EMPLOYMENT TRIBUNALS

Claimant: Mr Miethbauer

First Respondent: Bloor Homes (Services) Limited

Second Respondent: JS Bloor (Services) Limited

Heard at: Midlands (East) Region via Cloud Video Platform

Date: 28 May 2021

Before: Employment Judge Broughton

Representation
Claimant: Mr Morris - solicitor
Respondent: Mr Sheppard – counsel

RESERVED JUDGMENT ON A HEARING A PRELIMINARY ISSUE

The claimant's claim that he is a disabled person for the purposes of section 6 of the Equality Act 2010 is well founded and succeeds.

RESERVED REASONS

Background

1. The purpose of this hearing was determined at a previous preliminary hearing for case management, before Employment Judge Hutchinson on the 24th of February 2021; "*the issue of whether the claimant suffered from a disability at the relevant time "*

2. The claim form refers to two conditions which the claimant relies upon to establish his claim that he was a disabled person at the relevant time; General Anxiety Disorder and Obsessive Compulsive Disorder.

Relevant Period

3. The relevant period is not set out in the record of the previous preliminary hearing. I shall set out in brief the alleged claim and what was discussed regarding the relevant period at today's hearing.

4. The claimant was employed from 1 April 2021 until his employment ended on 17 July 2020. He was employed as a sales advisor.

5. The claimant's claim form alleges that the claimant was absent from work between 24 September 2017 and 28 May 2019 with General Anxiety Disorder (GAD) and Obsessive-Compulsive Disorder (OCD) and;

   "*That over the course of the next 12 months I was off work on 8 occasions, all of which related to my disabilities and the side effects of the medication that I was taking for them or had ceased to take for them".*

6. On 6 July 2020 there was a redundancy announcement and the claimant was informed that if there was no suitable alternative role found for him, his post would be no longer be required. He was informed by letter dated 13 July 2020 that the respondent had changed how attendance would be scored from a % attendance to the number of days absence taken over the period **1 July 2018 to 30 June 2020**.

7. The claimant scored zero points for attendance. He asserts that all his absences in the 2-year period (1 July 2018 to 30 June 2020) save 1 were related to disability; "*albeit labelled as a generic 'sickness."*

8. The claimant's claim is that he was discriminated against in being selected for redundancy because of his disability related attendance record during that two-year period.

9. The respondent does not dispute that the claimant was dismissed on the grounds of redundancy but does not accept that it took into account absences which related to his mental impairment.

10. The claimant contends that the relevant time for consideration of whether or not the claimant is a disabled person for the purposes of the Equality Act 2010 is therefore the period 1 July 2018 to 30 June 2020. Counsel for the respondent did not have definite instructions but did not assert that the relevant period was otherwise. As the claimant contends that the consideration by the respondent of absences during this period was the act of discrimination and it is those absences within this period which relate to his disability, that period must be the relevant period for these purposes.

Issues

11. The issues for this tribunal are therefore as follows;
    11.1 Did the claimant have a physical or mental impairment/s?

    11.2 Did the impairment/s have a substantial adverse effect on his ability to carry out day to day activities?

    11.4 Did the claimant have medical treatment or take other measures to treat or correct the impairment?

    11.5 Would the impairment have had a substantial adverse effect on his ability to carry out normal day to day activities without the treatment or other measures?

    11.5.1 Were the effects of the impairment long term?
    11.5.2 Did they last for 12 months or were they likely to last 12 months?
    11.5.3 If not, where they likely to recur?

Evidence

12. This was a fully remote hearing undertaken by HMCT's Cloud Video Platform (CVP).

13. The parties did not request any adjustments to the hearing.

14. The parties produced a joint bundle of documents numbering 109 pages. No other documents were produced during the hearing. Reference in this judgment to numbers in brackets are to pages in the agreed joint bundle.

15. I heard evidence from the claimant who affirmed that his evidence was the truth. The claimant produced a disability impact statement (p.39-42). I heard from no other witnesses from either party.

Findings of fact

16. I made the following findings of fact on a balance of probabilities.

17. The findings set out are not intended to be a complete record of all the evidence I heard during the hearing. I took all the evidence into account unless otherwise noted however, these findings are those material to my conclusions.

