EMPLOYMENT TRIBUNALS

Claimant: F

Respondent: The Commissioner of Police of the Metropolis

Heard at: **London South Employment Tribunal** **On: 27 January 2020**

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

Representation
Claimant: Ms N Owen (counsel)
Respondent: Mr P Livingston (counsel)

RESERVED JUDGMENT

It is the judgment of the Tribunal that:

The Claimant was disabled within the meaning of the Equality Act 2010 at all material times from 15 August 2017.

REASONS

INTRODUCTION

1. By a claim form presented on 18 April 2019, following a period of early conciliation from 20 February to 20 March 2019, the Claimant brought complaints of disability discrimination against the Respondent (failure to make reasonable adjustments, discrimination arising from disability and indirect discrimination). She is a serving Detective Constable, having joined the Metropolitan Police Service in 2009.

2. This hearing was listed to determine whether the Claimant was disabled at all material times. The Claimant relies on a mental impairment, namely mixed anxiety and depressive disorder, work related stress and grief reaction.

3. The Claimant claims that she satisfied the definition of disability from February 2017 onwards. The Respondent accepts that she satisfied the definition from 19 January 2019, but disputes that she did so before that date. For the period before January 2018, the Respondent does not accept that the Claimant had a mental impairment or that any impairment had a substantial adverse effect on her ability to carry out normal day-to-day activities ("the prescribed effect"). The Respondent accepts that the Claimant was diagnosed with depression on 19 January 2018, and that this was a mental impairment that had the prescribed effect, but does not accept that the effects were "long term" until 19 January 2019.

4. The disputed period is therefore February 2017 to 19 January 2019.

5. I heard evidence from the Claimant.

6. On the Tribunal's own initiative, with the support of the Claimant and no objection having been received from the Respondent, I make an Anonymisation Order under Rule 50 in respect of the Claimant because of the personal nature of the evidence relating to disability and the fact that she is a serving police officer.

FACTS

7. The Claimant joined the Metropolitan Police Service in 2009. At all material times she was a Detective Constable, dealing with serious and complex investigations at a particular London police unit. She moved to a different unit in February 2019.

8. In February 2016, the Claimant suffered the bereavement of a close friend. She says that since then she has suffered from anxiety, insomnia, poor concentration, migraines, breathlessness, heart palpitations, shakes, irritability and lack of resilience.

9. The Claimant was given four days' compassionate leave in February 2016.

10. On 13 August 2016 the Claimant broke down in tears at work and was advised by her superior officer, DS G, to attend her GP.

11. The Claimant attended her GP on 15 August 2016. The record of the appointment states:

> "Grief reaction best friend died from cancer < 6 months ago, had to meet with the deceased family last few days felt it became painful and distressing, has been exp sleep disturbance and tearful, recent holiday helped but on return to work as police officer her manager advised rest, refer to local support group meeting… at local venue details given and pt will attend meantime recall 1w sooner should worsen or concerned…"

12. The Claimant was signed off work for one week due to "grief reaction". She attended the GP again on 22 August and was signed off for a further week. On the second occasion the GP noted "refer to mind anxiety grief reaction… continues to feel tearful and anxious in workplace situations".

13. Also on 22 August DS G referred the Claimant to Occupational Health ("OH"). The referral form states:

> "[The Claimant] has recently suffered a bereavement… [She] by her own admission has struggled to process this event. Self referral numbers were provided and called by no reply has occurred. On 13/08/2016 [the Claimant] dissolved into tears when working as part of a weekend cover team. This was following a memorial picnic with her friends family…
>
> It is now quite clear the effect this event has had on [the Claimant]. Her ability to manage her workload and perform at the level normally associated with [her] have fallen considerably. This is due to the stress/ depression she has been under. [The Claimant] is an exceptionally private person and it took the public display for both her and I to realise the degree it was affecting her."

14. The Claimant was also referred for counselling with the police counselling service. She attended a session on or around 23 August 2016. DS G asked the Claimant by text message on 26 August how it had gone. The Claimant replied:

> "Not too bad. Obviously got upset. The confusion, mood swings and inability to take criticism is all part of the grief so that's helpful to know".

