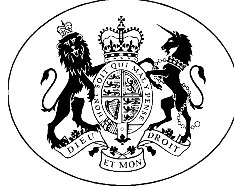

# EMPLOYMENT TRIBUNALS

**Claimant:** **Mr M Hathaway**

**Respondent:** **Santander UK PLC**

**Heard at:** **Cardiff** **On: 14 June 2019**

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

**Representation:**
Claimant: Mr L Welsh (Law at Work)
Respondent: Ms Wynn-Morgan (Counsel)

# RESERVED JUDGMENT

It is the decision of the Employment Judge sitting alone that the claimant had a mental impairment and was a disabled person by reason of that mental impairment at the material time.

# REASONS

### Introduction

1. The claimant was employed by the respondent as a Branch Director from April 2008 until his dismissal on 22 June 2018 for alleged gross misconduct. By way of a claim form presented on 24 October 2018 the claimant complains of unfair dismissal and disability discrimination (section 15 Equality Act 2010 discrimination arising from disability, and section 21 failure to make reasonable adjustments). For the disability discrimination claim the claimant relies upon two impairments: polycystic kidney disease ("PKD") and depression. The respondent disputes the claimant's claims.

2. Part of the claimant's case relates to a Training and Competence system introduced in mid 2017. The claimant was placed on a Development Action

Plan on 19 September 2017 having failed a quality check. On 4 October 2017, following a further review of the records maintained by the claimant, he was suspended on the grounds of allegedly falsifying observation records. He attended a disciplinary hearing on 28 March 2018 and a further disciplinary hearing on 20 June 2018. The claimant was told of the decision to dismiss him on 22 June 2018. An appeal hearing took place on 9 August 2018.

3. Within the particulars of claim appended to his claim form the claimant asserts that side effects of his medication for PKD include anxiety, confusion, disorientation and depression. Within the claimant's further and better particulars of claim the claimant asserts that his PKD causes dizziness and headaches which did not allow him to follow the Training Competence system correctly. The particulars of claim also confirm that the claimant relies upon depression as a second impairment. The claimant states that began following health scares surrounding his wife and son. The claimant asserts that his depression causes forgetfulness and lack of concentration which also did not allow him to follow the Training Competence system correctly.

4. Within amended Grounds of Resistance the respondent admits that the claimant's PKD amounts to a disability. The respondent does not admit, amongst other things, that the claimant's medication for PKD causes the claimed side effects or that the condition itself causes dizziness and headaches. The respondent does not admit that the claimant suffers or suffered from depression or that it amounts to a disability.

5. A directions order was made by Judge Frazer on 1 March 2019 at a case management preliminary hearing. The case is listed for a 3 day hearing in September 2019. It came before me to determine the question of disability.

6. I identified at the start of the hearing the potential for cross over between the symptoms claimed by the claimant as arising from PKD/ medication for PKD and the symptoms of his claimed depressive impairment. The respondent admits that the former condition meets the test of being a disability but not the latter. The respondent stated that it was not asking me at the preliminary hearing to make any findings as to the claimant's PKD and to concentrate only on the depressive condition. The claimant agreed. I also clarified with the claimant the material date relied upon, as the claimant must establish he met the threshold of being a disabled person at the time the alleged acts of disability discrimination occurred. The claimant stated that this was September 2017 onwards when the issues first started for the claimant which led to disciplinary allegations and thereafter the claimant's eventual dismissal.

7. I heard evidence from the claimant. I heard oral submissions from both parties' representatives. I was also provided with a bundle of documents extending to 85 pages.

**Findings of fact**

8. To the extent necessary to determine the question of disability, I make the following findings of fact.

Period to October 2017

9. The claimant was diagnosed with PKD in 1985. It is a condition that will requirement treatment for life. The claimant had a kidney transplant in June 2013. He has to self-catheterise daily and takes a range of medication including omeprazole, aspirin, adoport, and mycophenolate. Some of these medications are immunosuppressants to stop his body rejecting the transplanted organ. The claimant states that as a result of such medication and the requirement to self-catheterise daily, he is at greater risk of infection, including urinary tract infections (UTIs). He states that UTIs cause night sweats, shaking, sickness, pain and confusion. The claimant also states that adoport and mychophenolate mofetil can have side effects of insomnia, depression, anxiety, mood changes, dizziness, lack of energy, confusion and disorientation.

10. The claimant states that the impact of his own physical health issues, and health issues within his family built up and affected his mental health.

