EMPLOYMENT TRIBUNALS

Claimant: Miss Kate Hunt

Respondent: Amey Services Limited

Heard at: Cardiff (CVP) **On:** 18 January 2021

Before:

Representation
Claimant: Mr P Morris (Counsel)
Respondent: Mr A Crammond (Counsel)

RESERVED JUDGMENT

1. It is the decision of the Employment Judge sitting alone that the Claimant was not a disabled person at the material times under the Equality Act 2010. The Claimant's disability discrimination claim therefore cannot continue and is dismissed. The Claimant's unfair dismissal claim continues and separate case management orders have been issued.

REASONS

Issues

1. The issues to be resolved at this open preliminary hearing were identified by Employment Judge Howden-Evans in the order dated 6 April 2020 as follows: -
    a. *Does/did the Claimant have a physical or mental impairment, namely Chronic Fatigue Syndrome ("CFS"), anxiety, depression and work-related stress?*
    b. *If so, did the impairment have a substantial adverse effect on the claimant's ability to carry out normal day to day activities?*
    c. *If so, was that effect long term? In particular when did it start; and*

a) Has the impairment lasted at least 12 months?
b) Is or was the impairment likely to last at least 12 months?

d. *Are any measures (e.g., medication) being taken to treat or correct the impairment? But for those measures would the impairment be likely to have a substantial adverse effect on the Claimant's ability to carry out normal day-to-day activities?*

2. A discussion took place regarding the effect of the conditions and the relevant times. Mr Morris confirmed that the Claimant was seeking to rely on four health conditions: CFS, anxiety, stress and depression, both separately and cumulatively, and alternatively relied upon CFS alone. The Claimant's position is that all conditions are progressive.

3. Mr Morris also clarified that the Claimant's position was that she met the definition of disabled in respect of CFS in May 2015 and depression in 2016. No specific start date was provided in relation to anxiety and stress but it was understood by the Respondent that the discriminatory events were alleged to have taken place between August 2016 and 5 June 2019.

4. The Respondent's position is that there is no clear diagnosis of CFS and more generally that the Claimant has not suffered from any impairment, but rather has had normal reactions to challenging life events, bereavements and difficulties in the work place.

Procedure and evidence

5. The Claimant was represented by Mr P Morris, Counsel, and the Respondent was represented by Mr A Crammond, Counsel.

6. I read the Claimant's Impact Statement and heard oral evidence from the Claimant.

7. There was an agreed bundle of 356 pages in addition there was a supplementary bundle of 61 pages. Any page references in these Reasons refer to pages in the bundles.

8. I informed the parties that unless I was taken to a document in the bundle, it may not be read. Both the Claimant and Respondent provided oral submissions, and the Respondent also provided skeleton written submissions.

Facts

9. The Claimant commenced employment with the Respondent on 19 January 2015 and was employed as a Senior Ecologist. The Claimant was dismissed on 5 June 2019.

10. Throughout the Claimant's employment she had various work-related concerns which culminated in her lodging two grievances and the Respondent engaging in a formal absence management process and initiating disciplinary proceedings. For the purposes of this hearing, it is not necessary to make detailed findings of fact in relation to those matters, but it is necessary to note the relevant chronological events.
11. I have set out my findings of fact in chronological order as far as possible.

Impact Statement

12. The Claimant's Impact Statement provides little specific detail on the impact the various conditions relied upon had on her ability to undertake day to day activities. I find that the Claimant's evidence, as set out in the Impact Statement, can be succinctly summarised as follows.

Stress & Anxiety

13. In relation to the alleged condition of stress and anxiety the Claimant maintains that she suffered stress and anxiety due to a heavy workload and feeling unsupported since early 2015. She describes the following symptoms: chest pain, feeling cold and shaky, nauseous, near to collapse, dizzy and light-headed with heart palpitations, insomnia, feeling exhausted during the day, low mood, constant worry, inability to concentrate for long periods, feeling confused and frequent migraines (approximately 3 times per week).

14. The Claimant asserted that the impact of the symptoms of stress and anxiety were that they made driving, site work and report writing more difficult.

15. The Claimant states she attended her GP in August 2015 in regard to stress and anxiety but there are no medical records to corroborate this.

Depression

16. In relation to depression, the Claimant maintains that she first experienced low mood and feelings of worthlessness, exclusion and isolation in early 2016. The Claimant states that in 2018/early 2019 she also experienced lethargy, poor motivation, feeling tense and tearful, lost weight and experienced negative and suicidal thoughts.

17. The Claimant explains she was prescribed sertraline in June 2019, which she continues to take and that she feels she would not be able to cope without it.

18. The Claimant does not explain the impact of what she considers to be depressive symptoms on her day-to-day activities.

Chronic Fatigue Syndrome

19. The Claimant describes having symptoms of Chronic Fatigue Syndrome since early 2015, the symptoms being: profound tiredness during the day, drastically reduced activity and energy levels and struggling to concentrate.

20. In relation to the impact of her symptoms she states she *"found simple tasks of washing, dressing cooking, housework, shopping and climbing a few stairs at home were exhausting."* The Claimant did not specify a time frame or frequency in which these symptoms impacted her day to day activities. The Claimant also explained her poor memory means she forgets simple things such as her PIN, forgetting what to buy at the shop and recalling the right words and forming sentences. She also explained that her hobbies have been reduced due to fatigue and aching joints and muscles and that she is no longer able to scuba dive or hill walk and can only walk on the flat. She asserts she finds driving and journeys on public transport tiring.

21. In response to cross examination, the Claimant acknowledged there was some overlap between the symptoms attributed to the conditions relied on.

The Claimant's Medical Records

22. I have set out my findings of fact in relation to the Claimant's GP records chronologically where possible. However, as a general finding of fact I find that the Claimant did not consider her former GP, that she attended pre-September 2016, to be supportive and no medical records for the period pre-August 2016 have been provided. The Claimant's medical records contain a number of headings: Patient Details, Priority 1 Medical History, All Other Medical History (notes of appointments), Problems.

Fit notes

23. The Bundle contained a number of fit notes, but it was not clear if these were all the fit notes. The fit notes recorded the Claimant's absence as set out below:

    27 November 2015 – unfit for work for four weeks – anxiety (job related stress)

    9 June 2016 – unfit for work for four weeks – tiredness symptom

    6 July 2016 – unfit for work for four weeks – tiredness symptom

    12 August 2016 – may be fit for work – recommended phase return, amended duties, altered hours, workplace adaptions and reduce driving – tiredness symptoms

    29 June 2017 – unfit for work for one week – headache and dizziness following accident at work

11 July 2017 – may be fit for work 56 days – recommended amended duties – avoid dawn surveys and having to get up in early hours of the morning to drive which disrupts her sleep pattern – chronic fatigue

16 November 2017 – unfit for work for two weeks – Stress at work and migraine

15 May 2019 – unfit for work for two weeks– stress at work

2015

24. The Claimant found her workload to be challenging from summer 2015. The Claimant's role involved spending time in the Swindon office (which she commuted to from her home address in Ebbw Vale). She worked nights, unsocial hours and weekends with considerable travel at times to various sites.