15. The Claimant was reviewed by her GP on 30 August. The GP notes state:

> "Patient reviewed anxiety getting counselling from work – 6 sessions feels better exercising."

16. She was signed off until 2 October 2016, again due to "grief reaction".

17. On 21 September 2016 the Claimant had a meeting with DI M and DS G. It was noted that the counselling sessions had "already identified that the root cause of the issue is the grief reaction from the death of her best friend". It was also noted that the Claimant was "still struggling to process and deal with the grief reaction" and that throughout the meeting she "appeared upset and borderline tearful".

18. The Claimant returned to work in October 2016 and was temporarily assigned to the Missing Persons Unit.

19. Following a telephone assessment on 15 November 2016, an OH report was produced. It noted that the Claimant's symptoms had progressively worsened after the bereavement and it affected "her sleep, her emotion, concentration and she had migraine headaches". It was said that she had benefitted from counselling and

> "…appears to have made a good recovery from her physical symptoms of grief. She is aware that bereavement symptoms heal with the passage of time. There is no specific timeframe for this."

20. The report states that the Claimant was "fit for full duties". As for the prognosis, it states, "She is expected to make a full recovery over time and resuming active assignment, would facilitate this process as [the Claimant] seems to be contented when she is actively engaged in her normal duties." The OH advisor considered the Claimant was unlikely to be considered disabled "As her symptoms of bereavement are unlikely to last longer than 12 months moreover; she has made a significant recovery from it".

21. In the case notes, the OH advisor noted that the Claimant had a "catalogue of symptoms including insomnia, migraines, lack of concentration, anxiety, breathlessness, tearfulness and stress symptoms". It was also noted that the Claimant "perceives that most of her grief is actually associated with the uncaring/ unsupportive work environment but she does not wish to raise a grievance. Issues at work have been ongoing for a number of month's i.e. labelling, isolation of staff, favouritism etc." The notes record "Physical symptoms, anxiety, insomnia and tearfulness have stopped".

22. The Claimant returned to her normal duties shortly after this, in November 2016.

23. In her oral evidence the Claimant said that the reference to physical symptoms having stopped in November 2016 was wrong. She said she had had no alleviation from her symptoms since 2016. She accepted, however, that she remained at work from November 2016 until August 2017, in her normal role, and did not attend any other medical professional about these issues until mid July 2017. She said she was "trying to cope as best I could".

24. It appears that in July 2017 DS S became the Claimant's line manager because on 14 July 2017 DS S made another referral to OH. The referral form states:

> "During my initial interactions with [the Claimant] it has become clear that she is still heavily effected by bereavement episodes that she has experienced over the past couple of years as well has having strong negative feelings towards work and her managers because she perceived that they did not support her during this difficult time…
>
> [The Claimant] had a long period of sickness last year because of bereavement. She feels that her return to work was hasty.
> [The Claimant] has told me that she does not feel that her work is suffering currently."

25. The Claimant attended her GP again on 17 July 2017. The notes state:

> "Patient reviewed ongoing stress at work and feels that hasn't fully recovered from bereavement last year. Generally feels fine at home or at weekends but anxious in the work environment…"

26. The Claimant was referred for bereavement counselling with Mind.

27. Following a further telephone assessment on 31 July 2017, an OH report was produced which states that the Claimant had experienced symptoms of stress and anxiety "triggered by the work situation". The report states that the Claimant

said her GP's view was that she did not require medication but a change of working environment. At that time the Claimant was due to move in September to the telephone reporting unit. The OH advisor said the Claimant was "at work and continues to be fit for her role". As to prognosis, she advised that the Claimant was "expected to make a good recovery from her symptoms of stress and anxiety as she seems content presently with her current work environment in the telephone reporting unit". It is assumed that the OH advisor meant to refer to the Claimant's future move to the telephone reporting unit.

