claimant in connection with personal injuries sustained in the August 2017 RTA. His review of the General Practitioner records, pages 2 to 3 of his report, indicate that the claimant was seen on 24 January 2014 because of back pain and then on 6 October 2014 because of back pain. It appears that she was advised to be referred to physiotherapy. This visit to the GP comes shortly after the examination by Mr O'Dowd. It then appears that the claimant did not visit her GP between 6 October 2014 and 12 April 2016 when she presented with multiple joint pain. She was then referred to the Rheumatology Department. It was accepted, on behalf of the claimant, that this was not the same medical problem as the neck and back pain which are relied on within these proceedings.

39. The hospital admission in December 2013 is referred to in the 9 December 2013 entry on page 3 of Mr Malik's report.

40. She then attended hospital on 3 February 2014, having been referred to the Musculoskeletal Department, presumably following the GP's appointment on 24 January 2014 when she complained of back pain. She was treated with monitoring with exercises and analgesics.

41. There is a subsequent hospital appointment of 3 April 2014 when the claimant presented with "*mechanical lower back pain*" and she was discharged back to the GP.

42. I note that she does not see the GP after that discharge in early April 2014 until October 2014 when she is referred to the Physiotherapy Department and there is a hospital entry consistent with that.

43. There is a 29 January 2015 referral in the hospital records to a referral to the Musculoskeletal Department because of "*acute back pain. She had fairly constant pain from neck to sacrum*." And the claimant is described as having "*Thoracolumbar scoliosis mainly due to muscle spasm*".

44. I infer that there was some treatment in early 2015 because the entry on 5 May records that the claimant was discharged from the Physiotherapy Department after receiving treatment for spinal pain and it says, "*She has attended clinic four times and was discharged from clinic*". There is then a corresponding entry to the GP's entry about multiple joint pain showing that the referral to the Rheumatology Department had taken place.

45. The claimant is in receipt of Employment Support Allowance and she produced the DWP's assessment for Personal Independent Payment, as the relevant benefit was then called, on 2 June 2016. It is clear from this document, which is appended to Claimant 1st, that she was assessed as being entitled to the daily living components of the PIP at the enhanced rate from 14 March 2016 to 27 May 2019. As the respondent points out the claimant was assessed as not being entitled to the mobility component of the PIP on the basis that the assessor had decided:

> "you can stand and then move more than 200 metres. You were observed to walk at a normal pace unaided and told the Assessor you can walk five minutes before needing to rest."

46. On the other hand, the claimant had told the Assessor that she had difficulties with planning and following journeys and the problems with anxiety and depression have apparently caused the decision maker to conclude that "*The claimant's ability to plan and follow journeys was affected more by her psychological impairment than by her physical impairment*."

47. The daily living component of the PIP does appear to have been assessed taking in to account the effects of anxiety and depression upon the claimant's ability to take decisions about preparing and cooking meals, managing her medication or monitoring her health condition and washing and bathing.

48. In her first witness statement the claimant does not give very much, if any, detail of the effect of the conditions on which she relies on her ability to carry out day-to-day activities.

49. Her second statement confirms the health conditions that she relies on. So, in paragraph 2 she says she has restricted range of movement-major pain in neck, shoulders upper, middle and lower back, right arm, right hip and leg. She also says that she suffers from severe migraines, dizziness, fatigue together with blurred vision and that those can cause disorientation and brain fog. She describes neuralgic pain in her jaw and eye sockets and reduced sleep because of the pain.

50. She was asked in her oral evidence to specify with more precision the time during which the effects described in paragraphs 3 to 6 of her witness statement were noticed by her.

51. She gave the following evidence:

> "I did have problems before with physical and mental health and I was assisted to feed myself and to make sure that I did things before the road traffic accident. After the road traffic accident the pain element was larger. Before, the physiological element was greater but I did have pain. "

52. The claimant went on to say that dizziness and nausea and fatigue caused her greater problems after the road traffic accident in terms of her day-to-day activities but that she had received help with various things, including washing her hair and preparing meals before the August 2017 accident. After it, the pain element had been such and she was so unsteady that she could not safely get in and out of the bath and could not do anything to use her right arm. After the road traffic accident, she had been unable to do housework. She had been unable to do her shopping and as the pain got worse and worse and more chronic, she did not leave her house anymore. Since the accident the dizziness meant that she was unsteady and was not confident crossing the road.