25. The Claimant started to feel stressed and anxious from summer 2015, and experienced chest pains, feeling cold and shaky, near to collapsing, dizziness/light headedness and heart palpitations. The Claimant felt stressed and anxious due to what she considered to be a heavy workload and that she felt she was unsupported at work.

26. The Claimant started experiencing issues with sleeping in summer 2015, and felt fatigued during the day. The Claimant also started to experience difficulty concentrating. In cross examination the Claimant stated that she believed her sleep problems stemmed from work related stress and anxiety and confirmed that all her symptoms stemmed from work issues.

27. The Claimant visited her former GP in August 2015 and reported symptoms of stress and anxiety and frequent migraines. The Claimant had experienced migraines since she was a child, and they were typically once or twice a year. The Claimant was experiencing migraines several times a week. The GP notes within the Bundle start from September 2016, and there are no GP records for 2015 that corroborate the Claimant's account.

28. The Claimant's GP prescribed Amitriptyline. In the Impact Statement the Claimant states that this was prescribed for the migraines she was experiencing, and in cross examination stated it was also to help with the sleep problems she was experiencing. The Claimant took Amitriptyline between August 2015 and November 2015, and ceased taking the medication as it resulted her in experiencing "hangover" type symptoms.

29. The Claimant was assessed by Occupational Health on 19 November 2015, following a referral by the Respondent after the Claimant had stated she was experiencing dizziness and tiredness, loss of concentration and chest pains.

The Claimant reported to Occupational Health her views on work place pressures and that from June 2015 she was suffering with increased tiredness and fatigue. The Claimant reported that her GP had recommended she seek cognitive behavioral therapy but the Claimant did not pursue this. The Claimant felt unsupported by her GP.

30. Occupational Health, as reported in a letter dated 26 November 2015, formed the view that the Claimant had been experiencing episodes of anxiety, stating *"it appears obvious to me that Ms Hunt is showing signs of chronic anxiety.*" Further commenting:

"It would be my advice that an acute episode of anxiety which occurred at the beginning of this year and having not been recognised and addressed properly by Ms Hunt and support services, has become a chronic issue. The episodes she has been describing of chest pain and near collapse and feeling shaky, cold sweats and intermittent palpitations are typical of anxiety attacks".

" Ms Hunt becomes tired very quickly, she feels exhausted and cannot concentrate. Her brain, she states, feels fuddled. I feel with the sensation of the medication she was prescribed, her issues around concentration and feeling fuddled may well improve in the next few weeks as the medication wears off from her system".

31. Occupational Health noted a diagnosis of anxiety had not been made by her GP.

32. I find that the Claimant started to experience symptoms of anxiety from the summer of 2015.

33. The Claimant also reported that she tired quickly, felt exhausted and could not concentrate. Occupational Health commented that this could be attributed to the Amitriptyline, or anxiety.

34. Occupational Health commented that they felt CBT and mindfulness would be helpful, and recommended that the Claimant request a referral for mindfulness. The Claimant did not access the Respondent' Employee Assistance Programme at this time.

35. The Claimant was certified as unfit work for four weeks from 27 November 2015 and a fit note cites the reason for absence as being *"Anxiety (job related stress)".*

2016

36. The Claimant returned to work on 7 January 2016.

37. The Claimant, as set out in her Impact Statement, started experiencing some low mood and feelings of worthlessness, exclusion and isolation in early 2016.

38. The Claimant was assessed by Occupational Health on 10 February 2016. The Claimant reported three issues that she found problematic: poor sleep (commonly only sleeping for 2/2.5 hours per night), poor concentration (impacting efficiency at work and driving) and a concern that she may have nocturnal hypoglycemia. The Occupational Health report notes that the Claimant informed them that CBT was not available locally but that she had recently completed a six-week NHS stress control classes. This course is not referenced in the Claimant's Impact Statement and there is no documentary evidence, therefore I am unable to conclude if the Claimant attended such a course or not.

39. Occupational Health noted that the Claimant reported she continued to have poor concentration (causing difficulties with office work and driving). However, the Claimant remained in work undertaking her role.

40. The Claimant was assessed by Occupational Health on 25 May 2016. The Claimant reported that she had recently been given a glucose monitor, but she had not able to test herself throughout the period due to extreme light headiness. The Claimant reported continuing to feel constant fatigue, was still waking at night and had poor levels of concentration and motivation, together with dizziness. Occupational Health, in the report dated 15 June 2016, commented that the possibility of a depressive illness would be worth investigating. The report did not mention any continuing symptoms specifically relating to anxiety.

41. The Claimant was certified as unfit for work for four weeks from 9 June 2016 and a fit note cites the reason for absence as being *"Tiredness symptom".* The additional comments state *"possible depression".*

42. The Claimant's former GP prescribed Mirtazapine, an anti-depressant, in June 2016. The Claimant considered this was not effective and ceased taking after approximately four weeks. In cross examination the Claimant stated this medication was prescribed for anxiety, depression and sleep problems.

43. The Claimant was then prescribed Citalopram, in July 2016. The Claimant took this from July 2016 to approximately October/November 2016. In cross examination the Claimant stated this medication was prescribed for anxiety, depression and sleep problems.

44. The Claimant was certified as unfit for work for four weeks from 6 July 2016 and a fit note cites the reason for absence as being *"Tiredness symptom".* The additional comments state *"possible depression".*

45. The Claimant attended a return-to-work discussion on 5 August 2016.

46. The Claimant, within her Impact Statement, reported that her anxiety was exacerbated in August 2016 due to disciplinary proceedings.

47. The Claimant was certified as may be fit work for four weeks from 12 August 2016 and recommended the Claimant may benefit from a phased return.

Amended duties, altered hours and workplace adaptions and also stated *"Reduce driving"*. The fit note referenced *"Tiredness symptom".*

48. The Claimant attend an informal attendance review meeting on 15 August 2016. The Claimant subsequently amended the notes of the meeting to reflect her recollection of the discussion. The note, as amended by the Claimant, reports that the Claimant's various periods of sickness absence were due to *"exhaustion/tiredness/fatigue/insomnia due to a heavy workload since May 2015...".* It also states, again as amended by the Claimant: *"In May 2016 at Kate's most recent OH referral she was diagnosed as not fit for work, and told it was likely to be depression and that she would feel much better after four weeks on the medication. Her GP disagrees it was probably depression but still prescribed anti-depressants to help with the insomnia..."* The Claimant clearly explained during the hearing that there was no confirmed diagnosis of depression and that her GP was dismissive of her suggested diagnosis and that her GP had told her she was *"worn out".*

49. It was agreed that the Claimant would work a temporary varied work pattern, working full time hours with 2 days per week being spent in the Bristol office and the remainder worked from home with no site work.