11. On 10 May 2017 the claimant's brother underwent a kidney transplant. The claimant, as his brother's immediate family, spent time with him. The claimant explained, and I accept, that it brought the memories flooding back of his own transplant.

12. The claimant's wife has Crohn's disease and has been unwell for some time. On 7 June 2017 she underwent emergency bowel surgery. I find that it was around this time, in June 2017, that the claimant first started to display avoidant behaviours, in not fully supporting his family members with their health issues as he was unable to face or handle the pressure. He did not take his wife to the hospital on the morning of her operation, saying it was because of pressures of work. He also left his wife at home alone after the surgery to fend for herself.

13. The surgery did not bring the claimant's wife much relief from her symptoms. On or around 17 June 2017 she commented to the claimant words to the effect of, what was the point of her carrying on with her life if she was always going to be in that state. The claimant explained and I

accept, that he felt helpless to assist his wife and that he was useless as a husband.

14. At around this time the claimant was dealing with a disciplinary issue in his branch where it was alleged two members of staff had falsified records on an account. One member of staff was verbally aggressive to the claimant. The claimant states, and I accept, this added to his accumulating anxiety and sense of being overwhelmed.

15. Around 19 June the claimant developed a chest infection but continued to go to work. His wife then had to return to hospital for further treatment and he did not take her in, again going to work.

16. On 28 June 2017 the claimant's son told him and his wife that he had a potentially serious medical problem. Following a consultation on 6 July 2017 the claimant's son was told he needed urgent surgery.

17. On 7 July 2017 the claimant attended hospital for a kidney check up and his pulse was tracking abnormally low. He told them he had been suffering from headaches, dizziness and lack of concentration. The doctors advised they would monitor his results.

18. In mid July 2017 the claimant went on a break to Devon with his wife. The claimant stated that this was not a good holiday and that he treated his wife "like a dog." They had to return early as the claimant was unwell with a chest infection that had not properly cleared from the earlier bout. On 21 July 2017 his GP diagnosed him with acute bronchitis. On 24 July he had further UTI.

19. On 28 July 2017 the claimant's son attended for a pre-operation assessment and was also diagnosed with PKD. The claimant's son was acutely upset, and in emotional angry state, blamed the claimant for having a child knowing the disease was hereditary, and for giving it to him. The claimant was distraught and describes himself crying himself to sleep for many nights. He felt it was his fault and he knew the life that his son would lead, in fear of the disease. The claimant states that his father, aunties and uncle all died around the age of 56 and the disease feels like a death sentence. The claimant states that he is repeatedly troubled with his own thoughts that he will never see his children grow up, get married and have children.

20. On 7 August 2017 the claimant's son had surgery. The claimant's wife took their son in.

21. On 10 August 2017 the claimant was feeling unwell and his GP diagnosed a further chest infection. The claimant also saw the transplant team on 11

August as he was feeling worse. The claimant's pulse was again tracking low and he stated that he was struggling to remember things. He was advised that beta blockers could be causing the symptoms of low heart rate and associated side effects. He was told to stop the medication although that could cause side effects in itself. He was also diagnosed with a UTI. He still went to work.

22. On 5 September 2017 the claimant's son had an appointment. The claimant did not attend but went to work instead. His wife told him on the telephone that their son had a rare and aggressive form of cancer. The claimant said his world came crashing to a halt and he did not know what to do. He went even further in to denial and did not go home and instead returned to work. The claimant's son returned home to live with the claimant and his wife whilst he underwent intensive chemotherapy.

23. At around this time in late August and early September the claimant started to have suicidal thoughts and dreams. This included planning how to drive a car off Barry head.

24. The claimant was removing himself from his family and family responsibilities giving the excuse of the pressure of work. However, he was also having difficulties in work. The claimant gave examples of become aggressive with staff in work. He explained that historically he had been a good coach in work, making it fun and motivating but he found himself not coaching but grilling his staff and telling staff what to do and not to do and getting aggressive and speaking loudly at them. He would get annoyed and leave the room and everyone ended up upset. He also gave an example of having to speak to staff about being late for work and his deputy manager pulled him out of the room as he was screaming and shouting at the staff. The claimant gave another example of his area manager visiting and telling him that he was getting complaints about the claimant's aggression. He stated that he even then argued with his area manager. The claimant did not recognise he was behaving aggressively at the time but instead felt that the staff did not care. He became paranoid that they did not want to listen or be coached.

