EMPLOYMENT TRIBUNALS

Claimant: Mr L Morton-Buwerimwe

Respondent: Plusnet plc

Heard at: Leeds **On:** 19 November 2019

Before: Employment Judge Licorish (sitting alone)

Representation
Claimant: Mr P Ward (counsel)
Respondent: Mr S Hall (solicitor)

RESERVED JUDGMENT

1. At the relevant times, the claimant was a disabled person within the meaning of the Equality Act 2010.
2. The parties should proceed to comply with separate case management orders dated 29 November 2019 on the basis that all of the issues identified in respect of the claimant's complaints of disability and race discrimination will be determined at the hearing listed to take place in April 2020.

REASONS

1. This preliminary hearing was listed to determine whether, having regard to the provisions of section 6 and schedule 1 to the Equality Act 2010 (EqA), the claimant was at the relevant time a disabled person and therefore entitled to bring his complaints of disability discrimination.
2. The issues to be determined are:

   2.1 Did the claimant have the mental impairment of depression at the relevant times? On the basis of the substantive issues clarified at the end of the hearing, the disability discrimination complained of is alleged to have occurred between November 2017 and September 2018.

   2.2 If so, did the impairment have a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities?

   2.3 If so, was that effect long term? In particular, when did it start and:

   2.3.1 had the impairment lasted for at least 12 months?

2.3.2 was the impairment likely to last for at least 12 months? (In assessing the likelihood of the effect lasting 12 months, account should be taken of the circumstances at the time the alleged discrimination took place. Anything which occurs after that time will not be relevant in assessing this likelihood.)

2.4 In deciding the above issues, were any measures being taken to treat or correct the impairment? But for those measures, would the impairment be likely to have had a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities?

3. During the hearing, the claimant relied on a written witness statement, which the Tribunal read before he gave evidence. The claimant also provided a bundle of documents (marked C1, 16 pages of which were relevant to this hearing). At the beginning of the hearing it also became apparent that there were a number of relevant documents which had been disclosed by the respondent (marked R1, relevant pages from 75 to 164). The parties, however, had not been ordered to agree and produce a joint bundle.

4. Once sufficient copies of the respondent's documents had been obtained, the claimant's representative was given time to read those additional documents whilst the Tribunal read all of the relevant documents. Unfortunately this meant that, following the claimant's evidence and both parties' submissions, there was only a limited amount of time left for the Tribunal to arrive at and deliver a decision on the preliminary issue.

5. After discussion, it was agreed that we would use the remaining time to clarify the complaints and issues, and make orders to and list a final hearing. This was because the claimant is currently unwell. An unsuccessful attempt was made at a previous preliminary hearing to clarify the issues. In the circumstances, as the claimant had instructed a barrister to represent him at today's hearing, it seemed most sensible to take the opportunity to case manage the claim while the claimant had the benefit of legal representation.

6. Finally, the page numbers in these Reasons refer to the relevant pages in the bundles of documents before the Tribunal.

The claimant's evidence

7. The claimant describes his mental impairment as depression. He says that he was first diagnosed in around 2004. He has experienced several episodes since then, usually following a triggering event.

8. In further information about his claim provided in February 2019, the claimant explained that he first became ill following close family bereavements and again after a life-threatening car accident. In re-examination, he confirmed that the accident happened in 2009. Over the years he has been diagnosed with post-traumatic stress disorder (PTSD), severe depression and anxiety. In cross-examination, he explained that symptoms he has experienced in the past have included intrusive thoughts, nightmares, flashbacks, and efforts to avoid feelings that remind him of the traumatic event or trigger similar feelings. He can also feel detached and unable to connect with loved ones.

9. In terms of this case, the claimant says that the trigger was his suspension by the respondent in August 2017, following an altercation at work with a colleague. He was certified as unfit for work for approximately four months owing to "*stress at work*". He was also off sick from April to July 2018. He

was eventually referred for an occupational health (OH) assessment in March 2019, following a further period of absence from November 2018.

10. During his suspension, on 19 September 2017, the claimant went to see his GP owing to his "*low mood*". He recognised this as a sign of the return of his depression – that is to say, he stopped leaving the house, was worried about losing his job and was not sleeping. In cross-examination, he explained that he wanted to avoid descending into the particularly bad state he had experienced in 2009. The claimant was prescribed an anti-depressant (Sertraline at 50mg daily). From this time, he experienced the side effect of a severe stabbing pain which also led him to have panic attacks. His medication was eventually changed to Fluoxetine (at 20mg daily) in July 2019.