50. The Claimant attended a 1st Stage Formal Review Meeting on 25 August 2018. During this meeting the Claimant informed the Respondent that she had arranged to see a sleep specialist but there remained no diagnosis. The Claimant was issued with a written warning due to the level of her absence, 104 days since 11 November 2015.

51. The Claimant registered with a new GP in September 2016.

52. The Claimant attended Occupational Health on 16 September 2016, and this was followed by a report dated 20 September 2016.The report set out symptoms of insomnia and exhaustion being reported from summer 2015 and refers to *"an element of stress and anxiety with her symptoms".* Occupational Health asked the Claimant to consider an assessment by a psychiatrist in order obtain a more definitive diagnosis. The report stated: *"I have recommended that she see a consultant psychiatrist and she will investigate this, as this may all be due to a psychological reaction to stress that she experienced last summer...".* The Claimant did not pursue this route.

53. The Medical Records, under the hearing Priority 1 Medical History, state:

> "01/10/2016 CFS – Chronic fatigue syndrome chronic insomnia and possible CFS
> 01/06/2016 [X] Depression NOS".

54. The section also contains summary information of other health conditions in 1999, 1997 and 1996 that are not relevant to the issues.

55. I understand that NOS mean Not Otherwise Specified.

56. There does not appear to be a corresponding entry for the Claimant attending her GP on 1 June and 1 October 2016, indeed, the Claimant was registered with her former GP in June 2016, and I therefore find that it is likely that the Priority Medical History is a note of history reported by the Claimant to her new GP, or a review and note made by the GP, I am not able to make a definitive finding.

57. On 10 October 2016 the Claimant attended a telephone consultant with a private consultant metabolic physician, Dr Dev Detta. The Claimant, in cross examination, stated that she did not consider attending a psychiatrist would assist. The Claimant chose to try and further explore a physical/organic reason for her symptoms. The letter dated 14 October 2016 from Dr Detta to the Claimant's GP states: *"We discussed today that I have not been able to identify a metabolic cause for her symptoms".* It also states: *"Although the history is not classical, she does have some features suggestive of chronic fatigue syndrome. I am not an expert in this field, but as is the case for her sleep disturbance, CBT and possibly an exercise intervention may be appropriate. I have suggested that she may wish to seek advice with regards to this."*

58. I find that Dr Detta did not diagnose the Claimant with CFS on 10 October 2016, but rather raised with the Claimant and the GP that this may be explored and considered further.

59. The Claimant attended her new GP on 27 October 2016 and a discussion regarding her health took place. The Claimant described her symptoms and recent history and the GP recorded: *"18 months ago had stress in work, since then has had the following symptoms - lethargy fatigue on minimal exertion, "brain fog", occasional headaches, weight gain, hair thinning, poor concentration, night sweats found to have a goitre, TFTs and all bloods have been normal, one of the morning cortisols was low but repeat normal. Has been seen by Mr Holland and a metabolic specialist privately, told chronic fatigue syndrome."*

60. I find that Dr Detta was the metabolic specialist referenced in the above-mentioned note.

61. In cross examination, the Claimant stated that she discussed Dr Detta's report with her GP and her GP diagnosed her with CFS. The wording from the GP note is not entirely clear, but on balance, taking into account that the GP made a referral, seemingly to explore Dr Detta's query as to whether or not the Claimant had CFS, and the contents of Dr Llewellyn's report summarised below, I find that on the balance of probabilities, the Claimant's GP did not formally diagnose the Claimant with CFS but instead choose to send her on for further review by a specialist.

62. The Claimant's GP referred the Claimant to Dr Llewelyn, Consultant Physician General Medicine/Infectious Diseases.

63. On 28 October 2016 the Claimant emailed Mike Cornerford of the Respondent and informed him she had a diagnosis, but did not say what the diagnosis was.

2017

64. On 15 February 2017 the Claimant attended an appointment with Dr Llewelyn, Consultant Physician General Medicine/Infectious Diseases. In a letter to the Claimant's GP dated 15 February 2017, Dr Llewelyn stated: *"Dev thought that sleep was going to be important and wondered about the chronic fatigue spectrum".*

65. The letter later goes on to state, in reference to the tiredness and query regarding CFS: *"2. I wouldn't label her in any way for something so transient and I have recommended some behavioural work targeting fatigue and sleep. 3 Should insomnia still be a problem after a year of underlying behavioural modification, there may be scope in considering Pregabalin. This is not a hypnotic but it does improve the quality of sleep...".*

66. The letter closes by stating: *"Either way her eventual prognosis is excellent.* [New paragraph] *I haven't arranged to see her again myself."*

67. I find that Dr Llewellyn's letter is clear, he did not diagnose CFS, and did not endorse any purported diagnosis of CFS, on 15 February 2017.

68. The Claimant was not seen by Dr Llewellyn again.

69. The Claimant attended Occupational Health on 1 March 2017, as reported in a letter dated 7 March 2017. At the assessment the Claimant reported a diagnosis of CFS, the report states: *"...she has now been diagnosed with chronic fatigue syndrome. She has therefore been referred for an NHS appointment and saw a consultant neurologist at the Royal Gwent Hospital in February 2017. He has confirmed the diagnosis and provided further advice. She reports no further investigations are planned and she has been discharged from further hospital care. Miss Hunt continues to have symptoms associated with chronic fatigue with insomnia, profound fatigue, reduced activity level and impaired concentration".*

70. The report later goes on to state: *"Miss Hunt has now been diagnosed with chronic fatigue syndrome. She has no other health problems that would prevent her from working effectively."*

71. The report also states: *"Miss Hunt reports work-related stress due to long hours of work and volume of work from her date of employment".*

72. I find that that the Claimant did not accurately report to Occupational Health the medical appointments and information given to her on 10 October 2016 or 15 February 2017 and the report made to the Occupational Health does not accord with the information in the letters dated 10 October 2016 and 15 February 2017 and her inaccurate reporting heavily influenced the contents of the report. As set out above, I have found that Dr Llewellyn did not diagnose or confirm any diagnosis of CFS. It remained unexplained why the Claimant reported this to Occupational Health. I do not find that the Claimant deliberately or untruthfully misled Occupational Health, but consider she may

have recalled events and conversations differently. The report does not specifically mention any ongoing symptoms of anxiety or depression.

73. The Claimant attended her GP on 28 March 2017, and a review of Dr Llewelyn's report took place. She was advised to take iron tablets due to low iron levels. She reported that the had been undertaking mindfulness for insomnia. The note records *"poor sleep causing problems at work, travels as an ecologist, constantly tired, advised could try the pregabalin..."*. The Claimant was prescribed pregabalin and advised to review with the GP in 2 weeks.

74. The Claimant attended her GP on 28 April 2017 and it was noted *"Patient reviewed thinks pregabalin is helping, no se, asking for note as they are still putting her on night shifts and long drives, up ladders doing bat surveys, even though occ health have said she shouldn't be doing these."* I find the Claimant did not report any symptoms to the GP at this appointment.