53. She was taken to the assessment for PIP from March 2016. She agreed that she had been working for the respondent as a Legal Secretary at that point and was asked how she had been coping with work. Her response was that she used to be very exhausted. She had taken the whole of her lunch hour to rest in the car or, in the summertime, to lie down in the park. In the evening when she got home from work, she laid down suffering from pain and exhaustion and someone would prepare food for her and feed her. At the weekend, she would be completely exhausted and in pain or knocked out on tramadol. She described herself before the August 2017 road traffic accident as suffering tremendous pain and a migraine by the weekend. She said that she took tramadol when she was so nauseated with the pain that she was obliged to. Usually she would make do with co-codamol but perhaps every third weekend she was obliged to use tramadol.

54. However, later in her evidence it became clear that she had not been prescribed tramadol since a prescription issued by the hospital and she dated this as being January 2015 when she had been referred to the Musculoskeletal Department (see page 4 of Mr Malik's report and paragraph 36 above). She accepted that she had possibly been given 30 tablets by the hospital and had been eking them out. By my estimation, this means that some 30 tablets had lasted the claimant for a minimum of two years and seven months (the time between the January 2015 appointment and the August 2017 collision. So, she cannot have been using them as frequently as every third weekend.

55. The medical evidence which comes next in time are the Med 3 certificates which are exhibited to Claimant 1st and show that she attended the GP following her accident and was certified unfit for work, initially until 31

August 2017, and then from 16 November continually to September 2018. The claimant has also produced a report from a Medico-Legal GP called Dr Naidoo, that was prepared for the purposes of the personal injury claim that arose from the August 2017 collision. It is based on an interview that she gave to Dr Naidoo on 27 September (that is to say, during the period under consideration in this preliminary hearing). It is the first exhibit of Claimant 2nd.

56. The report describes ongoing symptoms reported to Dr Naidoo at the examination of neck pain and stiffness, headaches, upper back pain and stiffness, mid back pain and stiffness, low back pain and stiffness, and dizziness. Dr Naidoo reports that the physiotherapy that the claimant had shortly after the accident she did not regard as having helped her more than a little. The present situation is described on page 5 as being that since the accident the claimant was unable to do hoovering, housework, lift heavy items, manage the shopping and her personal care was initially severely restricted but "*the problem resolved after four weeks*". She is described as having anxiety when driving or when a passenger but that is describe as mild or, in the case of driving, moderate.

57. Dr Naidoo says, in respect of the earlier road traffic collision, that the claimant had "*fully recovered after six months*". He carried out a physical examination but, on the claimant's account, did not carry out an investigation of her mental state, for example, by way of a questionnaire. At the then present time Dr Naidoo reported that the whiplash injury suffered in the accident "*is currently causing severe disability*". He recommended additional physiotherapy and "*I anticipate that with appropriate management, the neck pain and stiffness will resolve in six months from the date of this examination. There will be no long-term sequelae*."

58. He recommended eight sessions of physiotherapy and accepts the reported effect but in general terms says that they will resolve within five to six months of the date of the examination, making a period of seven and a half months from the date of the accident.

59. The claimant is critical of Dr Naidoo's investigation of her state of health. First, she said that there had not been any investigation of her mental state. Therefore, when - on page 6 of the report - Dr Naidoo says, "*Based on the interview and my clinical observations today Ms Mitterhuber was not suffering from anxiety and she was not depressed*", this was, according to the claimant, an opinion given without knowledge of her previous medical history and without investigating anxiety and depression by any of the clinically recognised methods.

60. She also points out that Dr Naidoo did not have her GP or hospital medical records. She did not agree that she had recovered from the February 2012 accident within six months and she was adamant that she would not have told Dr Naidoo that that was the case because that was untrue.

61. It is clear, looking at the GP records that are analysed in Mr O'Dowd and Mr Malik's reports respectively, that the road traffic collision in February 2012

caused pain and that whether the pain caused by the collision continued after six months or not, the claimant was still suffering pain in her back and neck long after August 2012. She was suffering it intermittently up to December 2013 when there was a severe flare-up. It would be extremely surprising, given the claimant's evidence to Mr O'Dowd, if she had said to Dr Naidoo that she considered the road traffic collision from February 2012 to have caused symptoms that were entirely resolved within six months. Furthermore, Mr O'Dowd's evidence is that there was an underlying condition. The claimant's evidence is that that underlying condition was causing her pain that got to the point, by the end of the working day, that it severely impacted upon her ability to do normal tasks such as prepare a meal. Regardless of what the claimant said to him the statement that the claimant had fully recovered after six months does suggest that Dr Naidoo did not have the claimant's pre-accident records – if it is intended to mean that she was entirely free of back and neck pain by August 2012.