11. In the claimant's view, without his medication he would not have been able to leave the house. He would feel isolated and cut himself off from all contact even with friends and family. He would also not be able to get a decent night's sleep, making him tired throughout the day. His mood would be so low that he would be unable to communicate. He is confident about his view because this was what he went through in 2009. At that time, he also completed a course of cognitive behavioural therapy (CBT) and was able to "*get back 'on track'*". Before then, he left his house only to buy food. In cross-examination, he explained that he would be forced to go to the shops "*due to hunger*". The medication gave him a "*safety net*" in order to do this. He also neglected basic personal hygiene to the extent that he would go for several days without washing.

12. More generally, he is usually able to improve his mood by going to the gym or spending time with his children. However, during particularly low periods he finds it difficult to keep up with these coping strategies. Before his suspension in August 2017, he found attending work to be a positive experience and it therefore usually had a beneficial effect on his health.

GP records

13. The claimant produced a summary of his GP records from 16 August 2017 to October 2019 inclusive. It confirms that he was prescribed the anti-depressants he identifies throughout this period (C1, page 11). He was signed off work in September 2017 with "*stress*" owing to (among other things) "*issues at work*" (C1, page 1). On 16 November 2017 he reported "*been off work … been looking after the family, been to the gym, been happy, plans to resume work in part time would help with stability … wants a fit note on stress ground for reduced hours*" (page 2).

14. On 2 May 2018, the claimant was diagnosed as having a "*Major Depressive Disorder … (Ongoing Episode)*". A patient health questionnaire records that he was experiencing "*trouble*" with sleeping, appetite and concentration, and he had been "*feeling bad*" about himself. On 17 May 2018 it was noted that the claimant had "*ongoing low mood symptoms*", which the claimant explained had been triggered by impending legal proceedings against a previous employer. From that point, the reason for his unfitness for work is given as "*depression*" (C1, pages 3 to 4).

15. On 20 June 2018, the claimant's GP provided an opinion as to the causes of the claimant's depression at the request of the solicitors conducting his claim against his previous employer. Of most relevance, the notes record: "*h/o*

depression since 2007, motivational issues and poor sleep initially … he completed 7 session of CBT to help deal with PTSD and low mood in 2009-2010, but he struggles with feeling or being unsupported and poor motivation. He did not respond to invitation to engage with counselling in 2012. I believe he struggles with complying with medication as collected prescriptions for 4 months in 2012, 2 months in 2016, 6 months in 2017 and only two months' prescriptions in 2018" (C1, page 5).

16. By 3 July 2018 he is described as "*alert and well*" and certified as "*may be fit for work …. Diagnosis: stress, depression*". However, he was signed off work for a further period from 16 until 22 July 2018 with "*stress*" (C1, page 5). He was again signed off with "*work related stress*" from 14 November 2018 (C1, pages 5 to 6). In February 2019 he described his mood as "*fluctuates day to day, sometimes feels he can't do much and stays at home*" (C1, page 8). Finally, the claimant's GP records, which were printed on 10 October 2019, describe the depressive disorder as an "*Active Problem … (02 May 2018 – Ongoing)*" (C1, page 16).

The respondent's records

17. On 23 March 2017, the claimant was interviewed by his manager about an ongoing sickness absence. The claimant reported that he was "*not mentally capable to come back to work*" at that time (R1, page 102). The claimant's manager also completed a "*health and wellbeing passport*". This document is stated to be relevant to "*any employee who has a disability or long-term health condition, that they believe could impact on their ability to work currently or at some point in the future*". The claimant described his "*disability*" as "*stress and depression*" and its pattern as "*recurrent*" (R1, page 96).

18. On 17 November 2017, the claimant's manager noted that he had "*gone into a bad mental state*" during his disciplinary suspension, was "*battling with his depression*" and had "*put in a flexi working request to reduce his hours due to his stress levels*" (R1, page 109). On 18 November 2017, it was further recorded on his health and wellbeing passport that the claimant "*was not in a good way*" following his suspension and "*has got very bad depression from being out of work for such a long space of time*".

19. In March 2019, the respondent referred the claimant for an OH assessment. The referral form states that the claimant "*suffers from Stress/Anxiety/Depression and over the last 12 months 95% of his absences have been related to this condition*" (R1, page 146). The resulting report confirmed that the claimant "*has a history of anxiety and depression and has been on an off medication a number of years*", and stated that the prognosis was "*guarded*". The adviser also states: "*in my opinion, his condition is likely to be considered a disability because it would have a long term, substantial, adverse impact on his ability to undertake normal daily activities without the benefit of treatment … certain individuals may be more susceptible to it than others and react to external factors and require support and medication from primary care … this seems to be the case with [the claimant] …*" (R1, pages 150 to 151).

