Case Number: 2204955/2020

Reserved Judgment

EMPLOYMENT TRIBUNALS

BETWEEN

Claimant	**and**	**Respondents**
Ms A Box		**Wunderman Thompson (UK) Ltd**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

SITTING AT: London Central **ON: 12 March 2021**

BEFORE: Employment Judge A M Snelson

On hearing Mr M Greaves, counsel, on behalf of the Claimant and Mr R Dennis, counsel, on behalf of the Respondents, the Tribunal adjudges that the Claimant was at all relevant times disabled within the meaning of the Equality Act 2010.

REASONS

Introduction

1. The Claimant, Ms Ashley Box, who is now 33 years of age, was employed by the Respondents, a New York-based marketing communications agency, for more than seven years ending with her dismissal on 18 May 2020. At the time of her leaving she held the role of Account Director.

2. By her claim form presented on 17 August 2020, she complains of unfair dismissal, discrimination arising from disability, failure to make reasonable adjustments and victimisation. By their response form the Respondents reply that she was fairly dismissed on the ground of redundancy and dispute all allegations of unlawful discrimination and victimisation.

3. In her grounds of complaint the Claimant explicitly pleads a diagnosis of anxiety and depression (para 7). In the grounds of resistance, para 87, the Respondents plead:

> **On the basis of the sick notes provided by the Claimant, the Respondent accepts that the Claimant has depression and anxiety. The Respondent does not admit that depression and anxiety amount to a disability/disabilities at the time of the alleged discriminatory treatment or at all.**

4. Pursuant to a case management order of Employment Judge Isaacson the matter came before me in the form of a public preliminary hearing held by CVP to determine the question whether the Claimant was disabled within the meaning of the Equality Act 2010 ('the 2010 Act'). It was agreed that for the purposes of this dispute the relevant period, during which the alleged acts of discrimination and victimisation occurred, is 1 April 2019 to 18 June 2020.

5. The Claimant was represented by Mr Mark Greaves and the Respondents by Mr Ronnie Dennis, both counsel. The Claimant gave evidence and was cross-examined. A bundle running to approximately 240 pages was put before me. I also had the benefit of Mr Dennis's written closing submissions and a bundle of authorities. The hearing occupied most of the sitting day and I reserved judgment to allow time for careful reflection.

The Law

6. The 2010 Act s6 materially provides:

> **(1) A person (P) has a disability if –**
>
> **(a) P has a physical or mental impairment, and**
> **(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.**

7. "Substantial" means more than minor or trivial (s212(1)).

8. Schedule 1 to the 2010 Act contains further provisions supplementing the s6 definition of disability. By para 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.

9. Para 5 enacts the important 'deduced effects' principle, requiring the Tribunal to disregard the effect of treatment being applied to the relevant impairment where, but for it, the impairment would be likely to have an effect satisfying s6(1)(b).

10. By para 2(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 the effect is likely to recur.

11. In these contexts, something is "likely" if it "could well happen" (see the statutory Guidance on the Meaning of Disability 2011, para C3).

12. The Equality Act 2010 (Disability) Regulations 2010 provide that certain conditions are not to be treated as impairments for the purposes of the 2010 Act. These include addiction to, or dependency upon, alcohol (reg3(1)).

13. The burden of proving disability is on the claimant: see *Tesco Stores Ltd v Tennant* [2020] IRLR 363 EAT, at para 11. Whether or not a person has a disability has to be judged as at the date of the alleged discriminatory act.