25. At home the claimant would ask his wife about her appointments but stated that somehow he would turn that in to an argument. He states that he treated his son the same way and was in denial that his son had cancer. He would tell his son there was nothing wrong with him and turn it into a blazing row. He would then go into the bedroom and put headphones on and listen to music to get away from it. He said he would go to bed at 8pm to get away from things but that it did not help as he could not sleep. When he did sleep he had nightmares and hot sweats.

26. The claimant explained that he was not making anyone's lives either at home or in work a good place to be in at that time and the more helpless he felt about not being able to do his job properly or support his family properly, the cloud bearing down on him got heavier and heavier.

27. The claimant was also suffering from confusion and forgetfulness at times. He gave examples of his wife telling him about appointments that he would forget and plan his day in work and then find his wife and son were expecting him to give them a lift. The claimant was an ardent ice hockey supporter and forgot to go to a match as he forgot the game was on. He gave examples in work of forgetting to be in observations and being generally forgetful to the extent that in a managers meeting his manager would make comments such as "how come you don't remember things". He would write things down in a book to try to help to remember but then forget to look into the book.

28. The claimant also stopped participating in hobbies and activities. He stopped running and bike riding and stopped taking the dog out for a walk. He lost energy and motivation stating he would be on the sofa or in bed by 8pm of an evening. He stopped going food shopping with his wife. He felt tired, and gave the example of feeling really tired in work in observations. In work he also would try to hide away in the office instead of being on the shop floor doing the tasks he should be doing. He became disinterested in ice hockey, giving his tickets away to friends. The claimant would go into work thinking about what was happening at home, and at home he would be ruminating over why he was behaving the way he was at work or how to avoid situations in work.

29. The claimant also developed auditory hallucinations as he would think that his wife had said something to him when she had not, and he also suffered from them in work when he thought someone had said something only to find out that they had not or that there was no one in fact standing behind him. He recalled his deputy manager telling him that he was doing "her head in" by saying "sorry, what was that?" when she had not said anything. He said he also had dizziness at times.

30. The claimant also became paranoid about his wife and his manager and what they thought of him (or what his manager thought of his branch) and that it meant that he felt like he could not speak to either of them. At home his denial that there was anything wrong and inability to speak also caused marital difficulties. His wife was angry with the claimant's behaviour and they would argue at home.

31. On 12 September the clamant had a further UTI. On 13 September 2017 the claimant saw his GP, having been sent there by the pharmacist when trying to get treatment for a cough. The note reports "Other than feeling run

down (Currently being treated for UTI) well in himself." I accept, however, that the claimant was in denial at the time that there was anything wrong with his mental health.

32. On 19 September 2017 the claimant was placed on an action plan in work. On 22 September 2017 the claimant was given a further 6 weeks of antibiotics to clear his infections.

33. On 28 September the claimant's son told him that he had something which might have indicated a further cancerous growth. The claimant's son was panicking. The claimant felt his life was spiraling out of control and that he was powerless to do anything.

34. On 4 October 2017 the claimant was suspended from work. He describes it as the final straw. He had been in work for a normal working day including a staff meeting where he had staff shouting at him. He ended up leaving the room. Later on that day he was told that he was suspended. After leaving work the claimant broke down and thought he would end it all as he could not support his wife and family and could not do his job properly either. He gave evidence of how, driving home, he wanted to drive into the central reservation to kill himself, and it was only when he noticed there was a family in the car behind him that he realised he could not put them at risk too. The claimant got home and broke down in front of his wife. He told her that he had been feeling depressed since October 2016 and that things had become progressively worse. He told her he had been feeling suicidal for about 6 weeks and had driven to places where he planned to kill himself but could never go through with it.

35. The claimant's wife arranged an emergency GP appointment. The GP surgery entry at [64] starts with a note by a Mr Joseph Forde about the claimant's cough and previous chest infection. It then states:

> "Been feeling down since May. Low mood, poor memory, withdrawn. Certain events over summer – son diagnosed with cancer, work stress, health issues, poor sleep, anhedonia, anergia. Symptoms particularly worse over last few weeks. Suspended from work yesterday due to errors made on paperwork. Some suicidal thoughts and dreams – driving car off cliff, but not seriously considered it. No previous history of depression or mania. No family hx of mental health. Some auditory hallucinations, paranoia to wife and work – both noticed by wife. Anxiety since before May.
>
> Plan: Time off work (sick note given). Pt and wife made aware of crisis team. Started diazepam, sertraline, zopiclone Pt advised to speak to renal specialist about change in medication before starting."