The relevant law

20. Section 6 of the EqA (so far as it is relevant) provides:

"*(1) A person (P) has a disability if –*

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities. …

(5) A Minister of the Crown may issue guidance about matters to be taken into account in deciding any question for the purposes of subsection (1).

(6) Schedule 1 (disability supplementary provisions) has effect."

21. Schedule 1 part 1 of the EqA deals with long-term effects:

"2(1) The effect of an impairment is long-term if –

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

(b) it is likely to last for at least 12 months, or

(c) it is likely to last for the rest of the life of the person affected.

(2) If an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day-to-day activities, it is to be treated as continuing to have that effect if that effect is likely to recur.

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 –

(a) measures are being taken to treat or correct it, and

(b) but for that, it would be likely to have that effect.

(2) 'Measures' includes, in particular, medical treatment."

22. A Tribunal must take into account any aspect of the Guidance issued under section 6(5) of the EqA (2011) which it considers to be relevant. The Guidance states (at A5): "*A disability can arise from a wide range of impairments which can be … impairments with fluctuating or recurring effects such as … depression*" or "*mental health conditions with symptoms such as anxiety, low mood, panic attacks*". The Guidance also provides:

*"**Meaning of 'substantial adverse effect'***

B1. The requirement that an adverse effect on normal day-to-day activities should be a substantial one reflects the general understanding of disability as a limitation going beyond the normal differences in ability which may exist among people. A substantial effect is one that is greater than the effect which would be produced by the sort of physical or mental conditions experienced by many people which have only 'minor' or 'trivial' effects (this is stated in the Act at s212(1)). It should be read in conjunction with Section D which considers what is meant by 'normal day-today activities'.

Cumulative effects of an impairment

B4. An impairment might not have a substantial adverse effect on a person's ability to undertake a particular activity in isolation. However, it is important to consider whether its effect on more than one activity, when taken together, could result in an overall substantial adverse effect.

B5. For example … A man with depression experiences a range of symptoms that include a loss of energy and motivation that makes even the simplest of tasks or decisions seem quite difficult. He finds it difficult to get up in the morning, get washed and dressed, and prepare breakfast. He is forgetful

and cannot plan ahead. Household tasks are frequently left undone, or take much longer to complete than normal. Together, the effects amount to an impairment having a substantial adverse effect on carrying out normal day-to-day activities …

Effects of treatment

B12 … In this context, medical treatments would include treatments such as counselling … and therapies, in addition to treatment with drugs …

B13 This provision applies even if the measures result in the effects being completely under control or not at all apparent. Where treatment is continuing it may be having the effect of masking or ameliorating a disability so that it does not have a substantial adverse effect. If the final outcome of such treatment cannot be determined, or it is known that removal of the medical treatment would result in either a relapse or worsened condition, it would be reasonable to disregard the medical treatment in accordance with paragraph 5 of Schedule 1 …

B14 For example … A person with long-term depression is being treated by counselling. The effect of the treatment is to enable the person to undertake normal day-to-day activities, like shopping ang going to work. If the effect of the treatment is disregarded, the person's impairment would have a substantial adverse effect on his ability to carry out normal day-to-day activities.

Recurring or fluctuating effects

C5. … Conditions with effects which recur only sporadically or for short periods can still qualify as impairments for the purposes of the Act, in respect of the meaning of 'long-term' …

C6. For example, a person with rheumatoid arthritis may experience substantial adverse effects for a few weeks after the first occurrence and then have a period of remission … If the substantial adverse effects are likely to recur, they are to be treated as if they are continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term. Other impairments with effects which can recur beyond 12 months, or where the effects can be sporadic, include … certain types of depression …

C7. It is not necessary for the effect to be the same throughout the period which is being considered in relation to determining whether the 'long-term' element of the definition is met. A person may still satisfy the long-term element of the definition even if the effect is not the same throughout the period. It may change: for example activities which are initially very difficult may become possible to a much greater extent. The effect might disappear temporarily. Or other effects on the ability to carry out normal day-to-day activities may develop and the initial effect may disappear altogether."