14. In a frequently-cited passage in *J v DLA Piper UK LLP* [2010] ICR 1052, the EAT (Underhill P and members) passed these comments (footnotes removed):

> **41 The facts of the present case make it necessary to make two general points about depression as an impairment. …**
>
> **42 The first point concerns the legitimacy in principle of the kind of distinction made by the tribunal, as summarised at para 33(3) above, between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to them as symptoms of low mood and anxiety. The first state of affairs is a mental illness or, if you prefer, a mental condition, which is conveniently referred to as clinical depression and is unquestionably an impairment within the meaning of the Act. 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, if the jargon may be forgiven, adverse life events. … We accept that it may be a difficult distinction to apply in a particular case ... Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If, as we recommend at para 40(2) above, a tribunal starts by considering the adverse effect issue and 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.**
>
> **…**
>
> **45 The second general point that we need to make about depression as a disability concerns the question of recurrence. … We proceed by considering two extreme examples. Take first the case of a woman who suffers a depressive illness in her early twenties. The illness lasts for over a year and has a serious impact on her ability to carry out normal day-to-day activities. But she makes a complete recovery and is thereafter symptom-free for 30 years, at which point she suffers a second depressive illness. It appears to be the case that statistically the fact of the earlier illness means that she was more likely than a person without such a history to suffer a further episode of depression. Nevertheless it does not seem to us that for that reason alone she can be said during the intervening 30 years to be suffering from a mental impairment (presumably to be characterised as "vulnerability to depression" or something of that kind): rather the model is of someone who has suffered two distinct illnesses, or impairments, at different points in her life. Our second example is of a woman who over, say, a five-year period suffers several short episodes of depression which have 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 such a case 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, *ie* even between episodes: the model would be not of a number of discrete illnesses but of a single condition producing recurrent symptomatic episodes. In the former case, the issue of whether the second illness amounted to a disability would fall to be answered simply by reference to the degree and duration of the adverse effects of that illness. But in the latter, the woman could, if the medical evidence supported the diagnosis of a condition producing recurrent symptomatic episodes, properly claim to be disabled throughout the period: even if each individual episode were too short for its adverse effects (including "deduced effects") to be regarded as "long-term" she could invoke paragraph 2(2) of Schedule 1 (provided she could show that the effects were "likely to recur"): see para 8(2) above.**

15. Mr Dennis also drew my attention to a number of reported decisions of the higher courts stressing the value of expert evidence in resolving disputes about disability in the particular context of mental health conditions. These include *Royal Bank of Scotland Plc v Morris* (UKEAT/0436/10/MAA, unreported, 12 March 2012, Underhill P, para 62), *Royal Borough of Greenwich v Syed* (UKEAT/0244/14/LA, unreported, 26 June 2015, Wilkie J, para 37) and *Woodrup v London Borough of Southwark* [2003] IRLR 111 CA (Simon Brown LJ, paras 11-13, Clarke LJ, para 22).

The Facts

The main narrative

16. The Claimant's mother and sister both suffer from long-term depression and have been on medication for many years.

17. Her own first experience of a mental health problem was in 2010. At its worst, the condition resulted in quite severe symptoms, which included muscle aches and muscle weakness, tiredness and difficulty in sleeping, memory loss, concentration problems, 'brain fog', irritability and tearfulness and a tendency to withdraw from family, friends and social interaction generally. Nonetheless, she was able to manage the disorder. She found a course of counselling beneficial and took no medication at that time. From 2011 to 2014 any residual symptoms were minor.

18. In early 2014 the Claimant experienced further mental health problems. In April of that year she was diagnosed with depression and anxiety for which she was prescribed medication and Cognitive Behavioural Therapy ('CBT'). She understands the trigger to have been the death of her grandmother and the consequential effect of that bereavement on her mother. Her symptoms were more severe than those experienced in 2010. She was signed off work for 10 weeks.

19. Although her medication regime has been adjusted from time to time, the Claimant has remained on antidepressant medication continuously since 2014.

20. By the middle of 2014 the Claimant's condition had largely stabilised and she was able to return to work. She experienced a mild recurrence of her symptoms in 2016 which seems to have resulted from the breakdown of her relationship with her then boyfriend. Further CBT again proved beneficial (in combination with the ongoing medication regime).

21. In April 2019 the Claimant began to experience fresh symptoms of anxiety and depression. These were similar to those of 2014, including tearfulness, pain, fatigue and memory and cognitive impairment. It was at this point that she first received psychotherapy, attending regular sessions, initially weekly and later fortnightly (see further below). Despite this assistance, she reached the point at the end of May at which she felt overwhelmed and unable to cope with her work. She certified herself unfit for several days and then was signed off sick by her doctor.

