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EMPLOYMENT TRIBUNALS

Claimant:	**Mr David Lane**
Respondent:	**Ministry of Defence**
Heard at: Birmingham	**On: 3 and 12 June 2019**
Before:	**Employment Judge Woffenden**
Representation	
Claimant:	**In person**
Respondent:	**Mr D Maxwell (Counsel)**

JUDGMENT having been sent to the parties on 29 June 2019 and written reasons having been requested in accordance with rule 62(3) of the Employment Tribunal Rules of Procedure 2013, the following reasons are provided.

REASONS

1. The claimant was employed by the respondent from 10 August 2009 until he resigned with effect from 29 August 2018. He had presented a claim to the tribunal on 28 February 2018 in which he claimed that he had a longstanding disability (Post -Viral Syndrome which he said was otherwise known as '*ME or Chronic Fatigue Syndrome'*) and the respondent had failed to comply with its duty to make reasonable adjustments which caused stress and (in addition to bullying by his line manager) a '*relapse of symptoms'*. The allegations span the period from October 2016 to January 2018.

2. There was a Preliminary Hearing before Employment Judge Dimbylow on 14 March 2019 at which he decided that there should be an Open Preliminary Hearing ('OPH') to determine

   (i) whether the claimant was a disabled person in accordance with the Equality Act 2010 at all relevant times from 30 September 2016 to the claimant's resignation on 29 August 2019 because of the following conditions; (1) depression and anxiety, and (2) post viral syndrome (otherwise known as ME or chronic fatigue syndrome ('CFS') ('the disability issue);

   (ii) whether the claimant's application to amend his claim form dated 17 February 2019 should be granted in whole or in part ('the Amendment Application')?

   (iii) whether having regard to the time limit contained in section 123 of the Equality Act 2010 (3 months) the tribunal has jurisdiction to consider the claimant's discrimination complaints ('the time limit issue'?

   (iv) whether to strike out all or part of the claim because it has no reasonable prospect of success?;

   (v) whether to order the claimant to pay a deposit (not exceeding £1000) if it seems that any contentions put forward by the claimant have little reasonable prospect of success?;

   (vi) subject to the outcome of the OPH further case management orders for the just disposal of the claims.

3. At the commencement of the hearing the claimant confirmed that reasonable adjustments to be made for the purposes of the OPH were as set out in paragraph (4) of Employment Judge Dimbylow's order sent to the parties on 18 March 2019. Mr Maxwell confirmed that the respondent did not ask me to determine the time limit issue at 2.iii) above. In relation to the amendment

application at 2 ii) above , after discussion I decided the claimant should give oral evidence about the facts on which he relied in contending the claim was within time or there was conduct extending over a period or that it was just and equitable for time to be extended . If necessary and after being afforded time for preparation, Mr Maxwell could then cross examine him.

The Disability Issue

4. After discussion at the commencement of the hearing the claimant confirmed that he wanted to rely on the impairments of (1) post viral syndrome (first diagnosed on 20 December 1991), (2) anxiety, and (3) depression (though he was unsure whether in relation to (2) and/or (3) they were impairments in their own right or a symptom of (1)). For the purpose of this judgment references to post viral syndrome ME or CFS are synonymous. He told me his case was that either (1) he is a person who has had a disability, or (2) the post viral syndrome had recurred from 30 September 2016, or (3) its effects (which had never gone away in their entirety) fluctuated. In the case of (2) and (3) this was caused by stress at work and/or it occasioned a break down in any coping strategies he had used to manage (1). The respondent had conceded the claimant was a disabled person by reason of anxiety only and from 19 May 2018.
5. I heard from the clamant who gave his evidence by way of a witness statement dated 20 October 2016 ('the witness statement'). There was an agreed bundle of documents of 316 pages. I have read and had regard only to those documents in the agreed bundle to which the parties referred in the witness statements or in cross examination and in their skeleton arguments.
6. From the evidence I saw and heard I make the following findings of fact:

    6.1 The claimant's date of birth was 23 August 1979. When he was 11, he was diagnosed with post viral syndrome and was off school for about

12 months. During school he believes he managed the symptoms of post viral syndrome (which he contends include fatigue headaches muscle pain and sore throats) by avoiding physical exercise. He left school at 16 and entered full time employment, believing he managed any symptoms by limiting social activities and maintaining a bedtime routine to ensure sufficient refreshing sleep. He has married and has 2 children, the youngest being born in October 2016.

6.2 The claimant started work with the respondent on 10 August 2009.He was employed as a senior weapons effects on structures engineer.