28. As to the Equality Act 2010, the OH advisor said:

> "While ultimately it is for a tribunal to determine whether an individual is considered to be disabled, in my opinion [the Claimant] is unlikely to be covered under the Act as her symptoms of stress, although it affects her health, it does not appear to have significant impact on her ability to undertake normal daily activities."

29. An initial letter from Mind following a telephone triage assessment on 26 July 2017 recorded the problem as "Client reported that she had a bereavement February 2016". It noted the Claimant's scores on depression and anxiety scales as, respectively, PHQ9: 8 and GAD7: 10. The evidence as to the interpretation of those scores was unclear, however, because a document produced by the Claimant to translate such scores into "mild", "moderate" etc was not consistent with the assessments by the Mind counsellors. I can therefore place no weight on the scores in themselves.

30. On 30 August 2017 the Claimant was signed off work for one week due to "grief reaction".

31. A further referral to OH was made on 15 September 2017. It refers to some difficulties between the Claimant and her line managers in the period since early 2016. It states:

> "[The Claimant] has now seen a recurrence of the physical symptoms she had of anxiety and tearfulness at work. She has been advised by her GP that she does not require medications and her symptoms are being caused by her workplace…"

32. On 19 September the Claimant attended her GP again, who recorded the following in the notes:

> "Grief reaction ongoing following bereavement of best friend. Exacerbated a lot by difficult work environment and work place stress. Had bereavement counselling which helped with physical sx anxiety (insomnia, breathlessness) but recently these have returned over past months. Triggered by change in role at work. Initially moved from high intensity role to lower intensity on recommendation from OH but now being moved back. Requesting a letter to OH, recommending that she stay in her current role. She prefers to be at work but in lower intensity role. Discussed MIND – encouraged to chase/ re-refer. Discussion started fluoxetine, suggested that as situation quite up in the air perhaps based to reassess if still needs them once know more about work

> situation. Pt happy. Symptoms of anxiety largely related to workplace, feels better at home/ not at work. Denies low mood. Due to be going on 2 weeks police respite in 2 weeks…"

33. The GP wrote a letter to the Respondent's OH department on the same day as follows:

> "[The Claimant] has been diagnosed with a grief reaction following a bereavement of a close friend last year; this condition is on going and we are continuing to manage it and support her with this. The grief reaction reduced her ability to cope with her previous high intensity role and I understand that [the Claimant] is managing her condition much better in her current role as an investigator. However she has informed me that she due to be moved back to her higher intensity post of detective on 16/10/17. She is concerned that this move will result in a deterioration in her mental state. I would be grateful if you could review this as it may be detrimental to her recovery."

34. A further OH report was produced on 22 September 2017. It states:

> "**Summary of health issues**
> [The Claimant] has been suffering from stress related symptoms initially due to bereavement, her best friend died in February 2016 following ill health which was unexpected. She did not take any time out but continued to work. She did not have time to grieve as work was always very busy. Eventually she was signed off sick for 9 weeks as the symptoms worsened and she had only just started counselling therapy. [The Claimant] returned to work slightly earlier than her GP recommended as she was put on a phased return and to a low stress posting. This was only for 2 weeks after which she returned to her normal role. She informed me that some of her colleagues were not very supporting making remarks that upset her. She did not have the resilience to face this so she requested to be moved to a different area. She was given a new line manager with the move. She has problems with management as felt that she was being bullied especially by the way she is being managed. This has triggered anxiety and stress related symptoms that she was experiencing previously. She continues to be under the care of her GP but did [not] require any treatment at the time. She was deployed to work in a different unit for a short period of time, the nature of the work there was highly stressful but she had no problems. So she has attributed the anxiety and stress to her normal workplace and the management there.
>
> [The Claimant] is currently working at Telephone Investigation Unit it was initially arranged for her to work there for a year on attachment. But management has now decided that she has to move back to her previous workplace in Borough. The thought of returning to that workplace is causing her additional stress and anxiety. She does not feel that she is able to approach management if she has any problems. She is due to have counselling therapy at [a residential police rehabilitation centre] in October 2017.