22. The Claimant returned to work at the beginning of July 2019, initially four

days per week. Provision was also made for some home working. At that time she was still frequently tearful and struggling with low moods and concentration problems but she managed to remain at work and her condition gradually improved. In part, she attributes the improvement (which was not sustained) to a change in her medication. She also points to the benefits of new 'coping mechanisms' which she adopted at the time, in particular starting yoga and meditation and joining a gym and a pottery class.

23. In the autumn of 2019 the Claimant's mental health condition deteriorated once more. She experienced increased anxiety, which was associated at least in part with changes at work (apparently resulting from a merger between the Respondents and another agency) and an unsettling atmosphere with rumours of redundancies. Her symptoms of pain, tearfulness and impairment of memory, concentration and cognitive functions returned. Two occupational health assessments were carried out. Risk assessments and other measures were proposed and, it seems, implemented. In addition, the Claimant attended a one-day stress workshop and also signed up to a five-week managing anxiety course funded by the NHS. It was not until December (more than six months after the May sick leave began) that she returned to office-based full-time working.

24. Pressures experienced by the Claimant arising from organisational changes and job security concerns only increased in the New Year, culminating in the redundancy process, which began with her being put at risk of redundancy in April 2020 and ended with the dismissal of her appeal two months later. In addition she had to deal with the unusual and isolating consequences of the Covid-19 pandemic and the death of a close family member.

25. There does not seem to have been any significant change in the Claimant's mental health condition between autumn 2019 and summer 2020. If anything, it worsened over that period. Her GP notes for 7 May 2020 include:

> **Mixed Anxiety and depressive disorder (Review) …been on 100mg of sertraline for approx 1yr…since booked appt mood has worsened…struggling to sleep, tired much of the time…6yrs ago – severe depressive episode…flared 12 months [ago] and started sertraline…increase 150mg, then 200mg sertraline.**

The notes for 1 June 2020 read:

> **…[sertraline] increased up to 200mg…general tiredness/weak legs after a minor exertion; sleeping better – not feeling recharged…not feeling at the level could perform in an interview – not herself – running at 50- 60%...still having psychotherapy.**

Practitioner assessments

26. Sick certificates issued in respect of the Claimant have routinely cited 'depression' as the reason for her unfitness for work. Her GP practice classifies her condition as 'mixed anxiety and depression disorder'. Her psychotherapist describes her condition as 'low mood depression'.

27. Over time, the Claimant has been treated by CBT specialists, a psychiatrist, a number of clinicians at her GP practice and a psychotherapist, as well as

receiving the benefit of the expertise of an occupational health practitioner and the providers of the stress workshop and managing anxiety course referred to above.

28. The Claimant came into contact with her psychotherapist, Ms Satya McBirnie, when she attended the Better Lives course commencing in March 2019. Ms McBirnie has since retired but still practises on a private basis and the Claimant continues to attend sessions with her regularly. In a letter of 8 February 2021, she includes the following observations:

> **I first met Ms Box when she presented at Better Lives in April 2019. It was apparent at assessment that Ms Box was struggling with debilitating depression and anxiety. She had been on anti-depressants for many years since the diagnosis of clinical depression and appears to have been managing relatively well up until recently when her depressive symptoms became complicated by extreme anxiety.**
>
> **…**
>
> **Over the next year Ms Box attended a range of mental health support groups, including an NHS six-week course on managing depression and anxiety. She also attended weekly counselling sessions for a year. …**
>
> **Ms Box was always (and still is) highly committed to learning to understand and develop strategies to manage her long-term mental health condition.**
> **…**
>
> **The last few years have been a struggle for Ms Box, not helped by the pandemic and her outstanding issues with the way she was made redundant, however she is to be commended for keeping focused on positively managing her mental health. …**

29. The occupational health practitioner referred to above was Ms Julie Williams. Her professional grounding was as a nurse. She has many years' experience in occupational health practice. In an assessment dated 28 August 2019 following a referral by the Respondents, she included these observations:

> **As you are aware from your referral, Miss Box has suffered with anxiety and depression … and has intermittent periods of worsened condition. Miss Box saw her GP and different medication has been advised, she has been advised to see a psychologist who has advised she undertakes a four-day week for six weeks, this is to end shortly but she is still suffering. Her attendance is impacted with time out and leaving early.**
>
> **…**
>
> **… Around end of May beginning of June 2019 she reports a sudden drop in mood for unclear reasons, again she saw her GP and psychologist she had further time out, her medication was altered which seemed to help but a further increase was required about four weeks ago.**
>
> **At this time she is struggling with low mood, focus and concentration she was tearful on the call, despite her increased medication. …**
>
> **…**
>
> **In my clinical opinion Miss Box is fit to continue in her current role with extension of support if operationally feasible for six weeks. …**
>
> **…**

> **… Miss Box's anxiety and depression are long-term health conditions that she will have to live with and manage and she ought to be considered a vulnerable employee. In my opinion she is going to remain susceptible to episodes of potential destabilisation on an ongoing basis.**

Medication and its effects

30. The Claimant gave evidence concerning the effect of medication on her condition. She pointed out that on first being prescribed the medication she had experienced the effect that it had upon her. She also observed that there had been occasions when the level of medication had had to be adjusted and gave evidence about the (significant) effect of such adjustments. Finally, she mentioned that she had at least once found herself without her medication and had accordingly perceived at first hand the (significant) effect of even temporary withdrawal from the medication. Her evidence on these points was not tested in cross-examination and I accept it.

31. It was (rightly) not suggested on behalf of the Respondents that, once prescribed, the medication was simply automatically renewed without clinical consideration being given to the need for it. It is evident from the medical notes that careful thought was given to the drugs most appropriate to the Claimant's case and the correct dosages. These matters were reviewed and, as I have noted, adjustments made.

Alcohol consumption

32. At some time prior to 2019, the Claimant's consumption of alcohol increased.[1] By 2019 she was conscious that it had become a problem. She gave up drinking completely in January of that year but felt no better for doing so. In late March she attended the Islington drug & alcohol and mental health service, 'Better Lives' and with its support abstained entirely for a period of 12 weeks. In her evidence she agreed that stopping drinking had contributed to the improvement in her condition but stressed that she had continued to have good days and bad days during the period of abstinence and that she had built her (partial) recovery in the summer of 2020 on the combination of measures and therapies (including self-help therapies already mentioned) which she had taken. She later resumed drinking alcohol and in May 2020 was noted by her GP as consuming around 20-30 units (or around two to three bottles of wine) per week.

33. Although a note in the GP record of 7 May 2020 refers to her being conscious of her use of alcohol and to the need to reduce her consumption and avoid a "negative drinking approach", there is, so far as I am aware, no medical record of any medical practitioner or other healthcare professional attributing the Claimant's mental health problems wholly or even in part to her alcohol intake.

Analysis and Conclusions

34. As a preliminary point, I have considered whether there is anything to be

[1] She told 'Better Lives' that the increase had occurred over the preceding two years.

gained by attempting to reach a view on the proper interpretation of the Claimant's condition prior to 2014. A moment's reflection has persuaded me that it would be neither proportionate nor practical to do so. Whether what happened in 2014 was a recurrence, in more serious form, of a condition first manifested in 2011 or a brand-new complaint is, in the scheme of things, a question of little significance and one on which on which, for want of evidence, it would be very difficult to arrive at any worthwhile finding. Accordingly, I will confine my analysis to the period from early 2014 onwards.