6.3 On 4 October 2016 the claimant saw a GP at the GP practice of which he was a patient. They discussed symptoms of work-related stress and what the GP in question described in his letter to the respondent dated 27 December 2017 as '*potential*' low mood. He was given a statement of fitness for work advising him he was not fit for work until 9 October 2016 because of work related stress. He was also prescribed 7 tablets to help him with sleep. He returned to work on 10 October 2016.

6.4 On 27 April 2017 the claimant saw a GP complaining of a sore throat and headache. He was diagnosed with tonsillitis for which he was prescribed penicillin and certified as unfit for work. He had had 10 days' absence from work due to sickness in a rolling 12-month period.

6.5 On 31 May 2017 the claimant saw a GP complaining of a sore throat and headache. He was diagnosed with tonsillitis for which he was prescribed penicillin.

6.6 On 11 June 2017 the claimant attended a Walk-In Centre complaining of a sore throat and headache. He was told he did not have tonsillitis but was prescribed penicillin.

6.7 On 22 June 2017 the claimant saw a GP complaining of a sore throat and headache. He was again told he did not have tonsillitis but to try gargling with aspirin. He was given the same advice when he attended his doctors on 28 June 2017 complaining of similar symptoms.

6.8 Following an incident at work on 14 August 2017 the claimant experienced an increase in anxiety which caused his throat to feel tight and inhibited his ability to speak fluently. Sore throats, headaches and insomnia prevented him from engaging in physical activities inside and outside the home. He withdrew from social situations and avoided meetings and telephone calls at work. However, he attended work and no performance issues were raised.

6.9 The claimant contacted the respondent's Wellbeing Service on 30 and 31 August 2017 while on leave. He described being anxious having trouble sleeping and thinking things over all the time. He was advised to refer himself to the respondent's counselling service and the first appointment took place on 27 September 2017. He attended 8 such sessions in all until November 2017 when the counsellor became unwell.

6.10 On 19 October 2017 he was seen by a GP and certified as unfit for work for a month because of '*anxiety neurosis/work related stress'*. He remained so certified until 8 April 2018.

6.11 On 20 October 2017 the claimant raised a formal grievance in which he complained of bullying and said he had been struggling with anxiety for some time and had been signed off with work related stress. He had not also mentioned CFS because at that time his main concern was the physical effects of anxiety which he was experiencing.

6.12 On 6 February 2018 the claimant again attended the Walk-In Centre complaining of symptoms like those set out at paragraphs 6.4 to 6.7 above.

6.13 While he was off work his sister (who was on maternity leave prior to the birth of her child) returned to Derby (where the claimant lived) from her home in Edinburgh. She appears to have taken charge of the claimant's situation at this point and it was she who made the claimant provide a copy of a letter from Queens Medical Centre dated 20 May 1993 for the purposes of a referral of the claimant to Occupational Health. The letter confirmed the claimant had been diagnosed with post viral syndrome in 1991 and was to be exempted from physical exercise and games at school. An Occupational Health report dated 23 March 2018 was subsequently prepared on the claimant in which the claimant was referred to being off work sick since the previous October with '*an anxiety state'* said to have been caused by '*work related stress from bullying and harassment by his line manager*'. It described him as being under the care of his GP but noted that he had not required medication or counselling and was fit for work subject to recommendations. It said that it was unlikely '*the Equality Act would apply here as the condition has not required treatment and hasn't caused significant incapacity'*. I accept the claimant's evidence that although no medication had been prescribed for him by his GP this was because of the reluctance he had expressed to take any; he felt he knew what the issue was, all he wanted was separation from the manager in question and medication would mask the problem. He had in fact received counselling (via the respondent) but not via his GP.

6.14 On 3 April 2018 the claimant saw a GP complaining of symptoms like those set out at paragraphs 6.4 to 6.7 above and was diagnosed with tonsillitis for which he was prescribed penicillin. It is the claimant's belief that the symptoms he experienced on each such occasion were those of post viral syndrome.

6.15 The claimant had seen Dr Wilson (who was a locum at his GP practice) on 29 March 2018.He told him about CFS as part of his medical history. He had previously mentioned it to another GP there (Dr Kay) soon after he went off work in October 2017, but the latter had dismissed it out of hand. Dr Wilson had asked the claimant more questions and was more interested in ascertaining any underlying medical issue.

6.16 The claimant's GP surgery wrote to the claimant on 4 April 2018 to tell him that Dr Wilson had referred him to the Chronic Fatigue Clinic at the Royal Derby Hospital.