There is a further entry that same day by Dr Ueberhorst which states:

> "..renal transplant for polycystic kidneys, works for ban[k], recent illness in family, wife operation, son diagnosed with ? cancer in ?epidydimis, awaiting hospital reviews and decisions, poor sleep, nightmares, poor concentration, restless, moody, thoughts of self harm but no plans, crying yesterday, admitting to wife how he is feeling, his mum no diagnosis of mental health but never left house, advice re start sertraline, short term zopiclone, diazepam, wife with check with renal clinic re meds, med3, review 2-3 weeks or sooner, advice re crisis team, will try to get counselling through work."

36. The GP entry records that a med 3 was issued for 21 days with a diagnosis of stress at home. The claimant's GP also told his wife to remove his car keys and watch him closely and she stayed by his side, working from home, for several months.

37. The claimant told me in evidence, and I accept, that in the period October 2016 until his breakdown following his suspension at work, there was a build up of his mental health difficulties. His infections were getting him down (he had had 6 months of antibiotics to try to kill the recurrent infections) and he had to catheterize daily, not always in the most sanitary of conditions. His brother had his transplant and his wife was very ill and was very upset and what particularly took its toll on the clamant was that he could not step in and help her condition. There was then his son's serious health issues of both cancer and the PKD diagnosis which made the claimant feel even more helpless, together with what was happening in work and the medication he was taking for his PKD he also felt was not helping him. He told me that he had explained to his counsellor that it was like layers in a cake and everyday he felt like there was another layer added to it. He felt that whether at home or in work he was not doing his job properly and that in hindsight he should not have been in work, but at the time he could not see it.

After 6 October 2017 until January 2018

38. The claimant states that after the GP visit for the first couple of weeks he was in an almost comatose state due to the sleeping tablets. He started counselling and at first he could not really speak to the counsellor but she gradually drew it out of him. The claimant was very withdrawn and wanted to stay in bed all day and close out the world. He found it an effort to get out of bed and get dressed and on days that he could he would stay in his pyjamas. The claimant describes how he became withdrawn but also felt guilty as he could not support his wife or son with their health issues. He had disrupted sleep and sometimes when he could sleep he would then sleep excessively. He had nightmares about killing himself and would wake

up in cold sweats. His appetite would come and go. Some days he would not eat at all and others he would not stop eating. He states he was not able to concentrate or remember the smallest of things. He lost confidence and did not want to leave home which became his safe place. He did not want to talk to or meet any of his friends and did not go to the ice hockey. When trying to watch TV he could only watch it without any distraction and sometimes could only watch for 5 to 10 minutes before losing concentration. He felt constantly on edge, waiting for something to happen and became very paranoid.

39. A GP entry dated 1 November 2017 records an update about the claimant's son condition and says "feeling sl better, calmer, taking 22 year old son to various appointments, seen counsellor through work, advice re ct sertraline 50mg, further med3 and review." The claimant was signed off work for a further month. A GP entry dated 29 November 2017 records a further update on the claimant's son and then states "still c/o anxiousness, took him several hours to contact work on phone… would like to increase sertraline, work supportive, counselling has been helpful." The claimant's sertraline dose was increased and he was signed off work for a further month.

<u>After January 2018</u>

40. On 10 January 2018 the GP entry reads:

> "feeling better, wife feels not ready to return to work, sleep improving, son has had second chemo and coping well, hoping to return to work in smaller branch in February, advice to d/w work phased return, further med3."

The claimant was given a further med 3 for 42 days. There are no further relevant entries in the GP records other than continued prescriptions for antidepressants at the same ongoing dosage

41. In the period January to August 2018 the claimant had a gradual improvement in his condition which he said was due medication, counselling and practicing mindfulness, albeit he remained on medication throughout and still is now. He stated that he still had forgetfulness, dizziness and found it hard to concentrate for periods of time. He gave examples of forgetting to go the shops, and when applying for jobs he would forget what jobs he applied for and who he was expecting a call from. During this time he gradually returned to dog walking, attending ice hockey matches and shopping with his wife. He did not and does not feel as confident as he used to do and is more quiet and reserved in himself than before. He told me he practices mindfulness and thinks about things before he does them,

and that whilst he has good days and bad days the depression still affects him on a daily basis.