62. Mr O'Dowd's report suggests that by the time he saw her in September 2014, some two and a half years after the first road traffic collision, the claimant was suffering significant symptoms from an underlying condition and that that condition had been already symptomatic prior to the February 2012 collision. The exacerbation of the pre-existing condition in the collision had, according to Mr O'Dowd, been resolved by the time he saw her. And, as I have said before, the ongoing symptoms were, in his view, "*gradually turning into a more complex chronic pain condition*".

63. There is no evidence in the recount of medical history in Mr Malik's report that between the date of Mr O'Dowd's report and the second road traffic accident the claimant had received treatment for that complex condition which was a combination of persistent musculoskeletal pain and significant concurrent psychiatric problems.

64. The claimant was referred to the Physiotherapy Department immediately following the second collision and a discharge sheet, prepared by Vahideh Khademi, confirms that at that time the claimant had a reduced ability to carry out housework, driving, hair washing, hobbies, sleeping, work and education and that that has been unchanged following the treatment received. Among the further comments is "*her condition is becoming chronic and is getting worse. As a result, it has affected her mood. It will be beneficial for the patient to be supervised by a Pain Clinic to manage her problems*."

65. The claimant was referred for an MRI scan and the diagnostic, dated 22 June 2018, suggests that the results were entirely normal for a woman of her age. Ms Treasure, a Physiotherapy Specialist, suggested continuing in physiotherapy or referring to a Pain Clinic. She has prepared a letter that was sent to the claimant's GP on 17 September 2018 and which is exhibited to Claimant 3rd. Her account of the history is that the claimant has a long history of spinal and limb pain:

> "symptoms started following a road traffic accident in 2012 and were not helped by physiotherapy. In August 2017 the pain worsened following a second RTA

> when the patient's car was hit from behind. Miss Mitterhuber reported that her symptoms were progressively worsening. She described generalised cervical thoracic pain with radiation into the posterior right upper limb associated with numbness and tingling. She also had a history of migraines, sinus problems and jaw pain. She has a low back pain radiating into the posterior aspects of the legs to the ankles. Both NHS and private physiotherapy with multiple referrals have been unsuccessful. She had worked as a Legal Secretary but lost her job due to regular sick leave. She is aware of her low mood and its influence on her symptoms. Pain was constant and she also reported dizziness, fatigue, altered vision, nausea and brain fog. She had anxious thoughts at times and these have also exacerbated her pain. She lived with her daughter and reported rarely leaving her house."

66. The recommendation is that the claimant "*would benefit from a multi-disciplinary team management approach to her symptoms, particularly given the large affective component of her presentation*."

Submissions.

67. On behalf of the claimant, Mr Burrett argued that the claimant suffered from a number of impairments at the material time (see para.28 of his skeleton argument) and that it was the effects of those impairments which should be considered. Caselaw, such as College of Ripon & St John v Hobbs [2002] IRLRL 185 said that it was not necessary to show the cause of the impairment or to categorise it; it was the effect which needed to be considered. These impairments had had an adverse effect on the claimant's ability to carry out activities concerned with personal care, domestic chores, shopping, travel, hobbies/socialising and work (C's skeleton argument para.35) and it was argued that this was substantial.

68. The long-term requirement of para.2(1)(a) of Sch.1 was satisfied because the claimant has been suffering with the adverse effects of her impairments (both pain in the neck and anxiety/depression) since the early 1990s. It was evident from the medical records and the PIP assessment that from at least April 2016 the adverse effect of the claimant's impairments was substantial: those adverse effects worsened following the collision on 12 August 2017 and have continued to deteriorate. Dr Malik's diagnosis of severe psychological overlay was consistent with Mr O'Dowd's report which diagnosed chronic pain syndrome and significant neck and back pain. That was an impairment that has existed for more than 12 months prior to the material time and continued afterwards. As to the physical pain, simply because she did not attend her GP, that should not be taken as evidence that she was not suffering pain.

69. Contrary to the respondent's arguments that there was limited evidence of anxiety or depression, Mr Burrett relied upon the PIP assessment in March 2016 which concluded that the claimant had problems with anxiety and depression. That assessment could not be viewed in a vacuum. On the strength of the assessment, the claimant was awarded PIP at the enhanced rate up to May 2019. That supported a finding in day to day activities such as hoovering and shopping her mental impairment had a substantial adverse effect upon her. I was reminded how the claimant said she had

coped with work by going to extensive lengths such as resting at every available opportunity and being left wiped out for the weekend which would itself have an effect on her ability to carry out day to day activites.