75. On 5 May 2017 the Claimant attended a meeting to discuss the OH report and her role/engagement.

76. The Claimant had an accident at work on 6 June 2017. It is not necessary to set out the details of the accident.

77. The Claimant attended a telephone assessment with her GP on 28 June 2017. She did not report any symptoms.

78. The Claimant attended a capability discussion on 6 July 2017.

79. The Claimant raised two grievances on 7 July 2017. It is noted for chronological purposes that the grievance outcome was communicated to the Claimant on 26 September 2017 and an appeal hearing took place on 21 December 2017. The grievance appeal outcome was communicated to the Claimant on 2 February 2018.

80. The Claimant contacted her line manager on 10 July 2017 to confirm that she would be in work, that her fatigue was much reduced and requested chargeable work.

81. The Claimant attended her GP on 11 July 2017, regarding test results and was advised to take iron supplements daily due to low ferritin levels. There was also a discussion regarding insomnia, and the Claimant's GP referred her to a sleep clinic. The notes state: *"2 yr h/o disturbed sleep. Started following period of stress in work. Works as an ecologist so sometimes has to do night reports. Over past 2 yrs has also sufferd [SIC] with CFS and under c/o Dr Llewellyn but much improved past 4 months following his advsie [SIC] re relaxation therapy etc. Sleep still disturbed but now able to have a few hours sleep..."*

82. On 25 July 2017 the Claimant spoke with her GP and requested a fit note to cover the period 29 June to 6 July following her accident at work. The

Claimant was provided with a fit note which cites the reason for absence as being *"Headache and dizziness following an accident at work".*

83. The Claimant was certified as may be fit for work for 56 days from 11 July 2017 because of Chronic Fatigue. The fit note ticks the box recommending amending duties and contains the following comments: *"Please can patient avoid dawn surveys and having to get up in early hours of the mornings to drive which disrupts her sleep pattern.".*

84. The Claimant continued to attend work. On 26 July 2017 the Claimant emailed management requesting chargeable work.

85. The Claimant attended a telephone appointment with the GP on 12 September 2017 and the GP notes: *"insomnia has much improved now and sleeps ok at home but stays in hotels with work or if staying at someone else's can't sleep – discussed also lost a few kilos in wt over last few months, has been more active eating ok and feeling better in herslef [SIC]."* The Claimant did not report any adverse symptoms or negative impact to her GP.

86. The Claimant was due to attend a disciplinary hearing on 15 November 2017 but was unable to attend as she became unwell with a migraine on route to the hearing.

87. The Claimant attended her GP on 16 November 2017 and the note records *"Stress at work ongoing problems with employer related to CFS. Is subject to a number of issues including a disciplinary related to a workplace accident, Has kicked off her migraine again and exacerbated her CFS related to stress".* On 16 November 2017 the Claimant was advised to restart Pregabalin, *"for stress/sleep and migraine control"*. The Claimant took this medication until June 2018.

88. On 16 November 2017 the Claimant emailed her line managers to inform them that she had been signed off by her GP until 29 November 2017. She stated: *"This is purely because of the immense and continued stress I have been under at work since my accident from the 'home visit' meeting, grievances, disciplinary hearing and all the associated issues and has nothing to do with my CFS/ME."*

89. The Claimant returned to work and attended a return-to-work discussion on 29 November 2017. On 30 November 2017 the Claimant requested chargeable work.

90. On 15 December 2017 the Claimant informed her line manager that she was experiencing side effects from taking the Pregabalin. The Claimant felt pressured to cease this medication.

2018

91. On 10 January 2018 the Claimant attended her GP and discussed two issues, the first that there was no need to prescribe iron and the second being

her use of pregabalin, which the Claimant was self-adjusting. The Claimant reported that she was not tired during the days and was sleeping longer, she also referred to ongoing stress issues at work. The Claimant did not report any other symptoms. The Claimant was further reviewed by her GP on 5 March 2018 and 6 March 2018 in relation to her prescription of pregabalin, and she explained that she had been sleeping around 9 hours per night but that had reduced to 3 or 4 hours per night. This remained the position in March, and the Claimant had not experienced further migraines. I find that pregabalin was issued by the GP primarily to deal with her increasing migraines.

92. On 16 February 2018 the Claimant was assessed by Occupational Health and a report dated 22 February 2018 was issued. The report states: *"With regard to the chronic fatigue syndrome, her condition remains stable. She has had a review appointment with her Consultant Neurologist in February 2017 and is continuing with self-help therapies, which she also finds beneficial.".*

93. I find that the Claimant did not accurately explain the medical appointments and outcome letters and this has influenced the content of the report in relation to CFS.

94. The report explains that the Claimant was experiencing work related stress due to the internal grievance and disciplinary processes.

95. The Claimant was reviewed by her GP on 26 April 2018 and the reduction of pregabalin was discussed, and the Claimant indicated to her GP that she wished to reduce and phase off the medication. No other symptoms were reported. On 31 May 2018 the Claimant had a telephone review with her GP and reported she was under pressure from the Respondent to stop taking the medication.

96. In July 2018 the Claimant undertook catch up calls and emails with her line manager. She reported a vicious circle of stress aggravating insomnia that leads to tiredness and then fatigue, which the Claimant stated can aggravate her ME. The Claimant reported enjoying a holiday and cycling round lake in Lake District.

97. In November 2018 the Claimant experienced two family bereavements, which resulted in her experiencing depressive symptoms.

98. In cross examination the Claimant explained that she considered her depression started in 2016 but it was in 2018 when depression *"really took hold".*

99. On 8 November 2018 the Claimant underwent a Psychological Assessment undertaken by Dr Kate Fitzgerald for the purpose of providing the Respondent with further information about the Claimant's health conditions. The report, which amounts to 9 pages, noted the Claimant reporting difficulties with her managers during the previous three years. In relation to CFS, the report noted that the Claimant had reported that she *"began suffering with Chronic Fatigue Syndrome <u>likely as a result of the very heavy workload"</u>,* noting the Claimant added the underlined words to the report. The report also noted that the

Claimant had completed *"a range of psychometric measures to aid assessing prevalence and severity of Depression, Anxiety, severity of somatic symptoms, and work and social adjustment2 [SIC]. The employees' score on these measures falls within the normal range for experiences of anxiety and somatic symptoms. This may be indicative that she is finding that she is finding a way to maximise the opportunity to improve her physical and mental health, given her CFS".* I find that at the date of the assessment, the Claimant was not experiencing symptoms of anxiety.

100. The report stated that the Claimant *"scores on a measure of Depression fall within the mild to moderate range3".* It went on to also state *"The Clinician's interpretation of these scores is that the employee does not show any indicators of a severe mental health condition that would require immediate intervention. Given that she lives with CFS, she is managing physical symptomology well, which is having minimal impact on her overall wellbeing at this present time".* I find that on 8 November 2018 the Claimant was experiencing some mild symptoms of depression.