Generalised Anxiety Disorder (GAD)

2002 – 2009

18. The claimant's evidence under oath is that he had been suffering from symptoms of depression for many years but without a diagnosis. There is no medical evidence to support his account of that history (apart from a reference in the GP notes to the claimant informing his GP of his history) and he confirmed under cross examination that prior to 25 September 2017, he had not received any medical treatment for anxiety or OCD.

19. The claimant gave evidence that he is unsure of the original cause of the anxiety for which he would attend his doctor in September 2017, but he refers to various life events which could have contributed. He set those out in his evidence in chief as; his grandmothers house burnt down in 2002, and there were various events circa 7 years later in 2009 including a car fire in February 2009 and in 2009 his home was burgled.

20. The claimant would in December 2017 relay these factors to an Occupational Health nurse, who the respondent had arranged to carry out an assessment and she appears to have accepted his account of those issues as possible background factors (p.88). However, what caused the alleged impairments is not something which this tribunal is required to establish.

Absence from work: 24 September 2017

21. The claimant disclosed in the bundle computerised records from his GP surgery (p.50 – 77)

22. The undisputed evidence of the claimant in chief is that he was first off work on 24 September 2017 and first attended his GP on 25 September 2017 suffering from anxiety.

23. The claimant's evidence is that he began to carry out repetitive checks that the doors were locked when he left home, and did this increasingly when under pressure and stress but dismissed this initially as being a 'worrier' until he started to have panic attacks in 2017.

24. The claimant's evidence is that the panic attacks were related to both conditions namely the GAD and OCD. His evidence is that he would start with anxiety about touching food and contaminating it and then the "*OCD kicks in*" and he would worry about it until it spiralled out of control. He gave undisputed evidence that he had panic attacks on an almost daily basis about a month before he stopped work in September (i.e. from circa August 2017) and for about two months thereafter. He stopped having them after 4 or 5 sessions of CBT counselling, which he confirmed would have been in early 2018. He described the panic attacks as feeling "*like a heart attack*", he would sweat, shake and could not focus, the attacks would last about an hour and afterwards he would feel worthless. His evidence was that had he not been put on medication; he would not be able to keep rational enough to manage his anxiety in order to be able to prevent panic attacks.

25. The claimant described in his evidence in chief how "*just before"* September 2017, things had built up and that he was unable because of his worries, to leave the house alone and that he became "*something of a recluse*".

26. The incident on 24 September 2017, which lead to him seeking assistance from his doctor on 25 September 2017, he described under oath as when it 'all started'. His evidence is that he got into his car to go to work, he began sweating and shaking and sat in the car and felt so sick he could not drive. He went into the house and called his doctor. He felt ashamed, was very stressed and fear "*gripped*" him. He would not drive again until he had 3 or 4 sessions of CBT in April or March 2018, about 5 months later.

27. His symptoms on the 24 September 2017 are to supported by the computerised medical record from his GP medical centre (p.58). The first relevant entry I was taken to on 25 September 2017 includes the following reference;

"*25 Sep 2017*
History : symptoms for the last 10 years.
Feeling anxious all the time.
Heart racing
Double checking taps etc before leaving house
Double checking road if hits bump – worried he may have hit something/ someone
Asymptomatic when with girlfriend
…
Major: ***Chronic anxiety (E2004)"***

[Tribunal stress]

28. Although 'panic attacks' as not referred to expressly in the GP notes, there is reference to his heart racing and chronic anxiety and in the 27 September entry to the claimant suffering with "*anxiety, feels anxious and* ***panicky all the time***".

29. The further entry in his GP records on **27 September 2017** (p.59) also records a prescription for Propranolol 40 mg tablets.

30. The undisputed evidence of the claimant is that Propranolol is an anti- depressant medication, which was prescribed for him to take when he has panic attacks, which is

consistent with the entry on the 27 September 2017 for "*21 tablets with 1 to be taken prn".*

31. I accept the claimant's undisputed account given under oath, of how he was feeling on the 24 September 2017 and of the symptoms which he described as set out above in paragraphs 23 to 26 including that he was suffering from panic attacks and was prescribed medication for that reason.