42. The claimant told me that at the time of his GP appointment in January 2018 he wanted to try to go back to work and get the issues dealt with. He did not realise at that time that it was likely to result in dismissal, and says that with hindsight he probably would not have been well enough to return to work at that point in time anyway. The claimant did not in fact return to work for the respondent as he was suspended and went through the disciplinary process in March and June 2018 resulting in his dismissal. The claimant stated that he did not feel well enough to work until July or August 2018 when he started to look for another job. In October 2018 he started working for the British Heart Foundation as a store manager. He stated it took a month's training before felt comfortable in the work environment and communicating with customers. He stated he did not return to his GP for further appointments as he remained on the same medication and was issued with repeat prescriptions. He remains on the same medication and told me that there had been no suggestion that he try and reduce or come off his medication.

43. A letter from the claimant's transplant nurse specialist, dated 20 February 2018 [68], states that patients who take immunosuppression medication cab be more prone to infections and that the claimant does get several urine infections every year. It also states "He also had some unpleasant side effects to a medication called Bisoprolol, which caused him to have chest pain, his pulse rate drop, dizziness, shortness of breath, headaches and some memory loss. These symptoms lasted for a while, whilst investigations were carried out to find the cause."

44. Dr Harry Davies, from the claimant's GP surgery, prepared a report for the Respondent dated 4 May 2018 [58 – 59] which summarises the claimant's attendances. It states: "Looking at his notes it appears he was suffering acute stress reaction in response to stress at home which resulted in anxiety for which he was appropriately treated." He says "Given that Michael has not had any previous mental health issues, I would anticipate that the prognosis is excellent and that he would make a full recovery. As he has not been seen for a number of months regarding the issue it is difficult to know whether he has recovered and is stable already."

45. A letter from Ms Baldwin, Pancreas Transplant Recipient Nurse Specialist dated 19 July 2018 [69] again states that transplant patients can be more prone to infections and that the claimant had several urine infections which led to him being referred to the urology department at the hospital. She recorded that in the last year the claimant had been treated on more than 5 occasions by the transplant team with antibiotics and there may have been

more administered by the GP. She again repeated the same summary of the side effects of Bisoprolol.

46. A further letter from Dr Davies to the claimant's representative dated 9 May 2019 [84-85] describes the claimant's PKD. In relation to the claimant's mental health it states:

> "Regarding Mr Hathaway's depression, Mr Hathaway was seen on 5 October 2017. Although depression is not formally documented in Mr Hathaway's notes. Given that the patient's symptoms have been going on for over twelve months and having had an impact on day to day activity, I believe it would be defined as a disability."

47. The bundle also contains some information published about the medication that the claimant takes for his PKD, In particular it states at [82] uncommon side effects of Selexid (may affect up to 1 in 100 people) include headaches, dizziness and light-headedness. At [83], for Adoport, common side effects are "anxiety symptoms, confusion and disorientation, depression, mood changes, nightmare, hallucination, mental disorders, fits, disturbances in consciousness, tingling and numbness (sometimes painful) in the hands and feet, dizziness, impaired writing ability"

## Submissions

48. The claimant's representative submitted that it was clear the claimant had a mental impairment which substantially adversely affected the claimant's day to day activities. He submitted that the claimant's evidence was that the claimant (with the assistance of his wife) had traced his feelings of depression back to October 2016 and that by September 2017 the 12 month requirement had been met. It was submitted that the claimant's condition then continued to worsen following his suspension and the claimant was still unwell when dismissed in June 2018. The claimant still takes sertraline and there has been no discussion with his GP about stopping his medication.

49. The respondent relied on Ministry of Defence v Hay UKEAT/0571/07/CEA asserting that the claimant has to prove his depression is a distinct impairment or condition. The respondent argues that many of the symptoms the claimant has referred to are listed side effects for his PKD medication. The respondent acknowledged that the claimant had low mood, sleeplessness at times, nightmares and forgetfulness. However, the medical notes refer to a diagnosis of stress at home related to the claimant's wife and son's illnesses. The respondent therefore disputes that this amounts to a distinct condition. The respondent argues that the GP letter at [84-85] states that depression is not formally documented in the claimant's medical records and does not expressly say the claimant had

clinical depression. The respondent asserts that the claimant had simply stress at home and side effects of medication which is insufficient to constitute a distinct impairment or condition.

50. The respondent further argues that before the claimant visited his GP and sertraline was prescribed the claimant was still going to work and was still managing day to day activities. It is submitted that irritability and aggression was the highest evidence that was heard which is not a substantial adverse effect on day to day activities. The claimant was still carrying out day to day activities, even if it was not as normal, the threshold is high and it would not amount to a substantial adverse effect.