101. The report further goes on to note the fluctuating nature of CFS. I do not find that Dr Fitzgerald diagnosed the Claimant with CFS, but that she commented on the nature of CFS generally, and noted the Claimant reported that there was minimal impact at the time of assessment. The report, within the footnotes, also noted *"Anxiety and mood disorders are highly prevalent in patients with ME/CFS."*

102. The Claimant attended her GP on 13 November 2018 with health concerns that are not relevant to the issues. The Claimant did not report any symptoms relating to the conditions relied upon as disabilities.

103. The Claimant was in work and was busy in December 2018 and had been working unusual hours. Her line manager explained that she wished the Claimant to stick to normal working hours and not exceed 40 hours per week.

2019

104. On or shortly before 29 January 2019 the Claimant contacted her GP and requested *"amitriptyline for long term insomnia."* The GP records note that this medication had not been prescribed by the practice previously and an appointment was required.

105. The Claimant attended her GP on 31 January 2019. It is recorded that she reported feeling *"depressed mood and poor sleep, some negative thoughts over past 1 week, no active plans self harm."* The Claimant's GP referred her to the Primary Care Mental Health Team, and the recorded referral set out in the notes gives further insight into the Claimant's health and symptoms at the time:

> *"Thank you for assessing Kate regarding possible psychological therapy. Over the past 4 years or so she reports a very stressful time, particularly in work. She works as an ecologist, following advice from occupational*

health she now works from home. She has struggled with chronic fatigue symptoms and insomnia but these had improved greatly last year. She presented in surgery today reporting low mood since last August, worse since November and particularly worse over the last week. Her sleep is poor again, she lacks motivation and feels very emotional. She reports negative thoughts, some thoughts of self-harm but no active plans and reports her mum and partner as protective factors. She has had recent bereavements in November, her father died of cancer, her uncle also died. In 2017 as saw Dr Meirion Llewelyn re the CFS and took pregabalin for the insomnia on he [SIC] advice, she got benefit from this but ended up stopping on advice from her work. She repots [SIC] completing a MIND anxiety management course last year which she found very helpful. In the past she has found no benefit from mirtazapine nor citalopram. She currently does not want to take medication for the above symptoms but is very keen to explore counselling/CBT."

106. In a catch up call with her line manager on 1 February 2019 the Claimant advised *"that its not been an easy couple of weeks, she feels mentally exhausted, and is feeling low, and not sleeping well. KH feels more mentally exhausted, and expressed that everything has caught up with here [SIC] from the last 3.5 years and Christmas family bereavements."* The note later records *"Kate explained that the fatigue had not returned, however she felt in low mood more now."*

107. The Claimant's medical records note an entry by the Primary Health Care Team dated 12 February 2019:

"Seen today for PCMHSS assessment. Kate described a very difficult and traumatic few years whereby she has been systematically bullied and marginalised in her workplace to the point where she has been allegedly told that she is unable to take treatment for her existing conditions. She has been disciplined and treated in a punitive manner. This coupled with the recent death of her Father and Uncle have totally destablised her to the point where she was very tearful and distressed during our consultation and showed clear symptoms of a depressive condition. Also having suicidal thoughts with some loose planning of driving off a cliff. However, she has strong protective factors with Mother and her Partner. She appears to be struggling with what action she needs to take next regarding her job and her health. We discussed her joining a union and having some advice, support and guidance and I have asked her to consider this and I have given her some info and CALL helpline detailed to look at until our next appt on 5th March where we will determine what therapy would best suit her needs at this time."

108. On 20 February 2019 the Claimant attended an appointment with Dr Jose Thomas, Consultant in Respiratory & Sleep Medicine, at Nevill Hall Hospital. A report of the same date cites two diagnosis: Chronic insomnia disorder and depression. Dr Thomas does not himself diagnose CFS, but the

report states: "*She was seen by an Endocrinologist who diagnosed chronic fatigue and was subsequently seen by Dr Meirion Llewelyn".* I find the Claimant did not accurately report her assessments to Dr Thomas.

109. The Claimant attended Dr Thomas again on 26 February 2019, following a period of sleep monitoring. The Claimant underwent CBT for Insomnia in February, March and April 2019.

110. The Claimant attended a meeting with the Respondent on 26 February 2019 to discuss the working relationship. The Claimant reported during the meeting that she had *"been having CBT for insomnia – this has helped, the fatigue now completely gone. One thing he did recognise was that early mornings were a problem. He did say I would feel worse initially but was for long term gain. He would have liked to see more progress but work-related stress has affected that. I have the odd bad night but no fatigue and when I do have to get up it is okay. Doesn't stop me doing anything in my personal life."*

111. The Claimant attend a follow up appointment with the Primary Care Team on 5 March 2019 and the Claimant reported having had a slightly better few weeks and was booked on a course. No further 1 to 1 appointments were scheduled and no symptoms were recorded.

112. The Claimant attended her GP on 11 March 2010 and requested a letter be sent to the Respondent. She reported feeling much improved, that fatigue was resolved and the *"only issue was stress related to manager at work".*

113. On 28 March 2019 the Claimant's GP wrote a letter to the Respondent setting out recommendations for undertaking her role. The letter also states: "*Kate has been diagnosed with a chronic insomnia disorder and chronic fatigue symptoms. Since November 2018 Kate has experienced two family bereavements. This resulted in her having a few difficult weeks, feeling low in mood on top of her work related management stress. Kate has recently been having some Cognitive Behavioural Therapy for insomnia 9CBT-I) at Aneurin Bevan Sleep Centre (Nevill Hall Hospital) and some treatment with our Primary Care Mental Health Support Services, including a Mindfulness course. Kate's conditions have responded well to these treatments, resulting in her feeling more positive. Her chronic fatigue symptoms are currently mild and well controlled, providing she has sufficient rest. Kate is not on any regular medication at present".*

114. The Claimant's insomnia was made worse by her worrying about work matters, as recorded in Dr Thomas' report dated 17 April 2019.

115. The Claimant attended a meeting with the Respondent on 19 April 2019 to discuss work matters. During the meeting, as recorded by the meeting notes, the Claimant stated: *"I saw a private consultant specialist who diagnosed Chronic Fatigue Syndrome in Nov 2016. He suggested more mindfulness relaxation and it did make a big difference."*

116. The Claimant attended her GP on 13 May 2019 and reported her sleep had been improving but had worsened following a letter from the Respondent. The Claimant also reported feeling stressed again regarding work issues. No other symptoms relevant to the issues in this hearing were recorded.

117. The Claimant's employment ended on 5 June 2019.

118. The Claimant attended her GP on 13 June 2019. She reported that she had been dismissed and an increase in stress and anxiety levels together with low mood. She was prescribed Sertraline.

119. The Claimant attended her GP several times post dismissal and remains on sertraline. I have not set out details of GP appointments post termination but find that on 19 August 2019 the Claimant's GP noted "*impression that of stress and fatigue secondary to work issues".*

120. Significant emphasis was placed on the accounts provided by the Claimant to medical practitioners for the purposes of producing medical reports and I have made findings on these below.