Likelihood of recurrence

C10 … it is possible that the way in which a person can control or cope with the effects of an impairment may not always be successful. For example, this may be because an avoidance routine is difficult to adhere to … If there is an increased likelihood that the control will break down, it will be more likely that there will be a recurrence.

Meaning of 'normal day-to-day activities'

D2. …In general, day-to-day activities are things people do on a regular or daily basis, and examples include shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking or travelling by various forms of transport and taking part in social activities. Normal day-to-day activities can include general work-related activities … such as interacting with colleagues, following instructions, using a computer, driving, carrying out interviews, preparing written documents, and keeping to a timetable or shift pattern."

23. The case of **Rayner v Turning Point 2010 11 WLUK 156** explains that in circumstances where a claimant was diagnosed with anxiety by his GP and his GP advises him to refrain from work, that is "*in itself*" evidence of a substantial effect on day-to-day activities, because were it not for the condition the claimant would have been at work, and his day-to-day activities included going to work. Appendix 1 to the EHRC Employment Code also provides guidance as to the meaning of "*substantial*" in that "*Account should … be taken of where a person avoids doing things … because of a loss of energy or motivation*".

24. Finally, in terms of recurring conditions a Tribunal need not be satisfied that the recurrence is likely to last 12 months. Further, it is the effects that must be likely to recur, not necessarily the impairment. The House of Lords in **SCA Packaging Ltd v Boyle and Equality and Human Rights Commission [2009] IRLR 747** held that the word "*likely*" in the equivalent provision to paragraph 2(2) means "*could well happen*" rather than "*possible*" or "*more likely than not*".

Conclusion

25. The claimant's and respondent's representative made oral submissions which the Tribunal considered with care. They are not repeated in full, but are summarised below where necessary.

26. In general terms, although the claimant's evidence during the hearing appeared occasionally to be at odds with that contained in the supporting documents (for example, his GP suggested a history of depression since 2007 rather than 2004), and at times he was unable to remember specific details about his periods of illness, the Tribunal found him to be a credible witness. The Tribunal is not therefore prepared effectively to disregard his evidence as vague and inconsistent (as the respondent submitted) on this basis.

27. Generally, the respondent further submits that the claimant has produced "*no medical evidence to back. up his symptoms*". In reaching its conclusions the Tribunal reminded itself (and the parties before submissions) that the claimant does not bear the onus of producing medical evidence to underpin each element of the definition of disability, so that in the absence of such evidence their case is bound to fail. It is the responsibility of the Tribunal to assess all the evidence that is presented and thereafter conclude for itself whether the claimant was a disabled person at the relevant time. The Tribunal must also give sufficient weight to the claimant's own evidence of his condition, and look at the broader picture of an impairment beyond any diagnosis or label.

28. Turning to the first issue: did the claimant have a mental impairment, namely depression, between November 2017 and September 2018 (or at any point during that period)? In summary, the respondent argues that the evidence suggests no more than an adverse reaction to events at work rather than a specific mental impairment. The respondent relies on the case of **Herry v Dudley Metropolitan Council and ors (UKEAT/0100/16/LA; UKEAT/0101/16/LA)** in which the EAT concluded that a Tribunal properly applied guidance contained in the case of **J v DLA Piper UK 2010 ICR 1052** and rejected the claimant's contention that he had a disability in the context of absences described variously as "*stress*" or "*work related stress*".

29. In the claimant's case (and based on the conclusions below in terms of the adverse effect of his condition, and the longevity of that effect), the Tribunal is satisfied that the claimant was not simply fed up, stressed, unhappy or indignant about his work or any other personal situation. Although his GP refers to "*stress*" or "*work-related stress*" during this period, his GP's notes confirm a history of depression from 2007, including a diagnosis of PTSD in 2009 and a major depressive disorder from May 2018 which was described as ongoing as at October 2019. The Tribunal is therefore satisfied on balance that the claimant had the mental impairment of depression between November 2017 and September 2018.

30. The next issue is whether that impairment had a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities. In this respect, the Tribunal must focus on what the claimant could not do. The respondent's position is that the Tribunal should not accept the claimant's evidence in this respect because the evidence does not support a sufficient level of impairment. In particular, although the claimant was certified as unfit for work from September to November 2017 and April to July 2018, the evidence suggests that this was because he was indignant about his treatment by the respondent, rather than (for example) an inability to get out of bed or leave the house.