35. Taking my lead from the *DLA Piper* guidance, I start with the question of adverse effect. On my primary findings of fact, it is evident that there were times between 2014 and 2019 when, despite her medication, the Claimant experienced a substantial adverse effect on her ability to undertake normal day-to-day activities. I have made findings on the impact on her mood, her cognitive functions, her preparedness and ability to interact with others and so on. But I have not found that the symptoms were continuous. The Claimant did not say that they were. Indeed she agreed that, barring the recurrence of symptoms in 2016, she managed, over nearly five years, to maintain a broadly even keel. She was, however, on medication throughout that period. That medication had been prescribed in 2014 as necessary and appropriate treatment for a diagnosed depressive condition. It was maintained, regularly reviewed and, where necessary, adjusted. (And, as I have also mentioned, it was not suggested that the medication was continued purely on a precautionary basis or as some sort of insurance.) I have noted the evidence which the Claimant gave of the beneficial effect of the medication (including where the dosage was increased), and on the deleterious consequence for her (on at least one occasion) of being without it. In my view she was a conspicuously straightforward witness and I have no hesitation in accepting her evidence in its entirety. Stepping back and viewing the material in the round, I form a picture of the Claimant between the summer of 2014 and early 2019 maintaining a broadly stable pattern thanks in significant part to the medication prescribed and her own efforts to take care of her mental health. In my judgment, it is proper to infer that, but for the medication, she would over that period have experienced continuing symptoms sufficiently acute to meet the undemanding requirement of constituting a "substantial" (*ie* more than minor or trivial) adverse effect on her ability to undertake normal day-to-day activities. No doubt those symptoms would have fluctuated in their severity but I am satisfied that they would have been present to a material extent throughout. I reject the logic of the Respondents' case, which was, in effect, that the medication served little or no purpose. I accept the Claimant's case that, to the extent that she functioned reasonably well up to early 2019, that state of affairs was to a highly material extent the result of the successful treatment of her condition, principally through medication. For these reasons, I am satisfied that, by operation of the 'deduced effects' principle, the Claimant must be regarded as having experienced substantial adverse effects on her ability to undertake normal day-to-day activities throughout the period from summer 2014 to early 2019.

36. It inevitably follows that the (deemed) adverse effects were not only "substantial" but also "long-term", since, on my finding, they are to be treated as having lasted for a continuous period of close to five years.

37. Was there an impairment? Manifestly, there was. Indeed, given the state of the pleadings (to which I have referred above) it was not easy to see what room there was for any disagreement on the subject. The Respondents have accepted in their pleaded case that the Claimant was subject to anxiety and depression. (In his closing submissions Mr Dennis appeared to suggest that the Respondents should be regarded as having admitted the conditions(s) only as at the date of presentation of the response form, but very sensibly did not attempt to make good that deeply unpromising point. The pleading (cited above), which explictly refers to sick notes produced by the Claimant, speaks for itself.)

38. What was the impairment? Self-evidently, it was a mental impairment, namely the depressive condition to which the Claimant became subject in 2014 (if not before). As the *DLA Piper* analysis reasons, once the substantial and long-term consequence is identified, the Tribunal is seldom faced with a difficult task in identifying the cause. None other suggests itself.

39. Having taken apart the constituent elements of the definition of disability, I have reassembled them and considered my analysis against all the evidence and the statutory language. This exercise confirms my view. In particular, the severity of the Claimant's illness in 2019 (which, as Ms Williams noted, was not explained by any clear cause or 'trigger'), reinforces my assessment that she was throughout the period from 2014 onwards subject to a significant mental health condition which, despite being managed effectively by medication over an extended period, left her vulnerable to episodes in which her symptoms were liable to become acute and require fresh interventions.

40. On this analysis, what is the proper interpretation of the events from early 2019 until the end of the relevant period in June 2020? It seems to me plain and obvious that, if I am right so far, the final 15 months were simply a continuation of the state of affairs which has been in play since early 2014. I reject Mr Dennis's generalised submission that the Claimant's symptoms over the last year or so of her employment should be seen as inconsequential reactions to 'life events'. Of course, concerns about work, job security and so on are commonplace stressors. So, for many, are the effects of the current pandemic. But the fact that particular stressors may have provoked particular symptoms (despite the protective effects of medication) is entirely consistent with the Claimant's case, namely that her condition fluctuated between periods when symptoms were suppressed and periods when they were not. In my judgment, there is no rational or evidential basis for the theory that, following her (partial) recovery in the summer of 2019, any underlying condition was swiftly and miraculously cured and all subsequent symptoms are to be newly classified as reactive blips. Her evidence and all the independent material argue compellingly in the opposite direction.