70. Alternatively, as at the date of dismissal, it was argued (C's skeleton argument para.50) that the period of impairment was likely to last for 12 months. This was on the basis that it was persuasive that the conditions had, in fact, lasted in excess of 12 months; Dr Naidoo's prognosis of the period of recovery (7.5 months from the accident) should not be relied on for reasons set out in para.50.b. of the skeleton argument and, in any event, he was of the opinion that she "could well" not recover in the timescale predicted. This should satisfy the lower threshold applicable to the prospects of the effects lasting into the future.

71. Finally it was argued that when you step back and look at the cumulative effect of various mental health and physical conditions, the task is more straightforward than taking the sequential approach.

72. For the respondent, Mr Green argued that I should be very careful about following the suggestion that the symptoms recorded in the PIP provided evidence in relation to the claimant's confidence of substantial adverse effects which could then be taken over by a completely different impairment. Paragraph C2 of the 2011 Guidance referred to the cumulative effects of relative impairments. To do as argued for the claimant, I would have to find that the lack of confidence which led to the successful claim for a PIP was related to the symptoms following the road traffic collision of 12 August 2017. He gave the example of a person who has arthritis for many years which affects their ability to use their hands and then breaks their arm. The impairments caused by the broken arm cannot be said to be the same condition; they were not related to each other.

73. The respondent took me to paragraphs B16 and C11 of the 2011 Guidance and argued that the reliance of Dr Naidoo on the anticipated beneficial effects of physiotherapy meant that, in accordance with the guidance at paragraph B16, I should regard physiotherapy as a treatment that was likely to give a permanent improvement. Since this was a treatment that would cure the impairment, I could take the anticipated resolution of the adverse effects into account; Dr Naidoo's advice was that with the help of physiotherapy there would be no substantial adverse effects within 7.5 months of the collision. Mr Green argued that this opinion evidence of Dr Naidoo refuted the counterargument argues that to do so would offend against the principle of deduced effects set out in Sch.1 paragraph 5(1) of the EQA and would take no account of the reality that the claimant's previous experience of physiotherapy was that it had been of limited, if any, benefit to her specific situation.

74. The respondent reminded me that the claimant's own case was that it was the road traffic collision of 12 August 2017 that had led to an exacerbation of her physical symptoms such that they had a substantial adverse effect and that that and Dr Naidoo's opinion evidence about the prognosis meant that she was unable to succeed.

75. The respondent also argued that the claimant was unable to rely on Dr Malik's report or any other evidence that had been prepared following the material period as grounds for concluding that Dr Naidoo's prognosis was wrong. It was a retrospective view, not a later attempt to give a contemporaneous view of how long the adverse effects. Dr Naidoo's statement that the claimant had previously recovered within four weeks must have come from somewhere.

76. Next, the respondents argued that the claimant was not a reliable witness as to the continuity and level of her symptoms. Taking that into account, I should conclude that for two years prior to the road traffic accident she had only had mild symptoms of backache and then also that there must have been some improvement of her condition to enable her to return to work when she did on 1 September 2017.

77. Next, the respondent repeated that the claimant's previously understood case had been that there had only been a substantial adverse effect on her ability to carry out day-to-day activities following the road traffic accident. The focus of enquiry should be on the long-term nature of the impairment because the respondent accepted that the claimant had an impairment, and that it impeded her substantially on a day to day basis. However, the respondent did not accept that the impairment had a substantial effect before the collisions nor did the respondent accept that, after the August 2017 collision, the adverse effects were "likely to" last at least 12 months in total as that phrase was explained in SCA Packaging.

78. The respondent argued that the claimant's own oral evidence did not provide evidence of physical symptoms at all immediately prior to August 2017 and she said that the psychological effects were greater. [I pause there to say that my note of her oral evidence was that there was pain prior to August 2017 which got progressively worse during the course of the day but that she was able to carry on and function in pain. It was that the physical effect became so much worse after the road traffic accident that she was not able to function as she had before.] The respondents argued that I should therefore conclude that any previous issues with neck and back pain had been resolved by the point of the road traffic accident.

79. It was argued that the PIP was not evidence of physical impairment and there was no documentary evidence from the GP or any medical report that she had suffered mental health problems between 2015 and 2017.