51. The respondent referred to Royal Bank of Scotland PLC v Morris UKEAT/0436/10/MAA on the question of medical evidence. It was argued that the medical evidence is very limited. There is no psychiatric report or evidence about individual symptoms, the impact of them or prognosis.

52. The respondent states that there is no medical evidence to say the claimant's symptoms are not a side effect of medication for his PKD. It is submitted that the prescription of sertraline cannot confirm a diagnosis of depression as it is prescribed to many patients with low mood, sleeplessness and anxiety where there is not a diagnosis of depression. It was submitted that I have to consider whether this is a medicalisation of the claimant's personal circumstances and stresses at work. In summary, the respondent argued that the claimant was suffering from the side effects of his PKD medication or a reaction to adverse life events and did not have a mental impairment and medical evidence has not been supplied by the claimant to prove the contrary.

**The legal principles**

53. 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."

54. 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.

55. Under paragraph 5(1) an impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day to day activities if measures are being taken to treat or correct it and, but for that, it would be likely to have that effect. "Measures" include medical treatment. When determining substantial adverse effect on normal day to day activities, I therefore have to assess the effects of any condition absent mitigation by means of medication or other medical treatment.

56. "Likely" should be taken to mean "could well happen."

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

58. I have given regard to Ministry of Defence v Hay UKEAT/0571/07/CEA where Mr Justice Langstaff was dealing with an appeal in which it was not in dispute that it is possible to be disabled due to the cumulative effect of more than one impairment. The EAT adopted an approach to "impairment" from earlier case law identifying that the term should be given its ordinary and natural meaning and that it is not necessary to consider the cause of it. Further it was said that "the essential question in each case is whether, on sensible interpretation of the relevant evidence, including the expert medical evidence and reasonable inferences that can be made from all the evidence, the applicant can fairly be described as having a physical or mental impairment."

59. I am also assisted by the decision of the EAT in J v DLA Piper UKEAT/0263/09 in which Mr Justice Underhill stated:

"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 para. 38 above, to start 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 …"

60. Mr Justice Underhill further stated, on identifying whether there is an impairment at all, particularly in relation to mental health conditions:

"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 lay 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."

61. Mr Justice Underhill further identified at paragraph 44 of the judgment that terms such as "anxiety, stress, or depression" are often used as loose terms by laymen and some health professions and it is important to bear in mind that in considering both the impairment issue and the adverse effect issue tribunals may have to look behind the labels.

62. I have also had regard to the EAT decision in Royal Bank of Scotland v Morris UKEAT/0436/10/MAA in which Mr Justice Underhill stated:

"55. The burden of proving disability lies on the claimant. There is no rule of law that that burden can only be discharged by adducing first-hand expert evidence…"

At paragraph 61 of the judgment Mr Justice Underhill, on the facts of that particular case, found that there was no explicit evidence on the issue of whether improvement in the claimant's condition was only a result of the medication he was taking, and that the EAT did not think that safe inferences could be drawn from the fact that the claimant was told he should continue with the medication for six months, which might only have been precautionary. It was said "This is just the kind of question on which a tribunal is very unlikely to be able to make safe findings without the benefit of medical evidence." It was further said at paragraph 63.:

"The fact is that while in the case of other kinds of impairment the contemporary medical notes or reports may, even if they are not explicitly addressed to the issues arising under the Act, give a tribunal a sufficient evidential basis to make common-sense findings, in cases where the disability allegedly takes the form of depression or a cognate mental impairment, the issues will often be too subtle to allow it to make proper findings without expert assistance…"

## Findings

Adverse effect on day to day activities

63. As whether the claimant had a mental impairment is in dispute I find it helpful to follow the approach set out in J v DLA Piper and consider first whether, and for what period, there was an adverse effect on normal day to day activities.