32. The claimant's evidence is that the Propranolol however did not suit him and actually magnified how he felt. That is also supported by the GP records which record him informing the GP that they had not helped on 2 October 2017 (p.59) and 17 November 2018 (p.60).

33. In the **28 September 2017** entry in the GP records there is a reference to: "*Mental Health to Wellbeing Team".*

34. The claimant's undisputed evidence supported by the medical records and later reports from Changing Minds, is that he was referred for counselling by his GP to assist him with this obsessive behaviour.

35. The claimant in oral evidence described his OCD condition as an addiction to reassurance; *"I feel like a have done something wrong if I haven't checked. I am addicted to checking I have not done something wrong – I get reassurance – I am addicted to the reassurance*."

36. The claimant also gave oral evidence that it was similar with hygiene in that that he will go over in his mind about what he has touched and worry that he may get ill or someone he is feeding may and he will then wash his hands and then worry he had touched the tap and "*feel dirty again*." He referred to this cycle in his brain of anxiety.

37. The claimant would remain off work, certified as unfit by his GP for stress and letter Chronic Anxiety, from 24 September 2017 to 28 May 2018, a period of 8 months.

October 2017 – December 2017

38. I was taken through several computerised entries from the GP records and, in summary they set out the position as follows;

- That on **2 October 2017** the diagnosis was stress and that the claimant was "*struggling with work and anxiety and lots of pressure and stress"* He was certified as not fit for work (p.60).

- That on **16 October 2017:** He was signed as not fit for work with a diagnosis of Chronic Anxiety (p.60).

- That on **17 November 2017** it is reported that the medication Propranolol had not helped, and he was awaiting an appointment with Changing Minds. It also records; "*worsening symptoms discussed*" and he is **prescribed Sertraline 50 mg.**

- **1 December 2017**: There is reference to Chronic Anxiety (E2004) and of the claimant feeling a "slight *improvement*". There is further reference to Sertraline and that the claimant still waiting for a Changing Minds appointment.

- There are further entries on **13 December 2017** when there is reference to Sertraline 50mg,diagnosis of chronic anxiety and still waiting for Changing Minds appointment.

39. The claimant confirmed that the first time he had been prescribed Sertraline was on 17 November 2017, which is consistent with the GP records. His evidence that this is an anti-depressant medication was not challenged and I accept that this medication is an anti-depressant.

40. I find that the claimant's condition deteriorated as recorded on 17 November 2017 and this resulted in the prescription for Sertraline.

Without the medication

41. The claimant's evidence is that he is not sure whether the Sertraline is prescribed for the OCD or GAD or both but that "it *makes me better*". In response to my questions, he explained that the medication makes him more rational and improves his mood so that he can "*look at things in a clearer light*" and that it is a booster to CBT. If he did not take the Sertraline his evidence is that; "I *would not be able to have a rational discussion in my head".*

42. The claimant deals with the effect in his evidence in chief (para 11, 12 and 17, 18 and 19). His evidence on this issue is on the basis of what would happen if he had stopped his medication at any point including as at the date of this hearing. His evidence is that he is still taking Sertraline.

43. In his evidence the claimant describes how if he were to stop taking his medication completely, he believes that his anxiety would spiral out of control and would take over his life. He described how he would not have the concentration or motivation to do any normal daily activities including cooking a meal, going shopping, driving and washing himself. Before he was diagnosed, he referred to being unable to leave the house alone and even with the medication his chronic anxiety affects him in that he jumps from one anxiety to another throughout the day; "*one moment I will be worrying about touching something contaminated for example, the next I will be worrying whether I have done the work correctly and worrying at I have done it right or made a mistake…I am unable to come into contact with strangers or public places. I find it difficult to leave the house and lock up, for fear of me leaving something on etc. Preparing food is difficult and particularly, driving. Obviously without medication this all becomes far worse and unmanageable.*"

44. The claimant gave evidence that he knows what the effects would of not only his symptoms before he started the medication but because of how he feels when he takes his medication in the evening rather than in the morning; "*I notice my doubts in the evenings start to creep in - I know that feeling of what will happen - the circles I go in, in my brain, does not allow a rational thought in my brain – I keep catastrophising"*

45. The claimant also gave evidence that he gets the preliminary stages of panic attacks

still but he knows how to manage them and cope, however if he was not on medication his evidence is that he would not be able to keep rational and manage them.