> **Fitness for work and current capabilities**
> In my opinion [the Claimant] is fit for her role. However, I recommend you address the management issues otherwise it is likely to continue to exert a negative influence upon any future recovery. As the issues may take a period of time to resolve it would be prudent for her to continue to work at the Telephone Investigation Unit because if the problems continue for any length of time and with the continuous exposure to this there may be a heightened risk of this individual developing a significant depressive illness.
>
> **Equality Act 2010**
> While ultimately it is for a tribunal to determine whether an individual is considered to be disabled, in my opinion [the Claimant] is unlikely to be covered under the Act as recovery would be expected following the conclusion of the perceived workplace issues and within 12 months.
>
> …
>
> **Prognosis**
> Notwithstanding any unexpected problems full recovery would be expected with therapy and addressing the management issues. It is not expected to cause any long term health problems provided the underlying cause is dealt with."

35. The Claimant attended a residential police rehabilitation centre for two weeks and was discharged on 12 October 2017. The discharge letter states that the Claimant said her stay had been beneficial, but the letter also warned that her mental health would suffer if she returned to a place of work where she felt unsupported, misunderstood and marginalised. Her GAD7 (anxiety) score was noted to have reduced during her stay from the level of "moderate symptoms" to "no significant symptoms". Her PHQ9 (depression) score had also reduced, but both scores were classified as "no significant symptoms".

36. The Claimant was signed off by her GP for two weeks from 17 October 2017 due to "grief reaction". This was ultimately extended until 13 January 2018.

37. A further OH referral was made on 20 December 2017. It refers to Federation representatives and an "unconnected sergeant" having "serious and significant concerns for her mental health". It states:

> "She is emotionally fragile and has recently told her contact officer that her feelings of anxiety and stress are worsening. She cries during most interactions with her police contact officer and her federation representative… [The Claimant] has thus far refused to come back to work because of her negative perception of her local work place.
>
> …
>
> "OH did state during the last assessment that [the Claimant] was fit for duties however I have concerns that mental health has not been properly considered. I also believe that in the last few months, [the Claimant's] mental health has deteriorated considerably and urgent advice is sought

> regarding her mental health to help inform the direction and action that management might take."

38. The OH report, following a telephone consultation on 3 January 2018, notes that "there appear to be workplace related problems beyond purely medical issues that need to be addressed". It states:

> "[The Claimant] reports that she feels quite nervous returning back to Lewisham Borough. It is unlikely that her symptoms will resolve unless her workplace related concerns are addressed…
>
> … In my opinion [the Claimant] is unlikely to be covered under the Act as although she has a mental health condition, it does not have a substantial effect on her ability to carry out her normal daily activities without medication."

39. The Claimant attended her GP again on 19 January 2018. The GP notes state:

> "Endogenous depression first episode ongoing issues with work. culminated in emotional breakdown this week. not sleeping, poor concentration, teary, irritable, stopped going to the gym…"

40. The Claimant was prescribed Sertraline (50mg), an antidepressant, and Promethazine hydrochloride, a sleeping tablet. She continued to be reviewed by her GP over the following few months. On 20 March 2018 her GP wrote a letter "to whom it may concern" regarding the Claimant's anxiety at returning to her normal place of work. The letter states that the Claimant "has been reviewed by myself since October for grief reaction and depression".

41. Since there is no dispute that the Claimant's symptoms had the prescribed effect from 19 January 2018 onwards, and in light of the conclusions below, it is unnecessary to give further detail as to the effects and medical treatment after this stage. It is relevant only to note that the Claimant was referred to a police consultant psychiatrist who produced a report dated 26 April 2018. It states that the Claimant was "suffering from a mixed anxiety and depressive disorder, secondary to work related stress and grief from a loss of a friend two years ago". An OH report dated 15 August 2018 advised that the Claimant's medical condition was "likely to fall within the Equality Act".

THE LAW

42. A person has a disability for the purposes of the Equality Act 2010 ("EqA") if he or she has a physical or mental impairment, which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities (s.6 EqA).

43. The burden of proving disability rests with the claimant.

44. "Substantial" means more than minor or trivial (s.212 EqA).