80. In respect of any argument that the claimant was suffering from a condition that had recurring effects, the respondent argued there would need to be some sort of evidence of one impairment which recurred. The example given being of psoriasis which can return. Here, there was, according to the respondent, nothing that showed a recurring condition that had spontaneously come back in 2017. We knew that the claimant had a previous collision in which she was injured this condition it did not spontaneously come back in 2017; the claimant was injured in a road traffic accident. When there is an external and mechanical cause, it is unfortunate

for the claimant that she has had two road traffic accidents but there is no evidence of a recurring condition.

Conclusions on the preliminary issue

81. The way that the claimant identified her disability (para.6 above) was as a composite physical (chronic pain in her neck and back, dizziness, fatigue and migraine) and mental impairment (depression and anxiety). The adverse effects on her ability to carry out day to day activities which have been accepted by the respondent to be substantial and which followed the RTA on 12 August 2017 include inability to do housework (such as vacuuming) and shopping (including carrying heavy bags). At least initially there was a lack of steadiness which meant that she could not get in and out of the bath and could not do anything to use her right arm (see paragraph 53 above). See also the details provided to Dr Naidoo set out in paragraph 57 above approximately 6 weeks after the collision. There is considerably more detail before me about the claimant's state of health than there is about the effect of her health conditions on her ability to carry out day to day activities. Nonetheless, I conclude that, following the RTA on 12 August 2017 the physical and mental impairments from which she suffered did have that substantial adverse effect upon her abilities to carry out day to day activities.

82. It is argued by the claimant that the fourth limb of the statutory test of disability – that the substantial adverse effect should be long term – is satisfied in one of two ways. First because I should be satisfied that the claimant has been suffering from those adverse effects since the early 1990s and secondly, in the alternative, because even looking at the period from 12 August 2017 onwards alone, the effects were likely to last in excess of 12 months.

83. In my view, it is important to keep in mind that the claimant has alleged that she is disabled because of the diverse effects of different impairments in combination. The claimant has had the misfortune to suffer two RTAs. The first one had the effect I describe in paragraph 36 above. There was an underlying degenerative low back pain problem. The opinion of Mr O'Dowd that the claimant was developing a chronic persistent pain condition and recommendation that she should be assessed by a psychiatrist is not one which I have heard was taken up, but she had a significant history of anxiety and depression prior to the February 2012 RTA. My conclusion is that, on the balance of probabilities, the physical pain caused by the August 2017 RTA was a similar flare up to that described by Mr O'Dowd (see paragraph 34 above). His belief that the claimant was developing a chronic pain condition and that her intercurrent history of depression should be assessed by a psychiatrist causes me to conclude that at that time the claimant was suffering from the effects of essentially the same combination of impairments of which she presently complains.

84. Mr O'Dowd accepted the claimant's descriptions of restrictions on her "*occupational, recreational and domestic activities*" and although he is not of the view that, by the time he sees her on 2 September 2014, those

restrictions are caused by the first RTA, the evidence recorded in his report, both of his own observations and culled from her medical records, causes me to conclude that at that time severe neck and back pain (which triggered migraines) in combination with anxiety and depression caused the claimant to be disabled within the meaning of s.6 of the EQA both in terms of the substantial adverse effects of those conditions and the length of time that she had been suffering those effects. By the time of the O'Dowd report, she has been reporting these effects to varying degrees for more than 2 ½ years. It would be 5 May 2015 before she was discharged from physiotherapy.

85. However it seems to me that the adverse effects of the claimant's health conditions did not remain static over the period from 29 January 2015 (when she was reporting constant pain from neck to sacrum – see paragraph 43 above) to the time of the 2nd RTA. I bear in mind the way that the claimant described her disability to EJ Manley and the way she put her case before her (see paragraph 17 above). She said that it was only after the RTA on 12 August 2017 that her symptoms had become significant. It seemed to me that the claimant, in her oral evidence before me, struggled to distinguish between different points in time when describing the changing effects of her health conditions upon her – something which Mr O'Dowd also commented upon. The medical records and reports make clear that her contemporaneous accounts were that there had been improvements and relapses. She conceded before me that before the August 2017 RTA the physiological element was greater than the pain but said that she had had pain.