46. The claimant gave evidence in chief that if he stopped taking the anti- depressants his anxiety;

"*would spiral out of control and would take over my life, I would end up being confined to my house, unable to work and go out. I would not have the concentration or motivation to do any normal activities, including cooking a meal, going shopping, driving and washing myself. Before I got diagnosed, I was very ill and ultimately unable to leave the house alone…"*

And in terms specifically of the OCD; "…*it would quickly consume my life not allowing me to live a normal life. This would result in me doing the same thing for hours not being able to stop checking something and move on".*

47. The claimant also gave evidence about the effect of the OCD on his driving. He described how if he drives over a pothole, he will worry that the noise he had heard is actually because he has hit something or someone, he will need to return to check that he has not caused an accident which leads into a cycle of driving back to the same place to check.

48. The claimant gave evidence that he gets trapped in his own thoughts which causes a low mood.

49. With the medication the claimant's evidence is that he would still obsess about a particular worry and he gave examples of locking doors and how he would catastrophise about all of the things that could happen if he had not locked the doors properly and he will therefore have to "triple check the lock".

50. Although there is no medical evidence directly on the point about what the likely affects of the conditions would be without the medication, the claimant gave evidence under oath and I had no reason not to accept his evidence of what his experiences were both before he started taking the Sertraline and how he continues to be effected if he takes the medication later in the day.

51. I also take into account the observations of the GP who first diagnosed the claimant, in terms of his symptoms he had before he was prescribed medication and underwent counselling.

OCD

52. On the December 2017 the claimant was referred to MediWright/Occupational Health (OH) by the respondent and was seen by OH on 12 December 2017; the entry records that the claimant has always been a worrier but more recently this has become an *"escalating problem*".

53. The OH report from Ms Gale, the nurse who assessed the claimant on 12 December 2017 (p.87/88) makes the following observations, after making reference to the background factors he suggests lead to his anxiety;

"…*this has left Chris feeling vulnerable and anxious and more recently his* ***feelings of fear and anxiety have escalated resulting in him checking and re- checking plugs and sockets*** *in the homes as a result Chris tells me has has become fearful of leaving*

the home for any period of time and when he does he is constantly returning to carry out checks. He attended his own GP, who diagnosed anxiety and has referred him for specialist counselling support. … He has also been commenced on prescribed medication …"

"***Chris needs specialist counselling to help him learn to control his obsessive tendencies and he is currently waiting for the appointment from a counsellor who can support with this specific problem.*** *He is not fit to return to work at the present time due to the symptoms of anxiety he has described to me. I would like to re- consult with Chris straight after the Christmas period, by which time I am hopeful that he will have commenced his counselling, feel a positive effect from his medication and be able to plane a phased return to work..*" (p.88)

[Tribunal stress]

54. The claimant in answer to a question from the tribunal about whether this referral to Changing Minds was related to the GAD, was that the two conditions are "*intertwined".* The observations of the nurse the tribunal find, support the claimant's evidence on the connection between the two conditions.

55. Ms Gale refers to his anxiety "**resulting"** in the symptoms of what are obsessive behaviours checking doors etc. Although treated as a "*specific problem"* which requires specialist counselling to address, I find that there is sufficient evidence to find that there is a connection between the GAD and the resulting OCD.

Changing Minds

56. It is not in dispute that the organisation, Changing Minds is a department of Northamptonshire healthcare NHS who provide mental care services.

57. The claimant asserts that he had 20 or more sessions of CBT through Changing Minds.

58. Within the bundle (p.44) is a letter from Changing Minds dated 23 October 2017 to the claimant's GP, where Changing Minds refers to the claimant being referred to them but had not booked an Assessment Appointment. The claimant could not really explain this letter other than to say that he had sessions with them. The GP records refer to him in December 2017 as still waiting for Changing Minds appointment and there is reference in the GP entry on 15 Jan 2018(p 62) to; "*waiting for appt with wellbeing. Note discharge letter Oct 2017*". The entry on 15 February 2018 (p.62) would report however 3 sessions of counselling had been undertaken by this stage. I find that the claimant engaged with the counselling process and by February had received sessions of counselling to address specifically how to manage the obsessive behaviours.