45. Schedule 1 EqA further expands upon the definition in s.6, providing at paragraph 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.

46. "Likely" in this context means "could well happen" (SCA Packaging Ltd v Boyle [2009 ICR 1056).

47. Likelihood of recurrence is to be judged on the basis of what was known at the time when the alleged discrimination took place. Later events must be disregarded (Richmond Adult Community College v McDougall [2008] ICR 431).

48. Paragraph 5 of Schedule 1 states that the effects of medical treatment are to be disregarded in determining whether an impairment has a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities.

49. The statutory guidance issued under s.6(5) EqA deals with the question of impairments that have recurring or fluctuating effects. It states:

> C5. The Act states that, if an impairment has had a substantial adverse effect on a person's ability to carry out normal day-to-day activities but that effect ceases, the substantial effect is treated as continuing if it is likely to recur. (In deciding whether a person has had a disability in the past, the question is whether a substantial adverse effect has in fact recurred.) 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' (Sch1, Para 2(2), see also paragraphs C3 to C4 (meaning of likely).)
>
> 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. See also example at paragraph B11. If the substantial adverse effects are likely to recur, they are to be treated as if they were 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 effects can be sporadic, include Menières Disease and epilepsy as well as mental health conditions such as schizophrenia, bipolar affective disorder, and certain types of depression, though this is not an exhaustive list. 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.

A young man has bipolar affective disorder, a recurring form of depression. The first episode occurred in months one and two of a 13-month period. The second episode took place in month 13. This man will satisfy the requirements

of the definition in respect of the meaning of long-term, because the adverse effects have recurred beyond 12 months after the first occurrence and are therefore treated as having continued for the whole period (in this case, a period of 13 months).

In contrast, a woman has two discrete episodes of depression within a ten-month period. In month one she loses her job and has a period of depression lasting six weeks. In month nine she experiences a bereavement and has a further episode of depression lasting eight weeks. Even though she has experienced two episodes of depression she will not be covered by the Act. This is because, as at this stage, the effects of her impairment have not yet lasted more than 12 months after the first occurrence, and there is no evidence that these episodes are part of an underlying condition of depression which is likely to recur beyond the 12-month period. However, if there was evidence to show that the two episodes did arise from an underlying condition of depression, the effects of which are likely to recur beyond the 12-month period, she would satisfy the long term requirement.

50. In J v DLA Piper UK LLP [2010] ICR 1052 the EAT gave guidance on the approach to be taken in cases involving depression. Mr Livingston for the Respondent helpfully summarised the relevant guidance in his written submissions as follows:

    50.1. Although it is good practice for a Tribunal state separate conclusions on the questions of impairment, adverse effect, substantiality and long term effect – where there is a dispute about the existence of an impairment, it may make sense for the Tribunal to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adversely affected (on a long-term basis), and to consider the question of impairment in the light of those findings. (Para 40)

    50.2. There could be a distinction between two states of affairs which can produce broadly similar symptoms of low mood and anxiety. The first – clinical depression – is unquestionably a mental impairment under the legislation. “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 … ‘adverse life events’” (Para 42)

    50.3. Although the borderline between the two states of affairs is often to be very blurred in practice, “it reflects a distinction which is routinely made by clinicians … and which should in principle be recognised for the purposes of the Act”. (Para 42)

    50.4. This will not often cause a real problem because of the long-term effect requirement – if a Tribunal “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.” (para 42)

50.5. It should not simply be assumed that depression is long term because it is likely to recur. For example, someone suffering two periods of depression separated by decades would likely be regarded as have suffered two distinct illnesses. On the other hand, someone suffering several short episodes of depression over a five-year period which each had a substantial adverse impact on her ability to carry out normal day-to-day activities but who between those episodes is symptom-free and does not require treatment. In the latter situation "… it may be appropriate, though the question is one on which medical evidence would be required, to regard her as suffering from a mental impairment throughout the period in question". In this situation, "…if the medical evidence supported the diagnosis of a condition producing recurrent symptomatic episodes", that person could properly claim to be disabled throughout the relevance period even if each individual episode were too short for its adverse effects to be regarded as long-term. (Para 45)