86. The PIP assessment provides evidence of significant adverse effects on the claimant's abilities to carry out some tasks because of anxiety and depression which has justified her being awarded the daily living component (see paragraph 46 above) but the assessor has not assessed her as entitled to the mobility component. The different tests applicable for that benefit mean that the assessment is of somewhat limited value and I remind myself of the dicta in Goodwin that the fact that someone can carry out particular activities (such as the physical tasks set the claimant by the assessor) does not mean that her ability to carry them out has not been impaired.

87. Nonetheless, the medical evidence before me does not refer to neck and back pain after January 2015. The joint pain which was troubling the claimant in April 2016, she accepts to have been unrelated. The PIP assessment does not preclude the physical impairment still affecting the claimant but does not provide evidence of the degree to which it was affecting her.

88. That means that the evidence of the effect of neck and back pain, dizziness, and migraines on the claimant through the course of her employment by the respondent, prior to the August 2017 RTA is only that of the claimant herself. As I have already said, she has struggled to distinguish between the effects of impairments at different times. She did give evidence that she had to take extreme measures to cope with work (see paragraph 53 above) and I accept that the mere fact that someone is coping does not mean that

they do not experience substantial adverse effects upon their ability to carry out day to day activities. However, the claimant has clearly exaggerated the number of occasions upon which she had to take tramadol, given that she made a 2015 prescription last for more than 2 ½ years (see paragraph 54 above). She did not see the need to seek a replacement prescription, relying upon over-the-counter painkillers. I am therefore of the view that her evidence of the degree of pain from which she was suffering prior to the August 2017 needs to be heavily discounted. If she was in pain, that does not of itself mean that there were adverse effects on her ability to carry out day to day activities at that time and I do not find her evidence of the effect of her conditions on her abilities before the second RTA to be reliable – not because she is deliberately trying to mislead. It is rather that she has difficulty recalling her state of health at different periods of time.

89. I have concluded that, whether because of the January to May 2015 physiotherapy or some other reason, the pain suffered by the claimant in her neck and back probably reduced and her ability to carry out day to day activities probably improved. That is consistent with her own explanation to EJ Manley that it was from the point of the second RTA that the impact upon her of her conditions was substantial.

90. Consequently, to the extent that the claimant was disabled by reason of neck and back pain, migraines, fatigue, depression and anxiety at the time of the O'Dowd report that was, in my view, a past disability by the time of the second RTA. One cannot simply, in my view, ignore the way the claimant put her case before EJ Manley. As the respondent's pointed out, there were gaps in GP attendance, in particular after the attendance at hospital on 29 January 2015 with acute back point until the attendance on 12 April 2016 with an unrelated problem. There is no evidence of a GP appointment from then until the second RTA.

91. I accept the respondent's submission that it would not be right, in the context of a claim based upon a disability defined with an emphasis upon neck and back pain as well as depression and anxiety to say that the claimant fulfilled the long-term element of the definition of disability by focussing upon the effects of depression and anxiety prior to event which caused the neck and back pain. Essentially the claimant has a long history of neck and back pain and a long history of anxiety and depression. The former appear to have had a disabling effect on her abilities for a long period but then improved to the point when they were no longer disabling. The latter may have had a fluctuating but still present effect over a longer period. That does not mean that when the claimant suffers an unrelated incident which causes a further period of neck and back pain, she can immediately satisfy the long-term criteria for the physical condition. However, her experience of and response to treatment would naturally inform the prognosis for the later incidence of pain.

92. I also accept that this is not a case involving a recurring disability within the meaning of Sch.1 para 2(2) of the EQA for the reason articulated by Mr Green. In my view the adverse effect of the disability ceased to be substantial at some point between the two RTAs and there is very limited

evidence that the condition might spontaneously deteriorate (only the documented spasm in December 2013).

93. I therefore turn to the question of whether the claimant has shown that, from the vantage point of 1 September to 12 October 2017, the substantial adverse effects of neck and back pain, dizziness, fatigue, migraine and depression and anxiety which had started on 12 August 2017, were likely to last for at least 12 months in the sense that they could well last for twelve months.

94. Understandably, the respondent relies heavily upon Dr Naidoo's report. Reading it carefully, I am of the view that he says that it was the specific problem of severe restrictions on her personal care which were reported to have resolved after four weeks from the second RTA. The claimant said that she was unable to get out of the bath unaided and my sense is that was probably what he was referring to. Otherwise his conclusion that there would be a resolution of pain within a further six months doesn't make sense. I accept that the claimant would not have told Dr Naidoo that she had recovered from the first RTA in six months because that would be so markedly in contrast with the objective evidence about what happened. If she did then she was misremembering in the same way as she did when recounting her history to Mr O'Dowd.