31. On balance, the Tribunal accepts the claimant's evidence that the effect of his condition on his day-to-day activities during the relevant period was more than minor or trivial. According to that evidence, from September 2017 the claimant experienced periods of sleeplessness and anxiety about losing his job. He also avoided social interaction or activities, and leaving the house for example to go shopping. On this basis, he recognised the signs and sought help from his GP, who prescribed antidepressants. He told the respondent at the time that he had descended into a "*bad depression*" as a result of the length of his suspension. By 16 November 2017 he felt well enough to return to work but told his GP that he wanted to reduce his hours to "*help with stability*". At the beginning of May 2018 he also reported to his GP that he was having trouble with sleeping, eating and concentration. Although he again felt well enough to return to work at the beginning of July 2018, he was once more signed off for a short period towards the middle of that month.

32. The Tribunal further finds that without that medication, the course of CBT in 2009 and the claimant's coping strategies such as going to the gym and spending time with his children, the claimant would have been more adversely affected as he described in his evidence. The Tribunal is persuaded by that evidence because the claimant was able to point to his period of ill health from 2009 and describe how he was affected before seeking medical help. His GP was also of the opinion that at times he

struggled to comply with his medication as he had failed to collect his anti-depressants during periods in 2012, and between 2016 and 2018. It might also be that those periods in 2017 and 2018 may have coincided with a worsening in the claimant's state of heath in March 2017 and May 2018. Furthermore, although the respondent's OH adviser eventually assessed the claimant after the relevant period question, her view was that "*without the benefit of treatment*" the claimant's daily activities would have been substantially affected over a number of years.

33. The Tribunal is therefore satisfied on balance that the range of symptoms the claimant describes and which are recorded in the documents, and the resulting effect on his day-to-day activities together amounted to a substantial effect during the relevant period in accordance with paragraphs B4 and B5 of the Guidance.

34. The next issue is whether the substantial effect was long term. The first question is: when did it start? The claimant's conversation with his manager in March 2017 suggests that he was unwell certainly at around this period. In evidence, the claimant was able to explain when his day-to-day activities became substantially affected from November 2017. Based on the evidence, the Tribunal finds that the substantial effects on the claimant's daily activities began in March 2017, improved with medication and returned in September 2017, as a result of which he went to see his doctor. With the benefit of medication, coping strategies and reduced hours he was able to return to work in November 2017. However, he went off sick again in April 2018 and from that point was diagnosed with depression.

35. The second question is: for how long was the claimant substantially affected or likely to be? During the relevant time, the claimant does seem to have had periods when he was feeling comparatively well. For example, the claimant's GP describes the claimant as "*alert and well*" at the beginning of July 2018. The claimant's evidence suggests that his symptoms fluctuated during this period (and, indeed, he explained to his GP in February 2019 that, in effect, he has good and bad days).

36. However, the claimant was also prescribed medication throughout the relevant period. His discussion with his GP in November 2017 suggests that he must also continue to employ coping strategies to ensure that the management of his symptoms remains stable. In cross-examination, the claimant explained that medication helps him "*to get out and try to move forward. I would be in a dark place if not*."

37. In the circumstances, on balance the Tribunal is satisfied that the substantial adverse effect of the claimant's condition on his day-to-day activities (absent the effect of any treatment) had lasted for at least 12 months by March 2018.

38. Before that date, the Tribunal must consider the circumstances from around November 2017 to determine whether the effect of the claimant's impairment was likely to be long-term, including whether it was likely to recur.

39. Further and separately, if the Tribunal had been persuaded that the substantial effect of the claimant's condition was only sporadic during the relevant period, the Tribunal would have gone on to consider paragraph 2(2) of Schedule 1 Part 1 of the EqA and section C of the Guidance in any event.

40. In this respect the Tribunal concludes, on balance, that the substantial adverse effect of the claimant's condition as at and from November 2017

should be treated as long term. This is because the OH report supports the claimant's evidence that he is susceptible to reacting to triggers which make him unwell. His GP notes confirm that this had been the case with the claimant from at least 2007. He experienced a particularly bad recurrence of his symptoms in 2009, and a further major episode of depression (the effects of which were recorded by his GP) from April 2018. The Tribunal has found that the effects of the claimant's illness on his day-to-day activities were substantial and would have been more so in the absence of medical treatment and the claimant's coping strategies. As a result, the Tribunal concludes that the adverse effect of the claimant's impairment was at the very least likely to recur as at November 2017, in the alternative had in fact recurred in 2009 following the initial onset in 2007, and therefore should be treated as long term.

41. On that basis the Tribunal is satisfied that at the material times the claimant was a disabled person within the meaning of the EqA.

Employment Judge Licorish

Date: 3 December 2019