Case Number: 1600705/2018
1601386/2018
1600146/2019

EMPLOYMENT TRIBUNALS

Claimant: **Mr R Moon**

Respondent: **Slater & Gordon UK Limited**

Heard at: **Cardiff** **On: 24 February 2020**

Before: **Employment Judge S Moore**

Representation:
Claimant: In person
Respondent: Mr Quickfall, Counsel

RESERVED JUDGMENT

The claimant is a disabled person within the definition of Section 6 of the Equality Act 2010.

REASONS

Background Introduction

1. This was a Preliminary Hearing listed to determine whether or not the Claimant was a disabled person within the meaning of Section 6 of the Equality Act 2010. I had a bundle of documents amounting to 346 pages and a separate Authorities bundle. The Claimant's impact statement dated 25 October 2018 stood as his evidence in chief. I heard evidence from the Claimant. He required reasonable adjustments of regular breaks.

2. I make the following findings of fact on the balance of probabilities.

3. The Claimant has been diagnosed and intermittently treated for anxiety and depression since 2003. His GP reported in a letter of 17 August 2018 that his symptomology is always similar when he was struggling with significant

depressive symptoms, specifically sleep disturbance, morbid thoughts, low mood and tearfulness and often accompanied with anxiety and sometimes panic attacks. The GP also notes that there were several entries throughout the notes of his work situation which exacerbated his symptoms. Treatment usually consisted of anti-depressant medication and time off work to aid the Claimant's recovery and that he had had access to Primary Care Mental Health Team in 2018.

4. The Claimant has a history of recurrent depression and has been prescribed anti depressant medication including Sertraline and Citalopram. He has a history of migraines. In August 1996 the Claimant was referred to Community Mental Health Team regarding continual morbid thoughts regarding death which appeared to be obsessional and he was prescribed Prozac. He was subsequently seen by a Clinical Psychologist in December 1996 who stated the problem had developed 2 years previously. The Claimant was referred to the University Hospital Llandough regarding investigation of sleep apnea. His GP had scored him on the Epworth sleepiness score as 8 which was described as normal, but he was nonetheless still referred as the way that he was describing his sleepiness seemed to indicate a higher score. The Claimant did not attend the sleep apnea clinic.

5. There are also numerous other entries in his GP records for problems sleeping. For example, in 2010 he is recorded as seeing his GP for poor sleep patterns and prescribed Amitriptyline. Other relevant entries in the GP records as follows:

> 15/2/2013 depressive disorder. Months feeling low can have periods when everything is fine but only 1-2 days at a time. Trouble with relationships. Poor sleep.
> 2/10/2014 depressive disorder and EC low mood ongoing probably for years, trouble to cope sometimes, over-reacts, poor sleep, relationship problems.
> 31/7/2015 depressive disorder and mood deteriorated over the past few months, things getting on top of him, feels these are early signs of last episode.
> 24/8/2015 depression interim review, much better doing well, initial intolerance was gastroenteritis.
> 24/9/2015 depression interim review, doing very well, things have not been good in work but has been coping with things well. Family life good, moved in with partner, discussed continuing Sertraline for 6 months.
> 19/11/2015 depressive episode on Sertraline from previous doctor, has suffered from depression in the past. This is due to stress at work, works for law firm.

The Claimant had had breaks in taking anti-depressant medication when he had periods where he felt that he did not need the medication, but there was a history of anti-depressant medication going back years.

6. On 18 October 2016 he was referred to Cardiologists regarding palpitations. His GP reported that this was possibly due to benign paroxysmal positional vertigo with dizziness and vomiting.

7. During the relevant period the GP notes reported as follows. The claimant started on 100 mg per day of Sertraline again in early December 2017 for depressive symptoms including sleep disturbance, morbid panic attacks at night, constantly worrying and often crying. By 4 July 2018 he is reported as doing well on phased return, no longer feels low, but has anxiety attacks or feeling anxious, with the GP noting "sounds like many years of intermittent depressive and anxiety exacerbated by work situation, but this was being managed and resolved and he was feeling positive". He also reported to be back socialising with people, sleeping better and back to usual self.

8. I also had sight of a number of Occupational Health reports that had been commissioned by the Respondent, the first was dated 9 April 2018. It reports that he has a history of anxiety and depression throughout the Claimant's adult life and that during the last 2 years he had noticed a gradual worsening of symptoms with low mood, low self-esteem and loss of interest in usual activities. It goes on to say that the Claimant had found it increasingly difficult to communicate with colleagues verbally and now most communication is done by email only due to a loss of trust between himself and management and HR. He was having panic attacks particularly at night. The Claimant had been referred by his GP for Cognitive Behavioural Therapy and was on a waiting list. The Occupational Health reports that the Claimant was previously regularly exercising, but since the worsening of his symptoms of depression he had not been able to continue with the usual activities. It reported that his memory or ability to concentrate, learn and understand was affected by his condition reporting impaired concentration with usual routine activities within the home and it being observed as a common symptom with depression.