CONCLUSIONS

51. In light of the Respondent's concessions noted above, I approach the matter by addressing the following questions:

    51.1. Did the Claimant have a mental impairment that had the prescribed effect at any time before January 2018?

    51.2. If so, from what date was the effect "long-term"?

52. As to the first question, in accordance with the guidance in J v DLA Piper, I consider that this is a case in which it is appropriate to consider the effects before proceeding to consider whether the Claimant had a mental impairment at the relevant time.

53. Although the Claimant claims to have suffered from symptoms (anxiety, insomnia, poor concentration, migraines, breathlessness, heart palpitations, shakes, irritability and lack of resilience) more or less continuously since February 2016, there is little evidence of substantial effects until her first period of sickness absence in August 2016. For the first few months after the bereavement it appears the Claimant continued to attend work without difficulty. She did not seek any medical advice or treatment, and she has not given any examples of adverse effects on her ability to carry out normal day-to-day activities.

54. From mid-August 2016, however, the Claimant was visibly struggling at work, such that her superior officer made an OH referral and advised her to attend her GP. Her performance level had, according to the referral, "fallen considerably". DS G also referred to what he perceived as "depression/ anxiety". The Claimant's GP signed her off work on 15 August 2016, initially for one week, subject to review. By the time of the second appointment the GP noted "anxiety grief reaction" and a referral to Mind. The Claimant had a course of counselling. Ultimately her sickness absence, recommended by the GP, lasted seven weeks. She returned initially to different duties in the Missing Persons Unit, but then from November 2016 returned to her normal role.

55. I accept that during the period from 15 August until October/ November 2016 the Claimant was experiencing symptoms that had a substantial adverse effect on her ability to carry out normal day-to-day activities. The GP records, OH reports and OH notes show that she was suffering from insomnia, lack of concentration, breathlessness and tearfulness that were sufficiently serious to warrant referral for counselling and seven weeks off work. Her symptoms clearly impacted on her ability to communicate normally at work and to concentrate on her work. Indeed the Respondent did not challenge the Claimant's evidence about her symptoms during this period; it was merely put to her in cross-examination that she had made a good recovery by November 2016.

56. There is a dispute about the extent of the Claimant's symptoms between November 2016 and July 2017. The Claimant says she continued to experience the same symptoms. That may be correct, but there is no other evidence, medical or otherwise, of any significant problems during this period. She attended work in her normal role throughout and did not attend her GP or any other medical professional. Nor were any issues reported at work. Based on the evidence produced by the Claimant I am unable to find that she continued to suffer symptoms that had the prescribed effect during this period.

57. Clearly things changed in July 2017. The Claimant's then superior officer, DS S made another referral to OH, linking what he perceived to be the Claimant's current problems with the bereavement in 2016 ("still heavily effected by bereavement episodes"). There were, evidently, particular problems at work related to the Claimant not feeling supported. On 17 July 2017 the GP noted the Claimant felt she had not "fully recovered" and she was referred for bereavement counselling. The Claimant had a further OH assessment and started counselling with Mind. She was then signed off work by her GP with "grief reaction on 30 August 2017".

58. Taking into account the GP records and the OH notes, I am satisfied that in July/ August 2017 the Claimant experienced a recurrence of the symptoms she had experienced in the latter part of 2016, and that by the time she was signed off work on 30 August 2017 these symptoms were having an adverse effect on her ability to carry out normal day-to-day activities. The recurrence may have been triggered by the Claimant's feelings of not being supported at work, but all of the evidence, including in particular the reason given for sickness absence, points to there being a clear link with the bereavement in 2016. The OH notes from September 2017 refer to the Claimant having seen a recurrence of tearfulness at work, insomnia and breathlessness. I am satisfied that these symptoms affected her communication and concentration, as before, such that she required counselling and a further week off work.