121. On 5 December 2019, following referral by the Claimant's GP, the Claimant attended a telephone assessment with Dr P Stringfellow. The assessment was post this claim being issued. The assessment records the Claimant as reporting *"experiencing anxiety and low mood since 2015 related to employment dynamics".* It further notes her bereavements and states *"Diagnosed Chronic Fatigue Syndrome – memory concentration affected"* and later states *"Miss Hunt reports having diagnosis of Chronic Fatigue Syndrome, possible vulnerabilities?".* I find this was a noting of what the Claimant told Dr Stringfellow, CFS was not diagnosed at the assessment.

122. In 2019 the Claimant also undertook a Mindfulness Course and Chronic Pain Management course.

2020

123. On 4 May 2020 the Claimant's GP wrote a letter, for the purposes of litigation, and it states: *"Her health conditions:- Chronic Fatigue Syndrome, Chronic Insomnia Disorder, Depression, Anxiety, Left sided tinnitus".* The letter sets out the medical practitioners seen by the Claimant since September 2016 and the medication prescribed. In relation to CFS, it states *"September/October 2016 – Dr Datta – blood tests – normal – has features of Chronic Fatigue syndrome".*

124. On 23 July 2020 the Claimant attended a video examination with Dr Fady Joseph who produced a report dated 23 July 2020 for the purpose of a personal injury claim in relation to her accident at work. In relation to CFS, the Claimant reported to Dr Joseph that she had been diagnosed with CFS and in relation to depression she informed him that she was given a possible diagnosis in June 2016 but diagnosed formally in 2018/2019. The report, at paragraph 3.13, records leisure activities that that Claimant undertook prior to her accident in work in June 2017. Further, at paragraph 6.9 of the report it is

stated: *"She was seen by Dr Meirion Llewelyn, Consultant Physician on 15 February 2017 following referral by her GP because of her symptoms of fatigue, poor sleep, brain fog, night sweats, poor concentration and weight gain. No specific diagnosis was made to account for these symptoms but there was a suggestion from her GP that this was chronic fatigue syndrome".*

125. The report, at paragraph 3.9. records the Claimant *"gave me a history of her previous anxiety and stress related issues associated with her work related problems and poor sleep."*

126. Dr Joseph produced a further report dated 30 October 2020 following receipt of a further letter of instruction and provision of ambulance records. This report deals with the differing accounts of the Claimant's accident in June 2017. At paragraph 3.23 Dr Joseph notes: *"Moreover, it is more likely that the situation the Claimant found herself in with a very strained relationship with her employers and stress, was the actual cause of the deterioration in her mood, sleep and irritability."*

127. On 21 September 2020 the Claimant wrote a letter to Dr Llewllyn seeking a report. Dr Llewllyn did not provide a report.

128. A medical report, again for the purpose of personal injury litigation, was produced by Mr Dai Morgan on 19 November 2020. The report focuses on the impact of the Claimant's accident in June 2017, but there are comments in relation to the Claimant's activities within the report noting she went scuba diving prior to the accident, but does not specify when this ceased. It also noted the *"Claimant would normally go kayaking. She did not return to this until 2018 which after 40 minutes, produces stiffness and aching in her back and shoulders."*

129. A psychiatric report dated 12 January 2021 was provided by Dr S Davies following a request by the Claimant's solicitor, again it is understood for the purpose of personal injury litigation. I find the key points from the 31-page report in relation to the conditions relied upon by the Claimant in this claim are those set out below.

130. In relation to anxiety, it was reported that the Claimant had anxiety with impaired sleep prior to the accident in June 2017, and the accident contributed to the symptoms of anxiety for 6 or at most 12 months after the accident.

131. With regard to depression, Dr Davies' view was that the Claimant developed a mild depression approximately 18 months after the accident, therefore November/December 2018, and that in January 2021 when asses the Claimant was experiencing moderate to severe depression.

132. In relation to CFS, the Claimant informed Dr Davies, as reported by him, that by July 2015 she was experiencing feelings of exhaustion, stress and anxiety and only sleeping for 1 or 2 hours per night. The Claimant reported that in September 2016 a private endocrinologist, Dr Detta, mentioned CFS, and her GP confirmed this. She reported that her fatigue would not go away altogether. Dr Davies notes that the Claimant reported

that it could take her as long as 10/15 minutes to walk upstairs and the brushing her teeth was a lot of effort but she was doing things in the day, and refers to undertaking site work and long journeys at the end of 2016 and early 2017. There is no time frame or duration attributed to such difficulties. Dr Davies noted that the Claimant reported that *"She confirmed that in the six months prior to the index incident she was getting some enjoyment from kayaking on lakes in a fairly gentle way and also was doing some gentle hill walking in the Brecon area and a bit of cycling, perhaps once per month, but more often at the weekends she would rest. She would occasionally ride her horse".* These activities were being undertaken by the Claimant between January and June 2017. The Claimant told Dr Davies that she felt her fatigue was linked to insomnia. Dr Davies later reported that the Claimant resumed kayaking in early summer 2018. Dr Davies refers to some GP medical records that pre-date September 2016 that were not included in the Bundles. Based on the summary within Dr Davies report I find that in late 2015 and during 2016 the Claimant attended her GP and reported feeling very tired, poor sleep and working long hours in a stressful job.

133. Dr Davies set out a summary of his view on CFS generally towards the end of his report, and notes that the symptoms of depression and CFS, such as tiredness, can overlap. He later states the Claimant's *"account of her symptoms is not altogether typical of standard descriptions of chronic fatigue syndrome".* Dr Davies further states that the Claimant's concerns re tiredness pre-June 2017 met the criteria for a Somatic Symptom Disorder.

134. In cross examination the Claimant stated that that she had not undertaken scuba diving or undertaken strenuous hill walking since 2015 due to a lack of energy, but that occasionally she kayaks on calm lakes. She explained she was not able to undertake such hobbies due the extreme tiredness she experienced; she says as a result of her CFS. I find that the Claimant did not engage in very strenuous hobbies such as scuba diving from the summer of 2015 onwards and there was no clear information provided to Dr Joseph in relation to the reduction of her activities and the timing. I also find that the Claimant did undertake cycling, walking and lake kayaking from 2015 onwards, as reported to Dr Davies and her line manager as set out at paragraph 96 above.

135. Also during cross-examination the Claimant stated it took 10 minutes at a time to climb stairs, but there was no clarification on when that was or how often she experienced such difficulty.

136. Throughout cross examination the Claimant was clear that she considered work matters contributed to her symptoms and the symptoms associated with CFS fluctuated with the amount of stress she was experiencing. She explained that she felt fatigue was always present, but in quieter periods she would sleep better, 4 hours per night rather than 2/3 but that prior to May 2015 she had slept 8/10 hours per night. I find that the Claimant's sleep varied significantly between 2015 and June 2019 and that she slept less when matters at work were more challenging and internal processes were underway.