6.17 The claimant returned to work on 10 April 2018. On 16 April 2018 he had a serious panic attack. He went to see a GP (Dr Parkes) on 17 April 2018 and suffered another panic attack. He suffered another panic attack on his return to work that day. Dr Parkes referred him to Trent Psychological Therapies Service and prescribed Diazepam. On 18 April 2018 the claimant saw his GP again and had another panic attack there and at work on his return. He was also prescribed Citalopram.

6.18 A further Occupational Health report was prepared on the claimant dated 2 May 2018. It described the claimant as being in distress during the assessment and that he had been under the care of his GP and prescribed medication to help with his symptoms '*as well as being referred to a specialist for his symptoms which are consistent with chronic fatigue syndrome*.' Under the heading '*current outlook'* the author of the report

(an occupational health advisor) said the claimant had '*reported having physical symptoms of CF as a result of stress said to have been caused by workplace issues. CFS is a condition characterized by tiredness which is not relieved by rest. Stress is a known trigger for symptoms. Most individuals who suffer from CFS experience more severe symptoms and longer recovery times if they contract minor ailments such as coughs and colds*'. She opined '*My interpretation of the relevant UK legislation is that Mr Lane's condition of CFS is likely to be considered a disability because it*:

- is likely to recur

- would have a significant impact on normal daily activities without the benefit of treatment'

6.19 The claimant was certified as unfit for work because of anxiety with work related stress from 18 May 2018 to 17 July 2018. The medical statement said he might be fit for work taking account of the advice: '*workplace adaptations'*.

6.20 On 21 May 2018 the claimant was seen by a cognitive behavioral therapist at Trent Psychological Therapies Service. The therapist wrote to Dr Parkes and said the claimant had reported his main problem as low mood and anxiety reactive to work related stress, experiencing frequent panic attacks triggered by work or talking about it and intense psychological response when anxious, hands shaking, body tremors and difficulty in speaking and swallowing due to the feeling of throat tightening.

6.21 On 22 May 2018 the claimant attended the Chronic Fatigue Clinic. A letter was sent to the claimant's GP surgery on 23 May 2018 in which the account the claimant had given of his diagnosis with post viral syndrome and symptoms he had experienced was set out. It was said '*It*

is not possible to identify whether David has chronic fatigue syndrome or not due to the fact there are other reasons why he could be having his symptoms, including the amount of stress he is under at work and his poor sleep pattern'. If his stress at work could be resolved and his sleep pattern improved, but his tiredness symptoms remained it said it would be possible for him to return to the Clinic for further assessment. He was given a 6-month open appointment. However, the letter concluded that fatigue management strategies would not be of benefit to him and his symptoms would not improve until his situation at work was resolved. It was the claimant's evidence that he had been diagnosed with CFS by Dr Wilson on 29 March 2018 and referred to the Chronic Fatigue Clinic as a result of that diagnosis and not (as was put to him by Mr Maxwell under cross examination) in order to assess whether he was suffering from CFS. However Dr Wilson's concern at the consultation on 29 March 2018 was to ascertain any underlying medical issue. Although no referral letter has been disclosed by the claimant I infer from the contents of the letter dated 23 May 2018 from the Chronic Fatigue Clinic that Dr Wilson had asked for an opinion about whether the claimant had CFS and had not diagnosed the claimant with that condition himself.

6.22 On 25 May 2018 the claimant attended his GP surgery and was seen by Dr Parkes who diagnosed him as suffering from '*anxiety state NOS (ongoing episode*)'. On 30 May 2018 the claimant was certified as being unfit for work for a month because of anxiety with work related stress. Later that same day he was again seen by the Cognitive Behavioral Therapist at Trent Psychological Therapies Service and reported suicidal thoughts.

6.23 On weekend of 1 / 2 June 2018 the claimant was taken to hospital following an incident of self-harm and was put under the care of a crisis team and discharged from Trent Psychological Therapies Service (which is a primary care service). He was visited daily by the crisis team until 9 July 2018 from which date he attended weekdays at the Hope and Resilience Hub at Derby Hospital as an alternative to in patient care.

6.24 The claimant's Personal Recovery Plan prepared at the Hope and Resilience Hub dated 15 August 2018 noted he was '*experiencing depression and anxiety, following on a relapse in his mental health, due to work related stress*'. He was discharged on 22 August 2018 and resigned from the respondent on 29 August 2018.

6.25 On 29 August 2018 Dr Parkes wrote a letter to an occupational health practitioner who was preparing a report on the claimant. She described how the claimant had over the last 20 months had presented '*with anxiety and panic attacks'*. She also said prior to this he had never had any mental illness nor had he had any significant periods of sickness absence nor was there any history of impaired mental wellbeing, stress, anxiety or depression before October 2016. She had certified him as unfit for work from 28 August 2018 to 14 September 2018 because of '*anxiety with work related stress*'. The first diagnosis of depression by a doctor was in an outpatient letter of 19 September 2018 by which time the claimant had resigned.