59. In September and October 2017 there were discussions about the Claimant's role and whether she could return to her normal duties. According to the GP's letter of 19 September 2017 and the OH report of 22 September 2017 these issues were causing the Claimant stress and anxiety. The OH report advised that recovery was dependent on "the conclusion of the perceived workplace issues". During this period the Claimant also attended the residential police rehabilitation centre. Although she improved during her stay, almost

immediately on her return to work she was signed off again due to "grief reaction". This period of sickness absence lasted almost three months.

60. The evidence as to the effect on normal day-to-day activities during the period October 2017 to January 2018 is limited, but given the Claimant's previous symptoms, the fact that she was referred to the residential rehabilitation centre for treatment and the fact that she had a very lengthy period off work, I am satisfied that her symptoms had the prescribed effect from the recurrence in July/ August 2017 until January 2018.

61. There is no dispute that the Claimant had a mental impairment that had the prescribed effect from 19 January 2018.

62. As to whether the Claimant was suffering from a mental impairment prior to January 2018, the Respondent relies on the distinction in J v DLA Piper between mental impairments and reactions to adverse life circumstances and argues that the Claimant was experiencing the latter. I do not accept that argument. Although the term "depression" was not used by the GP until January 2018, the medical professionals involved in the Claimant's case have used the terms stress, anxiety, depression and grief reaction at various times to describe her condition since she was first seen in August 2016. Taking the evidence as a whole, it is clear that the Claimant has suffered from the same underlying mental impairment, the effects of which have fluctuated, since August 2016. The GP letter in September 2017 said the Claimant had been "diagnosed with grief reaction", which suggests she was suffering from a clinical mental impairment. The GP letter in March 2018 refers to "grief reaction and depression", which suggests that they are linked medical conditions. Further, the consultant psychiatrist's assessment was that the Claimant was "suffering from a mixed anxiety and depressive disorder, secondary to work related stress and grief from a loss of a friend two years ago", which is further medical evidence of a link. Even if the Claimant was not clinically diagnosed with depression before January 2018, her "grief reaction" was more than a normal reaction to adverse life circumstances. It resulted in two lengthy periods off work and two courses of counselling, plus the stay in the residential rehabilitation centre. It is not necessary to identify a particular clinical diagnosis; applying the guidance in J v DLA Piper, I am satisfied that the Claimant was suffering from a mental impairment from August 2016 onwards.

63. The second question, then, is at what stage the effect of the Claimant's mental impairment became long-term. I have found that the Claimant's impairment had the prescribed effect from mid-August 2016 to October/ November 2016 and again, when it recurred, from 30 August 2017 onwards.

64. I must therefore consider paragraph 2(2) of Schedule 1 EqA: "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." This provision only expressly addresses the "likelihood" of recurrence, but taking into account the statutory guidance I consider it also applies where the effect actually recurs. In the example of the person suffering from bipolar disorder given in section C6 of the guidance (see above), the long-term requirement was satisfied "because the adverse effects have recurred beyond 12 months after the first occurrence and are therefore

treated as having continued for the whole period". I consider the same analysis applies in this case.

65. The adverse effects to the Claimant first occurred, to the prescribed extent, on or around 15 August 2016. They then recurred beyond 12 months after the first occurrence, from (at the latest) 30 August 2017 onwards. The two episodes were clearly linked. Applying paragraph 2(2) of Schedule 1 EqA the effects are to be treated as having continued for the whole period. Although the effects did in fact recur, I do not find that at any stage prior to August 2017 they were "likely" to recur. The Claimant had apparently made a good recovery after November 2016 and the recurrence appears to have been triggered by problems at work. Given the relatively long period (November 2016 to July 2017) during which the Claimant's symptoms did not have the prescribed effect, and in the absence of any medical evidence that her symptoms were likely to recur, it cannot be said that that recurrence was likely.

66. The point at which the effects became long-term, therefore, was 12 months after the first occurrence, i.e. 15 August 2017. The Claimant was therefore disabled within the meaning of the EqA at all material times from 15 August 2017.

Employment Judge Ferguson

Date: 27 March 2020