*The period up to the claimant's suspension*

64. Whilst the claimant states, and I do not doubt, that he had some symptoms before May 2017, particularly with anxiety, I find on the evidence before me that it was from May 2017 (and particularly from June 2017 onwards when the claimant's wife attended for her operation) that the claimant had symptoms that began to materially affect normal day to day activities. That is supported by the GP record and also accords with the claimant's evidence, which I accept, that he became worse and more symptomatic as the "cake layers" built up. The first material "layer" being supporting the claimant's brother through his transplant in May 2017, followed thereafter by the claimant's wife's illness and operation in June 2017 and thereafter the ill health of the claimant's son and the claimant's own physical ill health. In terms of an adverse effect on normal day to day activities, and taking into account what I accept are only illustrative and non exhaustive but nonetheless helpful examples in the Appendix to the Guidance, these were:

- Low motivation in everyday activities (such as the claimant's hobbies of running, riding, attending the ice hockey, walking the dog

and going shopping with his wife, providing general everyday care for a sick relative as well as avoiding some work activities when in work);
- Frequent intrusive thoughts and delusions (the claimant's feelings of helplessness and inadequacy in home and in work, his suicidal thoughts and his paranoia and auditory hallucinations);
- Persistently wanting to avoid people or significant difficulty taking part in normal social interaction or forming social relationships (the claimant's avoidance of supporting his wife and son at medical appointments, or avoidance of generally caring for them in relation to their ill health, and regularly arguing with them and then avoiding spending time with them would, in my view, amount to a significant difficulty in maintaining a normal family relationship and would be in itself a normal day to day activity that was adversely affected. Similarly, the claimant's aggression and irritability with colleagues in work which adversely affected social interaction in work and standard communication between the claimant as a manager and his staff would in my view amount to a normal day to day activity);
- Persistent distractibility or difficulty concentrating (such as forgetting appointments, forgetting observations and other work related information and difficulties concentrating).

65. I must concentrate on what the claimant could not do, rather than 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. I therefore find that from June 2017 onwards there was an overall substantial adverse effect on the claimant's ability to carry out normal day to day activities.

*The period after the claimant's suspension*

66. During the above period the claimant's symptoms were gradually deteriorating and deteriorated substantially further following his suspension in October 2017 after which he attended his GP and was signed off work. The claimant's symptoms at this time, in terms of impact on normal day to day activities included (and this was when the claimant was taking medication):

- An inability to attend work or perform ordinary work functions;
- Difficulty getting dressed, because of low motivation;
- Difficulty following a normal eating pattern;
- Difficulty leaving the house;
- Continued low motivation in everyday activities;

- At times excessive sleep which would disrupt the claimant's capacity to undertake other normal day to day activities;
- Continued persistent distractibility or difficulty concentrating;
- Frequent intrusive thoughts and (the claimant's feelings of paranoia);
- Continued persistently wanting to avoid people or significant difficulty taking part in normal social interaction or forming social relationships (including withdrawing not just from outside the home social activities and relationships but also withdrawal from interaction within the family home).

67. Again, I consider that during that time this amounted to an overall substantial adverse effect on the claimant's ability to carry out normal day to day activities.

*January 2018 onwards*

68. I find that the claimant's degree of symptomatology, whilst taking medication, gradually started to improve from January 2018 onwards. Again in terms of impact on normal day to day activities (whilst taking medication and receiving other treatment):

- The claimant was unable to work (I accept that his last fit note ran out on or around 21 February 2018 but I accept the claimant's account of his condition that he was still not fit for work at that time and I find that is likely to have remained the case until around July 2018 when the claimant started to look for work and when the claimant's son's chemotherapy came to an end);
- The claimant had ongoing difficulties with his concentration and forgetfulness (for example, forgetting the jobs he applied for or who was calling him in relation to his job searches).

69. I find that overall, particularly bearing in mind my finding that the claimant was not fit for work until July 2018 that there was overall a substantial adverse effect on the claimant's ability to carry out normal day to day activities until July 2018. My finding is of course based on the claimant's symptomatology whilst he was receiving treatment. The assessment should be made on a hypothetical basis of what the claimant would be like if he were not receiving treatment. It is a matter of common sense to say that if the claimant were not receiving treatment then it is likely that his symptoms would have been worse to some extent. However, the degree and duration of that increased symptomatology is difficult to assess without evidence on the point from a medical practitioner. The above findings are, however, sufficient in any event to dispose of the issue before me without the need for such medical evidence.

Mental impairment

70. I therefore find that the claimant had mental health symptoms which had a substantial adverse affect on his ability to carry out normal day to day activities for the period June 2017 to July 2018. Bearing in mind the guidance in J v DLA Piper I am satisfied that this is sufficient evidence on which I can infer that the claimant was suffering from a mental condition which produced that adverse effect and therefore that the claimant had a mental impairment.