95. I find that Dr Naidoo's opinion that the claimant would be fully recovered within six months of the consultation leads to the conclusion that he probably did not have available to him all of the claimant's medical records as explored by Mr O'Dowd and Mr Malik. That was the claimant's evidence (paragraph 60 above) and I accept it. In particular, he cannot have been aware of the report of Mr O'Dowd or that on 16 October 2012 (i.e. 8 months after the 1st RTA – see paragraph 32 above) the claimant had an M.R.I. scan. That alone would have alerted him to the fact that his statement that the neck and back pain from the February 2012 RTA had resolved in six months was inaccurate as would the conclusions of Mr O'Dowd to which I refer in paragraph 35 above. Dr Naidoo, a medico-legal GP, does not engage in his report with whether or not the 2nd RTA has aggravated an existing condition (contrast that with Mr O'Dowd's report at paragraph 64).

96. Therefore Dr Naidoo's opinion that physiotherapy would be likely to lead to the neck pain and stiffness resolving by March 2018 was made in ignorance of relevant information about the effect of physiotherapy on the claimant's neck and back pain in 2012, 2013 and 2015 and in the mistaken belief that a previous bout of neck and back pain had resolved within six months. It is therefore not reliable as evidence of how long the substantial adverse effects of the claimant's neck and back pain in late 2017 were likely to last.

97. It seems probable to me that the claimant still had the underlying condition referred to by Mr O'Dowd and the depression and anxiety for which she was awarded the PIP. I do not forget that Dr Naidoo observed that the claimant did not appear to be suffering from depression and anxiety, but he was at pains to state that he based that solely on his clinical observations and interview that day. I accept the claimant's evidence that he did not carry out

any recognised evaluation of her mental state in his consultation with her. I therefore give little weight to that statement. In my view, the fact that she was also suffering from depression and anxiety could well have affected the time it would be likely to take her to recover from the direct effects of the second RTA.

98. I do not rely upon Mr Malik's report to come to that conclusion. I do not consider his report to be a reliable guide to the likelihood that the effects of the claimant's impairments were long term from the vantage point of September or October 2017 because of the possibility that the intervening loss of employment affected her psychological state.

99. My conclusion is that the evidence of the length of time it took for the effects of neck and back pain reported after the first RTA to resolve is a much better indication of what was likely to happen after the second than Dr Naidoo's opinion. The effects of the first RTA persisted from February 2012 until 2013 but then, because of the underlying condition, did not subside until after January 2015. There seems to me to be ample evidence from which to conclude that, in the claimant's case, as at September/October 2017 the substantial adverse effects could well have lasted for 12 months.

100. I have therefore concluded that the claimant was disabled within the meaning of s.6 of the EQA between 1 September and 12 October 2017 by reason of severe chronic pain (neck and upper, middle and lower back), severe dizziness, fatigue and chronic migraine in addition to depression and anxiety.

The application to amend

101. The claimant's application to amend was made by email dated 23 April 2019. In that email she sought to allege that the respondent treated her unfavourably for a reason arising in consequence of disability by,

    101.1 Moving her from the probate department (working for Devendra Rampersaud) to the litigation department (working for Maxine Maderson);

    101.2 Not properly consulting her about this move;

    101.3 Ms Maderson behaving aggressively towards her;

    101.4 Refusing to allow her to use the firm's case management system for work in the litigation department;

    101.5 Failing to carry out any workplace assessment;

    101.6 Summarily dismissing her on 12 October 2017, allegedly on performance grounds.

102. The claimant alleges that the reason for the above treatment was that she had taken sickness absence and was struggling with the excessive workload and that that arose in consequence of her physical and mental health condition resulting from her disability.

103. The claimant argues that this is a relabelling exercise and the facts stated in the statement of case give rise to the proposed s.15 EQA claim. It is argued that because of her disability and because she was struggling, the respondent ought to have carried out a workplace assessment. The behaviour for which she was dismissed arises from the fact that she was struggling. The move put her to a disadvantage because she was not allocated light duties. Although there was presently no claim in relation to the dismissal, the specifics relating to the dismissal were in paragraphs 23 to 27 of the particulars of claim. As to why the claim had not been put this way before, the claimant has been acting in person, assisted by her daughter who is a housing law solicitor. It was argued that the claimant would suffer prejudice if the claim were not amended, if the reasonable adjustments claim were not to succeed. On the other hand, it was argued that the respondent would suffer little prejudice because the claim was still at the preliminary hearing stage. There had yet to be disclosure and statements and therefore amendments would have cause no delay to the proceedings.