137. I asked the Claimant when and how often she experienced the difficulties set out in paragraph 18 of her Impact Statement *"I found simple tasks such as washing, dressing, cooking, housework, shopping and climbing a few stairs at home were exhausting .* In response, the Claimant stated that in September 2015 she recalled that she returned from site exhausted and collapsed in a chair and that brushing her teeth was an effort. The Claimant provided no further details on how any of her conditions impacted her day-to-day activities.

The Law

138. For the purposes of section 6 of the Equality Act 2010 (EqA) a person is said to have a disability if they meet the following definition: *"*

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."

139. The burden of proof lies with the Claimant to prove that she is a disabled person in accordance with that definition.

140. Further assistance on the definition is provided in Schedule 1 of the EqA. The definition poses four essential questions:

a) Does the person have a physical or mental impairment?
b) Does that impairment have an adverse effect on their ability to carry out normal day-to-day activities?
c) Is that effect substantial?
d) Is that effect long-term?

141. In Aderemi v London and South Eastern Railway Ltd [2013] ICR 591, Langstaff P stated: *"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 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 the 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 on his ability, that is to carry our 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 trivial. In other words, the Act itself does not create a spectrum running smoothly from those matters which are clearly trivial but provides for a bifurcation: unless a matter can be classified as within the heading of "trivial" or "insubstantial", it must be treated as substantial. There is therefore little room for any form of sliding scale between one and the other".*

142. The term "substantial" is defined at section 212 as "more than minor or trivial". Normal day to day activities are things people do on regular basis including shopping, reading and writing, having a conversation, getting

washed and dressed preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, socializing.

143. Under paragraph 2(2) of Schedule 1 to the Equality Act 2010, 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 to have that effect if that effect is likely to recur.

144. Paragraph 2(1) of Schedule 1 explains: "(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."

145. Likely should be interpreted as meaning "it could well happen" rather than it is more probable than not it will happen; see *SCA Packaging Limited v Boyle (2009) ICR 1056*.

146. A claimant must meet the definition of disability as at the date of the alleged discrimination.

147. As to the effect of medical treatment, paragraph 5 of Schedule 1 provides:

> *"(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 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 include in particular medical treatment..."*

148. Paragraph 12 of Schedule 1 provides that a Tribunal must take into account such guidance as it thinks is relevant in determining whether a person is disabled. Such guidance which is relevant is that which is produced by the government's office for disability issues entitled "Guidance on matters to be taken into Account in Determining Questions Relating to the Definition of Disability" ('the Guidance'). The guidance should not be taken too literally and used as a check list (see *Leonard v Southern Derbyshire Chamber of Commerce (2001) IRLR 19).*

149. I have also considered the principles in the following cases referred to by the Respondent in submissions:

Woodrup v London Borough of Southwark [2002] EWCA Cov 1716
Richmond Adult Community College v McDougall [2008] IRLR227, [200] ICR 431
J v DLA Piper UK LLP (UKEAT/0263/09)
Igweike v TSB Bank Plc [2020] IRLR 267 EAT
Henry v Dudley Metropolitan Council UKEAT/0100/16, [2017] ICR 610
Abadeh v British Telecommunications plc [2001] IRLR 23

Conclusions

150. The following conclusions and analysis are based on the findings which have been reached above. Those findings will not in every conclusion below be cross-referenced unless I consider it necessary to do so for emphasis or otherwise.

151. This is a complicated case, where there is significant overlap between the symptoms of the various conditions the Claimant relies upon as disabilities. There is also a complicated background of dispute and unhappiness in the workplace.

152. I considered the Guidance on matters to be taken into account in determining questions relating to the definition of disability. I was surprised that neither party in its submissions addressed me in this regard.

153. The Guidance under each of the sections states that a section should not be looked at in isolation but in conjunction with the other sections. The sections are: A (the definition), B (substantial), C (long term) and D (normal day to day activities).

154. I note that it is important to consider whether the alleged effects on day-to-day activity, when taken together, could result in an overall substantial adverse effect, paragraph B4.

155. I also considered the Guidance given in relation to cumulative effects of an impairment in paragraph B6.

156. In paragraph B9, the Guidance stresses the importance of considering the things that a person cannot do or can only do with difficulty.

157. I have set out above the key events and times that the Claimant was experiencing symptoms, and set out below is my analysis of whether each condition relied upon by the Claimant constitutes a disability.

158. The Respondent's position is that the Claimant is not disabled, that none of the conditions she relies upon amount to a disability, separately or cumulatively. It contends that this is a case to which J v DLA Piper UK LLP applies, namely that this is a case where the Claimant has had an adverse reaction to work situations and life events and is not one where there is a mental impairment. The Claimant asserts this is not a case which falls into the category of a reaction to challenging life events.

159. I have considered the guidance set out in *J v DLA Piper* in relation to approaching the issue of whether someone has an impairment. The EAT noted it was good practice in every case for tribunals to look at the issue of whether someone has an impairment separately from the question of whether it has an adverse effect on their ability to carry out normal day-to-day activities. However, that did not mean that tribunals should rigidly adhere to that approach, and in some cases (particularly if it involves

resolving difficult medical questions) it is appropriate to firstly consider whether the Claimant's ability to carry out normal day to day activities has been adversely affected. Where the answer is yes, in most cases a tribunal can infer that the Claimant was suffering from a condition which has produced that adverse effect, namely an impairment.

160. The case also gives helpful guidance on the distinction between depression and a reaction to adverse life events, but the focus must remain on the impact of any symptoms on day-to-day activities, and not the label places on symptoms.

CFS

161. I have found that at no time was the Claimant diagnosed with CFS by a medical practitioner. The Claimant was diagnosed with chronic insomnia, but there is no clear evidence of a diagnosis of CFS, rather there was a query raised by Dr Detta regarding whether some of symptoms experienced by the Claimant amounted to CFS. Although the Claimant asserts that she was diagnosed by her GP in September 2016, this is not borne out by the evidence. I have concluded that the Claimant, perhaps mistakenly, believes herself to have been formally diagnosed with CFS, and she then reported this belief in later appointments with her GP, to Occupational Health and to various other medical practitioners as set out in the finding of facts above.

162. I conclude that there were periods between 2015 and June 2019 when the Claimant was feeling extremely fatigued and therefore had much reduced energy levels, but I cannot conclude on the evidence before me that this was due to a clinically diagnosed condition of CFS. I conclude that the Claimant was likely to be feeling fatigued due to working long hours and having difficulty sleeping.

163. The Respondent asserts that no diagnosis of CFS means that the Claimant fails at the first hurdle as she does not have an impairment. However, the lack of a clinical label or diagnosis is not fatal, it is not a requirement of the legislation. I must consider the matter taking into account the legislation and the Guidance, together with principles derived from case law.

164. The Claimant was diagnosed however with chronic insomnia, which she does not rely upon, and took various steps to improve her quality of sleep. It is clear that she got less sleep at times when she was experiencing increased stress due to work events, and naturally, less sleep will increase the level of fatigue she experienced.