6.26 On 16 October 2018 a consultant occupational physician provided a medical assessment on the claimant's eligibility for Civil Service Injury benefit which referred to the claimant's periods of absence from work and that the claimant's GP had confirmed the only reason for his absences was mental health symptoms triggered by work related issues and that he

did not appear to have had a pre-existing history of mental health problems or other causes for the absences. He was in due course granted the benefit in question.

The Law

7. A person has a disability if he has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities (section 6 (1) (a) and (b) Equality Act 2010('EqA')). Whether a person has a disability is a question of fact for the tribunal to determine.

8. Under Schedule 1 EqA 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. If an impairment ceases to have a substantial adverse effect on a persons' 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.

9. In **Goodwin v Patent Office 1999 ICR 302** the EAT said that the words used to define disability in section 1 (1) Disability Discrimination Act 1995 (now section 6 (1) EqA) required a tribunal to look at the evidence by reference to 4 different questions:

    (1) Did the claimant have a mental and/or physical impairment? (the 'impairment condition').

    (2) Did the impairment affect the claimant's ability to carry out normal day-to-day activities (the 'adverse effect condition').

    (3) Was the adverse condition substantial (the 'substantial condition'); and

    (4) Was the adverse condition long-term (the 'long-term condition').

10. 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. 'Measures' includes, in particular medical treatment.
11. The question of long term effect has to be answered as at the date of the alleged discriminatory acts and not with the benefit of hindsight at the date of the hearing: See **Richmond Adult Community College v Mc Dougall [2008] ICR 431**. 'Likely' means 'could well happen' (**SCA Packaging Ltd v Boyle [2009] ICR 1056 (HL)).**
12. The provisions of the EqA also apply to people who have previously had a disability as defined.
13. The burden of proof is on the claimant to show that he was a disabled person in accordance with section 6 and with reference to Schedule 1 EqA at all relevant times.
14. Tribunals must take account of the Guidance on Matters to be Taken into Account in Determining Questions relating to the Definition of Disability (the Guidance').
15. Paragraph A5 of the Guidance states that a disability can arise from a wide range of impairments which can be '*impairments with fluctuating or recurring effects, such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy*'. It is not necessary to consider how an impairment is caused, even if the cause is a consequence of a condition which is excluded. What it is important to consider is the effect of an impairment, not its cause – provided that it is not an excluded condition (paragraph A7).
16. Account should be taken of how far a person can reasonably be expected to modify his or her behaviour, for example by use of a coping or avoidance

strategy, to prevent or reduce the effects of an impairment on normal day-to-day activities. In some instances, a coping or avoidance strategy might alter the effects of the impairment to the extent that they are no longer substantial and the person would no longer meet the definition of disability. In other instances, even with the coping or avoidance strategy, there is still an adverse effect on the carrying out of normal day-to-day activities (paragraph B7).

17. Paragraph B6 states that a person may have more than one impairment, any one of which alone would not have a substantial effect. In such a case, account should be taken of whether the impairments together have a substantial effect overall on the person's ability to carry out normal day-to-day activities. For example, a minor impairment which affects physical coordination and an irreversible but minor injury to a leg which affects mobility, when taken together, might have a substantial effect on the person's ability to carry out certain normal day-to-day activities. The cumulative effect of more than one impairment should also be taken into account when determining whether the effect is long-term.

18. Paragraph B9 states that account should also be taken of where a person avoids doing things which for example cause pain, fatigue or substantial social embarrassment because of the loss of energy and motivation. It would not be reasonable to conclude that a person who employed an avoidance strategy was not a disabled person. In determining a question as to whether a person meets the definition of disability it is important to consider the things that a person cannot do or can only do with difficulty. In some cases, people have coping or avoidance strategies which cease to work in certain circumstances (for example, where someone who has dyslexia is placed under stress). If it is possible that a person's ability to manage the effects of an impairment will break down so that effects will sometimes still occur, this

possibility must be taken into account when assessing the effects of the impairment (paragraph B10).

19. Under paragraph C6 it is said that '*Some impairments with recurring or fluctuating effects may be less obvious in their impact on the individual concerned than is the case with other impairments where the effects are more constant'. Further, it is not necessary for the effect 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 greater extent. The effect may even 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* (paragraph C7).