9. The next report I had sight of was dated 14 May 2018. It reported that the medication appeared to be improving his symptoms and in comparison to the previous assessment the Claimant had started re-exercising, re-joining the golf club and gym and was communicating with friends and family on social media. I also had sight of a GP letter dated 17 August 2018 from a Dr Cluett, this recorded that the Claimant had been seen in July 2018 and told his GP he had improved and was on a phased return and that it seemed depressive symptoms were no longer a problem but was still having chronic

anxiety with occasional panic attacks. He continued on 100mg of Sertraline per day.

10. I had sight of an Occupational Health report dated 20 September 2018. This refers to receiving a comprehensive report from the Claimant's GP as referenced above and reports that his symptoms are a combination of anxiety and depression such as sleep disturbance, morbid thoughts, low mood, tearfulness often associated with anxiety and sometimes panic attacks. In this particular more recent episode the Claimant had experienced symptoms more on a depressive side than anxiety. The improvements since December 2017 were attributed to the anti-depressant medication and counselling. The Claimant informed the Occupational Health doctor that he was not undertaking all of his duties on the phased return, he informed the Occupational Health doctor that on the Monday of that week he had felt despondent, tired and tearful and on the subsequent days he was getting ready to go to work he sat on the sofa and burst into tears and felt unable to go in and has been absent from work the rest of that week. The Occupational Health doctor reported that his symptoms matched those as described by his GP, poor sleep, low mood, tearfulness, signs of social isolation such as cancelling an event at Christmas already in September and not engaging with friends and family in the way he would normally do so. It does report he was able to play golf the previous day and that he was planning on attending a golfing holiday the following week.

11. The report advised the doctor believed the effect could be substantial for the Claimant. He advised that the severity of symptoms in depression and anxiety were fluctuant and unpredictable. In respect of the question, if there is impairment with adverse effect on the employee's day to day life if that effect long term?, the doctor stated as follows: "It might be that Mr Moon's perception of his work situation is in fact a symptom of depression, that one is not causing the other. However I believe that his view of the situation means that one cannot disentangle this easily. Hence my advice that mediation could be considered."

12. I was also referred to some email correspondence in the bundle which the Claimant relied upon to show how his condition was affecting him at certain periods of time.

13. In particular on 11 August 2017 the Claimant emailed a Melanie Heatherington to advise that he did not think he was very well. He reported that he could not stop bursting into uncontrollable sobbing and that his hands and legs were shaking constantly. By 18 December 2017 it had been recognised by the Respondent that the Claimant should not be receiving any emails whilst he was out of the office and issued an instruction to that effect. On 16 February 2018 the Claimant emailed a Miss Holt advising that he had been off work with anxiety and his health was continuing to suffer,

he goes on to say that he was shaking whilst typing the email and completely ceased to function as a manager. On 21 March 2018 I had sight of an email to the Equality Advisory Support Service which the Claimant had written at 23.45 at night in which he stated that he had just finished working on a complaint to the ACL (Association of Costs Lawyers) and the situation had overtaken every aspect of his life and he thought about it constantly. It also went on to say that he sometimes does no work whatsoever in a day, instead he gathers evidence to support his concerns and that he withdraws from any source of information during work hours to find vindication. He goes on to say he feels utterly useless and has been broken and is now performing at less than 50% of the manager he was prior to pressures and stresses, harassment and bullying.

14. On 29 March 2018 the Claimant emailed a Mr Baker and told him that he was struggling still and had had 3 panic attacks that week one during a trip to Asda which he described as one of his few ventures outside. He told Mr Baker he was in a desperate, desperate condition and did not feel ready to do anything. He had stopped golf or socialising with friends, doing things with his children and his partner and his children and had stopped attending the gym, swimming or family occasions having recently pulled out of a Mother's Day meal as feeling unable to participate. On 28 September 2018 the Claimant emailed a Raminda Grewal to advise that he had stayed in bed all day, slept all day and that nobody had noticed.

15. The Claimant's impact statement described the following impairments: Panic attacks, vertigo, dizziness, palpitations, rash, pins and needles, trembling and shaking, migraines, sleep disturbance, tiredness, fatigue, social interaction and communication avoidance, keeping fit apathy, uncontrollable emotions, dwelling on negative wrongs, forgetfulness and lack of self-esteem, confidence and fake syndrome. He went on to describe in paragraph 6 how the impairments affected his daily routine. The effect on normal day to day activities was not constant as the impairment of feeling depression will come and go and vary with intensity. The impact(s) he described was as follows: Neglecting personal hygiene, tendency to avoid human contact, looking down at the floor, experiencing greatly increased need to visit the toilet in work every day, tending to eat fast food and stop exercising, finding it difficult to contact friends and family for basic interaction and often refusing to answer his phone, withdrawing from family events including family Christmas party and celebration for Mother's Day. The Claimant at that point had also reported he had withdrawn from social events, skittles matches, golf for most of March and April 2018, ceased swimming for most of December, January and February 2018 and had subsequently stopped altogether, withdrawn from social media deleting chats with friends, no longer attending regular circuit training classes with his daughter, neglecting basic household chores, often finding tasks such as putting out the bins to be onerous so they would build in the garden, and

whilst off on sick leave he often would not leave the house, affected sleep pattern and concentration such as being unable to undertake simple tasks such as payment of household bills leading to two fines for non-payment of council tax, missing meetings and forgetting reading glasses, avoiding participation in communications that could be confrontational preferring to communicate in writing where possible, experiencing extreme tiredness at work, on occasions having to sleep in a disabled toilet, having no motivation and usual rules being devalued such as wearing jeans and other dress down clothes to work.