165. Despite suffering from significant fatigue at times, the Claimant was able to continue working for the most part and was only absent from work due to tiredness in June and July 2016.

166. As set out above, the Claimant did reduce the level of physical engagement in hobbies that she undertook from 2015 onwards. The Claimant's hobbies of scuba diving, kayaking and strenuous hill walking

were partly curtailed by her extreme fatigue, but these are not normal day to day activities, and indeed she continued with some physical hobbies. There is no evidence to suggest, over an extended period, that the Claimant could not manage the normal day-to-day activities such as getting dressed, cooking food, cleaning the house and attending work. The Claimant has not satisfied me that she had difficulty in undertaking day to day activities for an extended period of time. Although the Claimant described how walking upstairs and brushing her teeth was at one stage an effort, there is no evidence, from her directly, or in the various medical documents, that her level of fatigue meant that such activities were substantially impacted for any extended period of time.

167. The Claimant also refers to feeling "brain fog" but there was no detailed evidence of how often or to what extent the brain fog impacted on her day-to-day activities. I accept that she found writing reports could take longer but she maintained a job that required significant concentration at times. I conclude that her brain fog did not substantially and adversely impact on her day-to-day activities for an extended period.

168. Although she clearly felt very fatigued at times, she worked long hours with a lot of travel, the evidence does not demonstrate that the symptoms of fatigue, that she identifies as CFS, substantiality and adversely impacted her ability to undertake day to day activities on a long-term basis.

169. I found that the Claimant was not prescribed any medication to deal specifically with her symptoms of fatigue, and that the primary reason for prescribing pregabalin was to try and manage her migraines, but also to assist with sleep. However, the Claimant did engage in other means to improve her sleep as set out in my findings of fact above.

170. I therefore conclude that, considering my finding of facts and applying the law, that the Claimant's chronic fatigue does not meet the definition under section 6 of the Equality Act 2010.

Depression

171. I conclude that the Claimant started experiencing significant and identifiable symptoms of depression in November 2018, although at that that time, the start of November 2018, the symptoms were mild as set out in the report by Dr Fitzgerald: *"scores on a measure of Depression fall within the mild to moderate range3".* It went on to also state *"The Clinician's interpretation of these scores is that the employee does not show any indicators of a severe mental health condition that would require immediate intervention. Given that she lives with CFS, she is managing physical symptomology well, which is having minimal impact on her overall wellbeing at this present time".* I found that the Claimant's symptoms worsened as a result of family bereavements.

172. Although prior to November 2018 low mood and depression had been suspected previously. I conclude that although a query was raised by

OH in 2016 as to whether the Claimant was struggling with depression, there is no evidence of significant standalone symptoms of depression prior to late November/December 2019.

173. The Claimant's situation has to be considered as it stood at the relevant time and not with the benefit of knowing with hindsight what actually happened next. The Claimant was formally diagnosed with depression following her dismissal in June 2019, and this took place after the material period, and in accordance with the case law, I must not consider the diagnosis, and have only considered as far as it corroborates evidence in the relevant period.

174. I must disregard matters that took place following the effective date of termination. Although it is noted that the Claimant was prescribed sertraline, an anti-depressant, shortly after her dismissal, I have not taken this into account when reaching my decision.

175. Despite having depressive symptoms from late November 2018, the Claimant remained in work, and was not certified as unfit for work due to depression. I accept that the Claimant took active steps and lifestyle changes to assist herself in managing symptoms.

176. I do accept that at that time, November 2018, the Claimant had genuine symptoms including difficulties sleeping, tearfulness and low mood. I also conclude these symptoms worsened in January and February 2019 due to family bereavements and work-related issues. However, the Claimant did not give examples of how the depressive symptoms had a substantive and adverse impact on an actual activity of daily life whether in work or outside of work. On the evidence before me I find that the symptoms of depression did not have a substantial and adverse effect on the Claimant's day to day activities between November 2018 and June 2019 and indeed the Claimant remained in work and the focus of her medical support in early 2019 related to her insomnia and there was no regular attendance at or reporting to her GP of depressive symptoms.

Anxiety/Stress

177. There is a distinction between clinical depression and stress/anxiety. Undoubtedly the Claimant experienced periods of stress and anxiety as set out in the findings of fact above. The Claimant suffered more with the symptoms of stress and anxiety in close proximity to challenging work situations, namely the internal management and grievance processes.

178. The Claimant was absent from work due to anxiety and/or stress (according to the fit notes provided), noting they are very similar and treated as one condition within the Claimant's Impact Statement for the following periods:

Four weeks from 27 November 2015 – anxiety (job related stress)

Two weeks from 16 November 2017 – Stress at work

179. I accept the that the Claimant had the symptoms, as set out in paragraph 13 above, noting also that there is overlap between the symptoms she associates with anxiety and stress and those related to depression and CFS.

180. The Claimant's GP records do not indicate any pattern of regular attendance to discuss management of symptoms of anxiety or stress. The Claimant, during the relevant period, took Mirtazapine and Citalopram, on her own account for anxiety, depression and sleep problems for several months between June and October/November 2016. During the period that the Claimant was taking these medications she was absent from work in June and July 2016 but the certified reason for her absence was "tiredness symptoms". It is well documented that the Claimant felt the workload and travel requirements were excessive.

181. I conclude that the Claimant has not evidenced that that her symptoms of stress and anxiety, as far as they are distinguishable from her other symptoms, had an adverse effect on her ability to carry out normal day-to-day activities. As I have concluded that the Claimant did not meet the burden of proof, I have not gone on to consider if this was a case that fell into the category of *J v DLA Piper.*

182. The Claimant has not evidenced that the individual conditions relied on meet the definition under section 6 of the Equality Act 2010. I have determined that there is insufficient evidence for me to conclude that each separate condition had a substantial and long-term adverse effect on the Claimant's ability to carry out normal day-to-day activities.

Cumulative effect

183. There is significant overlap between the symptoms the Claimant attributes to the conditions of CFS, depression and anxiety/stress. I have concluded that separately, the symptoms relied upon under each head did not amount to a disability in the relevant period. I have now considered whether all the symptoms (and naturally the conditions) taken together had a cumulative effect which rendered the Claimant for the purposes of the Equality Act 2010.

184. I note that the Claimant has various fluctuating symptoms that recur and worsened and improved over a number of years.

185. I have concluded that even when taking all of the Claimant's symptoms together, at their worst, there remains insufficient evidence that when taken together her symptoms had an adverse effect on her ability to carry out normal day to day activities. Accordingly, I conclude that the Claimant has not evidenced that the cumulative effect of the conditions relied on meet the definition under section 6 of the Equality Act 2010. I have determined that there is insufficient evidence for me to conclude that the cumulative effect of

the conditions relied upon had a substantial and long-term adverse effect on the Claimant's ability to carry out normal day-to-day activities.

Employment Judge G Cawthray

Date: 9 April 2021

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON
9 April 2021

FOR EMPLOYMENT TRIBUNALS