71. I do not need to place a specific diagnostic label, let alone a diagnostic label of clinical depression, upon that mental condition/impairment provided I am satisfied (as I am) that it is a qualifying impairment as opposed to being simply (adopting the language used in J v DLA Piper) a reaction to adverse life events that falls short of amounting to a mental impairment. The fact that the claimant's mental impairment may have been caused or contributed to by adverse life events likewise does not prevent my finding that it is a qualifying mental impairment: the whole purpose of following the recommended approach in J v DLA Piper as undertaken above is to ensure that conclusion can be legitimately reached on the evidence available. As was said at paragraph 42 in that case "If… 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 twelve 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." I substitute here "mental health condition" for the terms "depression/clinical depression" used in J v DLA Piper but the point behind that quotation remains true and applicable here.

72. Likewise the fact that the contemporaneous GP records do not record "depression" but refer to "stress at home" and that the later GP reports refer to an "acute stress reaction" and a somewhat equivocal reference to "depression" at [84 – 85] do not prevent me reaching a finding that the claimant had a mental impairment based on the evidence before me: I must look beyond the labels applied.

73. The respondent argues that the claimant had side effects of his PKD medication and not clinical depression. I do not agree. The claimant's mental impairment was, I have found, a reaction to significant life events, but nonetheless a qualifying mental impairment for the reasons already given. This is supported by the medical report at [58-59] where Dr Davies states "he was suffering from acute stress reaction in response to stress at home which resulted in anxiety for which he was treated appropriately." The GP is not saying the claimant did not have a mental health condition (he terms it a "mental health issue") or that it was attributable to the side effects

of PKD medication. The case law warns not to take too rigid an approach to the terminology used by medical practitioners and others and encourages instead a focus on substantial adverse effect on normal day to day activities. As stated, I do not have to apply a diagnostic label of clinical depression or indeed any other diagnostic label provided I am satisfied it was a qualifying mental impairment; which I am.

Long term substantial adverse effect at the material time

74. The claimant's disability will therefore be the cumulative impact of both his physical and mental impairments and their combined overall long term substantial adverse affect on the claimant's ability to carry out normal day to day activities assessed at the material time complained about. The respondent does not dispute that the claimant's PKD amounted to a disability and therefore the overall assessment of disability factoring in all the impairments was not before me.

75. Nonetheless if hypothetically the claimant's mental impairment is considered in isolation, I would find that it amounts to a disability. As at September 2017, the claimant had experienced a substantial adverse effect on day to day activities for around 3 months. The test is of course whether, as at that time, that substantial adverse effect was likely to last for at least 12 months, and presuming that the claimant would not be in receipt of medication or other treatment. That is not an assessment that can be undertaken using the power of hindsight but must be assessed in the round and on the basis of what was known at that time. I consider that at that time it was likely to so last. The claimant was reacting to significant adverse life events, including his brother's condition, his wife's state of health and operation, his son's cancer and his son' diagnosis of PKD. It could be said a reaction to an adverse life event is likely to be transitory. However, I bear in mind that PKD is a lifelong, serious condition. The claimant was dealing with his brother's transplant and then his son's diagnosis and reaction to the diagnosis of PKD against the background of having the condition himself and his own knowledge and experience of the seriousness of it. The claimant's son's cancer was serious and the treatment pathway a potentially long and unknown road ahead. The claimant's wife's condition is again chronic and her surgery had, in terms of symptoms, been unsuccessful. These were therefore adverse life events which as at September 2017 were not likely to dissipate quickly and had an uncertain future ahead for the claimant's family and therefore for the claimant. I also take into account that this was an extreme accumulation of serious stressors at around the same time and also that as at September 2017 the claimant was on a downward spiral in terms of symptoms for which I must presume he then would not have received treatment. In total I am satisfied that as at September 2017 it "could well happen" that the substantial adverse effects would last approximately at least a further 9 months.

76. As at the time of the claimant's dismissal in June 2018 I also would find that the claimant's mental impairment would also meet the test of being a disability. At that point in time the claimant had experienced a substantive adverse impact upon day to day activities for around a 12 month period. I have found that as at June 2018 whilst the claimant was improving he was still symptomatic and was still unable to work even whilst taking medication. I therefore find that as at the date of the claimant's dismissal there had been a substantial adverse effect on normal day to day activities for a 12 month period, or even if that 12 month period had not completely expired there was little of that period left, and it was likely (in the sense of "could well happen") that it would so last for at least that 12 month qualifying period.

Employment Judge Harfield
Dated: 22 August 2019

JUDGMENT SENT TO THE PARTIES ON

………23 August 2019……….

……………………………………………….
FOR THE SECRETARY OF EMPLOYMENT TRIBUNALS