104. The respondent argued that it was not true to say that it was merely a relabelling because it was proposed to add a claim relating to dismissal. The claim form appeared well put together with a summary of the law and a statement of facts as they apply to the law. Nowhere does it say that it was unfair that I was dismissed or that dismissal was an act of discrimination. The argument moves away from the reasonable adjustments claim to a claim that the actions of the fee earner were effectively retaliation for sick leave. As a claim, the proposed amendment is 18 months out of time; if it were a brand new claim it would be refused. There is no explanation for the delay which affects whether there is prejudice to the claimant. There would need to be further evidence dealing with the amendment. There was no evidence from which it might be judged whether it would be just and equitable to extend time. Both that and the strength of the proposed claim is relevant to the question of prejudice. Although the respondent stated that one witness had left their employment Mr Green did explain that she was expected to give evidence anyway. Essentially the claimant seeks to bolster her claim when she has spoken to another representative.

105. In my view this is not a mere re-labelling. The original claim does not make a claim that the act of dismissal itself was discriminatory. If the claimant is able to prove her case and also prove that her dismissal was a consequence of any proven failure to make reasonable adjustment she would be able to claim losses flowing from the dismissal as losses caused by the failure to make reasonable adjustments. However, that is not to attack the reasons for the dismissal or the process followed. In my estimation this is a new cause of action and therefore a substantial amendment to the original claim. The application was made some 18

months after dismissal whereas, taking into account the period of early conciliation, the claim should have been presented by 24 March 2018 and is therefore 13 months out of time. Although disclosure and witness statements have not yet been exchanged, this hearing was to have been the full merits hearing. It is not as early on in the proceedings as the claimant's representative would argue and the issues were defined after a careful case management by EJ Manley.

106. There has been no explanation of the reason for the delay beyond reliance upon the claimant being a litigant in person. I do take that into account and also that she is vulnerable because of her mental impairment. On the other hand she has been supported throughout by her daughter who managed to use her legal training to good effect in investigating the rights of disabled people under the Equality Act 2010 sufficiently to enable the claimant set out the legal basis for her claim in her claim form. It seems clear that she had access to and the ability to understand sources of employment law. Disability discrimination is a technical area and lawyers who hold themselves out as practicing in employment law do not always articulate the claim properly at the first attempt. I do not lose sight of the fact that the claimant was acting in person and I do not think that too much reliance can be made on her daughter being legally qualified. However, the reason the application has been made does appear to be only that the claimant and her advisers now think that the claim might be better framed a different way. The claimant explains in her application that she has only recently instructed a direct access barrister and was not aware of the possibility of making the claim before.

107. This is relevant to the prospects that, if the amendment is permitted, the employment tribunal at final hearing would consider it to be just and equitable that they should have jurisdiction to hear the claim, notwithstanding the fact that it is presented late. That is not a forgone conclusion.

108. The respondent asserts that they will suffer prejudice because they will have to look to present different evidence. However, they do not allege that they will need to call different witnesses and the one witness they said had left their employment is to be called despite that. They would have to face a more complex case and it would involve more preparation. This is prejudicial but only in a limited way.

109. However, a provisional view of some of the claims which the claimant seeks to raise suggest that they are not, on the face of it, ones with strong prospects of success: the claimant would need to prove that the respondent had not properly consulted with her because she had taken sickness absence; that Ms Madderson had behaved aggressively towards her because she had taken sickness absence; had failed to allow her to use the case management system and failed to carry out any workplace assessment. These are all acts which do not lend themselves to a claim under s.15 of the EQA. This is relevant to the question of prejudice because there is less prejudice to a litigant who is unable to advance a

claim which has limited prospects of success. This is particularly so when there are other existing claims which can provide a route for the issues between the parties to be decided.

110. Taking all that into account I have concluded that the balance of convenience in the present case lies in favour of me refusing the application to amend. The issues remain as defined by EJ Manley with the exception of the issue of disability which has been decided in the claimant's favour.

111. The parties agreed that, in the event that I decided the preliminary issue in the claimant's favour, the case management orders of EJ Manley should be replicated with suitably adjusted dates. A separate case management order will be sent out at the same time as this reserved judgment.

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Employment Judge George

Date: ……24 June 2019 ……..

Sent to the parties on: ....27 June 2019...

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For the Tribunal Office