16. The claimant accepted that he was able to focus on drafting detailed Tribunal submissions, grievances and complaints within a short space of time. This was to the detriment of all other aspects of his life including his family and social relationships. The claimant admitted that he had become obsessed during this period with his complaints against the Respondent and had focused solely on those matters.

The Law

17. Section 6 sets out the definition of a person with a disability. I have also had regard to the Statutory Code of Practice Guidance on the definition of Disability (2011). I was referred to the case of **J v DLA Piper UK LLP Ltd [2010] IRLR 936** and a number of other authorities set out in the authorities bundle.

Conclusions

18. Does the claimant have an impairment which is either physical or mental? The answer to this is yes, the claimant has a mental impairment of depression and anxiety.

19. Does the impairment affect the claimant's ability to carry out normal day to day activities and does it have a substantial adverse effect? I have concluded that the impairment did have such an effect on the following normal day to day activities: Personal hygiene (unchallenged), tendency to avoid human contact by looking down at the floor (unchallenged), greater need to visit the toilet during work due to medication (unchallenged), withdrawal of social contact with friends and family and family events and social activities, neglecting basis household chores, not leaving the house, effect on sleep pattern and concentration suffering.

20. I did not accept that the fact the claimant was able to go on a golfing trip undermined the position in respect of withdrawal of social contact as there was evidence that the condition fluctuated. The claimant would have

periods where he was better then would experience low periods where he withdrew from social contacts.

21. The respondent submitted that the fact that the Claimant was able to engage in activities relating to submission of Tribunal claims at the same time as dealing with grievances and complaints undermined his evidence that his ability to concentrate was affected. However this was at the expense of being unable to undertake other simple tasks such as payment of household bills leading to two fines for non-payment of council tax. This evidence was unchallenged.

22. The respondent's submission in regard to causation was in effect that the symptoms had not been caused by the Claimant's impairment of depression and anxiety but rather by external factors, namely his disputes with the Respondent. In respect of sleeping difficulties they pointed to the sleep apnea entries in the medical records as evidence that his sleeping difficulties were not necessarily caused by his impairment. I found that the one reference to sleep apnea was insufficient to override the numerous other references to problems sleeping in the Claimant's records in connection with his depression and anxiety.

23. The respondent had not adduced any medical evidence that could lead me to conclude that the claimant's ability to carry out normal day to day activities as set out above was caused by external factors rather than his long standing, documented impairment of anxiety and depression. I was unable to understand the position taken by the respondent in this regard. Their own occupational health advisors had advised this was not a position that could be easily untangled. I considered this was a case where as a matter of common sense inference the claimant is suffering from an impairment which has produced these effects.

24. In relation to social interaction and keeping fit the Respondent asserted that these episodes were short lived, happening really only between April and by July 2018 he was back to his usual self, pointing to the fact that he went on a golfing holiday with friends in September 2018. The Respondent asserted that issues with concentration and communication was due to the fact that he no longer trusted the managers rather than his depression or anxiety, but they were not substantial and he was able to communicate at a very high level. There was always an external cause for such symptoms. The Respondent goes on to submit that the Claimant's reason for not being able to attend work during the first half of 2018 was because his relationship with his managers had broken down and had nothing to do with an underlying medical mental health condition.

25. I did not accept these as submissions. In particular I found the submission that there was always an external cause for his symptoms to be an

untenable position to have taken in light of the medical records. In my judgment the Claimant's medical records as well as the reports from the Occupational Health doctors and the Claimant's own GP all support that the Claimant was experiencing the substantial adverse effect on normal day to day activities due to his underlying condition of depression and anxiety. It was not possible to separate out and say that the impairments he experienced were due only to adverse situation at work during the relevant period.

26. Lastly, there was evidence that the periods during the relevant period where the claimant had improved was due to his medication and counselling. Had these treatments been removed I have no doubt the claimant would have been very severely incapacitated. In determining whether a person's impairment has a substantial effect on his or her ability to carry out normal day-to-day activities, the effects of measures such as the medication and counselling should be ignored.

27. For these reasons I find the claimant was a disabled person within the meaning of Section 6 EQA 2010.0

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Employment Judge S Moore
Dated: 5 March 2020

JUDGMENT SENT TO THE PARTIES ON 6 March 2020

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FOR THE SECRETARY OF EMPLOYMENT TRIBUNALS