20. In **Aderemi v London and South Eastern Railway Ltd [2013] ICR 591 EAT** Langstaff P said:

> "*It is clear first from the definition in section 6(1) (b) of the Equality Act 2010, that what a tribunal has to consider is an adverse effect, and that it is an adverse effect not upon his carrying out normal day-to-day activities but upon his ability to do so. Because the effect is adverse, the focus of a tribunal must necessarily be upon that which a claimant maintains he cannot do as a result of his physical or mental impairment. Once he has established that there is an effect, that it is adverse, that it is an effect upon his ability, that is to carry out normal day-to-day activities, a tribunal has then to assess whether that is or is not substantial. Here, however, it has*

to bear in mind the definition of substantial which is contained in section 212 (1) of the Act. It means more than minor or trivial. In other words, the Act itself does not create a spectrum running smoothly from those matters which are clearly of substantial effect to those matters which are clearly trivial but provides for a bifurcation: unless a matter can be classified as within the heading 'trivial' or 'insubstantial', it must be read as substantial. There is therefore little room for any form of sliding scale between one and the other."

21.I have read the parties' written skeleton arguments and heard Mr Maxwell's oral submissions on behalf of the respondent. The claimant did not make any oral submissions, relying on his written skeleton argument. In the latter the claimant made it clear that his case was that the substantial adverse effects of the impairment of post viral fatigue on his ability to carry out normal day to day activities had recurred in 2016 caused by the stress of being bullied.

Conclusions

22.The claimant had the condition of post viral fatigue in 1991. The Guidance recognizes CFS as an impairment with fluctuating or recurring effects.

23.However, I conclude on the balance of probabilities that ,as far as the claimant is concerned, although he had CFS for over a year when he was a child the substantial adverse effects of CFS on his ability to carry out normal day to day activities had ceased many years ago. The coping strategies he had put in place (see paragraph 6.1 above) which (in my judgment he could be reasonably expected to take) had altered the effects of CFS to such an extent that he no longer met the definition of disability .There was no evidence of any subsequent treatment for or of any measures taken to treat or correct CFS. There was no medical evidence that CFS was likely to last for the rest of the claimant's life or

that its effects were likely to recur or fluctuate or about the circumstances which would precipitate such a recurrence or fluctuation.

24.Although I do not doubt the genuineness of the claimant's belief that the symptoms he experienced from October 2016 onwards were those of a recurrence of or fluctuation in the effects of post viral syndrome the symptoms experienced by the claimant (as set out in paragraphs 6.4 to 6.7 and 6. 12 and 6.14) were given positive diagnoses by the doctors who treated him at the time. I accept Mr Maxwell's submission that the claimant's belief is with the benefit of hindsight fomented by his sister's review of his earlier diagnosis whilst a child. There is a conflict between the Occupational Health Report dated 2 May 2018 and that of the Chronic Fatigue Clinic dated 23 May 2018 as far as a diagnosis of the claimant's condition is concerned. I have preferred the latter because that clinic evidently specialised in CFS. It does not support a diagnosis of CFS or a recurrence of its effects.

25.The claimant has not proved on the balance of probabilities that the substantial adverse effects of CFS on his ability to carry out normal day to day activities had recurred from September 2016 onwards or that there was a fluctuation in those effects .There was no evidence before me from which I could conclude that the mental impairments of anxiety or depression were likely to or had developed from the condition of CFS which the claimant had had in his childhood or were symptoms of that condition.

26.The claimant was diagnosed with anxiety neurosis and work-related stress on 19 October 2017. This was a mental impairment. On that day he began a period of long-term sickness absence. Although he began experiencing symptoms of anxiety in August 2017 and it is possible the substantial adverse effect on normal day to day activities of the mental impairment of anxiety would have preceded the date of diagnosis, I had no cogent evidence before me from which I could

conclude with any certainty how long before the date of diagnosis this might have been. I conclude that the substantial adverse effect began when the claimant began his absence from work. There was no evidence from which I could conclude at this point that the substantial adverse effect was likely to last for at least 12 months or for the rest of the claimant's life. Mr Maxwell submits (and I accept) that by 19 May 2018 an adverse effect had lasted for 7 months (since although the claimant had managed to return to work on 10 April 2018 it was on a phased return to work) and given that was more than half a year it could then have been said it was likely (in the sense it 'could well happen') that it would last for at least 12 months in total. It was on that date therefore I conclude the claimant met the definition of disability with Section 6 EqA. As far as the mental impairment of depression was concerned the first definition of depression was on 19 September 2018 which was after the claimant's resignation and therefore outside the material period.

27 It follows therefore that the claimant's claims all predate the period when I have found the claimant was a disabled person and are therefore dismissed.

Employment Judge Woffenden

Date 09/12/2019