41. In case I am wrong in my understanding of events before early 2019, I must deal with Mr Greaves's secondary argument that even if one focuses only on the period from then until June 2020, disability is made out on the basis of that period alone. Here again, I have reached a clear conclusion. In my judgment it was plainly "likely" that, certainly by the time when the Claimant's symptoms became acute (not later than late May 2019), the impairment would last at least a year (the 2010 Act, sch1, para 2(1)(b)). To put the matter at its very lowest, there was a good

chance that it would. The prospect, in late May 2019, that the condition "might well" last a year would have been evident then, given the history going back to 2014, the fact that medication had been prescribed continuously since then and could be expected to be prescribed for an indefinite period into the future, and the fact that despite the medication and other therapies and measures (including giving up alcohol), the Claimant's condition had worsened to the point where she was unable to work. The conclusion is all the clearer when one bears in mind that the 'deduced effect' principle already discussed is again applicable here: the prospective assessment of 'likelihood' disregards the presumed effects of the medication that would have been prescribed.

42. For good measure, I would also hold if necessary that, even if the analysis was confined to the period from early 2019 onwards and the conclusion just stated as to the likelihood of the effects lasting for a year or more were not open to me, the Claimant would be entitled to succeed on the basis that the effects were "likely" to recur (sch1, para 2(2)). Here again, the 'deduced effects' principle is in play. In my judgment, there would have been, at the lowest, a good chance, given all the factors considered in the last paragraph, that (the effects of medication being disregarded) symptoms causing a substantial adverse effect on the Claimant's ability to perform day-to-day activities would have recurred.

43. I must now deal with Mr Dennis's arguments concerning the Claimant's consumption of alcohol. In the first place, I should note that, as I understood him, he did not in the end base his case on the proposition that the Claimant had (or had ever had) a condition which was expressly excluded from the protection of the 2010 Act. In those circumstances, I am not entirely clear why he took me to the 2010 Regulations (which for completeness only I have cited above).

44. The nub of Mr Dennis's argument was that the Claimant's symptoms were linked to her consumption of alcohol and that accordingly any condition or impairment on which she relied was not the cause of any adverse effect on her ability to undertake normal day-to-day activities or at least not a long-term cause of any such effect. In my judgment that argument was unsound. Rightly, no doubt, the Claimant acknowledged in cross-examination that by early 2019 she had come to use alcohol as a crutch or as she put it, a 'coping mechanism' and that it was not doing her any good. But she also said that 'dry January' that year left her feeling no better. Moreover, her 12 weeks' abstinence from late March to late June was manifestly not the panacea suggested by Mr Dennis. As I have recorded, it was towards the end of that period that her condition became particularly acute to the extent that she needed to take time off from work and experiment with fresh therapies and self-help remedies. Fortunately, in the short term her condition improved. I cannot accept Mr Dennis's suggestion, for which there is no evidence, that the abstinence from alcohol was the reason, or even a major factor. I agree with Mr Greaves that common sense argues strongly that her (partial) recovery in the summer of 2019 is much more likely to have been the product of the new help that she was receiving and the new efforts that she was making off her own bat to cope with her mental health difficulties.

45. Finally, I should say that I have not disregarded the authorities shown to me by Mr Dennis concerning expert evidence. Their key message, as I read them, is a

warning to the Tribunal not to resort to conjecture to fill an evidential gap, and in particular a gap which can only properly be filled by expert evidence. But here I agree with Mr Greaves that the evidence, taken together, leaves no such gap.

46. For all of the reasons stated, I conclude that the Claimant was disabled from 2014 up to June 2020 (and, no doubt, beyond).

Outcome

47. The Claimant succeeds on the preliminary issue and all of her claims can proceed to a final hearing if the parties cannot find a happier way of resolving this dispute.

_____

EMPLOYMENT JUDGE – Snelson
09/04/2021

Judgment entered in the Register and copies sent to the parties on : 09/04/2021

..... for Office of the Tribunals