January 2018 – December 2018.

59. I was taken to further entries in the GP records during 2018, which in summary confirmed the following;

    - That on **9 January 2018** the claimant was prescribed Sertraline again and the same dosage i.e. 50mg

    - That on **15 January 2018** there is reference to the claimant not being fit for work from 14 Jan to 14 Feb 2018 and again a diagnosis of Chronic Anxiety

- That on the **8 Feb 2018** the claimant attended his GP again and was prescribed further sertraline 50mg

- That on the **19 February 2018** the claimant had 3 sessions of counselling and reports it is *going well*. It also records that the claimants "*still [sic] not driving*". It also records that the claimant does not believe the Sertraline is working and that he is still feeling low mood and mainly linked to anxiety. It refers at this stage to; "*worsening symptoms*" and the dosage of Sertraline is increased to 100mg

- That on **19 March 2018** (p.62) that he suffers with chronic anxiety and that he is getting CBT, which is helping, and the counsellor states the claimant is **making good progress**. Reference is made to sertraline of 100mg and the claimant wanting to get back to work for May 2018.

- That on the **13 April 2018 (p.63)** the claimant is reported as "*making progress with OCD"* and has started driving. He is signed off from work until 28 May 2018.

- That on **23 April 2018** and **21 May 2018** there is a request by the claimant for sertraline 100mg

- That on **29 May 2018** there is reference to a not fit for work statement from 29 may to 3 June 2018 (p.64)

- That on **31 May 2018** (p.64): the claimant is reporting feeling better and looking forward to going back to work.

- That on **18 June 2018** and **31 July 2018** and **28 August 2018** (p.64 and 65) the claimant is still prescribed sertraline at 100mg.

60. The claimant's evidence when asked to clarify, was that the first time Sertraline was increased from 50 mg to 100mg was on 19 February 2018 and this is confirmed by the GP entries on 8 and and 19 February 2018 (p.62).

61. The prescriptions for sertraline at a dose of 100mg continue from **25 September 2018, in October, November and December 2018** (p.65)

OCD

62. The effects of the OCD itself, the claimant describes as compulsive behaviours which relieve the anxiety he feels, but without treatment quickly consume his life and result in him doing the same thing for hours or not being able to stop checking something .The need to keep checking that he has locked a door or not run over someone when driving not only means that he is taking more time to carry out an activity but it causes low mood and to avoid the low mood and the obsessive behaviours he then avoids leaving the house to remove the need to lock up and the anxiety caused by leaving the house or driving his car, it can also include obsessive behaviours around hygiene and repetitive hand washing.

63. His description of the effects is confirmed in part in a letter from Changing Minds dated **15 February 2018** (p.45) which confirms that the claimant had commenced a course of CBT and that;

"Christopher *reports his main issues to be Obsessive Compulsive Disorder (OCD), particularly relating to driving and checking doors."*

28 May 2018: Back to work

64. The claimant was absent from work from 24 September 2017 to 28 May 2018. The claimant accepted the respondent's record of his certified absences which dates his absences to the 28 May and thus the claimant conceded that this date "was about right" This would mean a return date on a balance or probabilities, of 29 May 2018.

OCD

65. There is a further report dated 25 June 2018 (p.46) from Changing Minds which reports that they had seen the claimant on 11 occasions and are to proceed to close this episode of care and make the following observations;

"*Christopher presented with symptoms consistent with Obsessive Compulsive disorder (OCD) namely checking rituals before leaving the house and* ***avoidance of driving*** *due to a compulsion to check route.* ***His main focus was on driving as the other checking subsided quickly****" and "Christopher is now back to work and able to drive the distance that he needs or cover. He reports recovery and his scores reflect this PHQ9 9 – 11, GAD7 1 – 4 and OCI 57-4 ."*

[Tribunal stress]

66. Under cross examination, the claimant accepted that the Changing Mind report identifies that the main issue in terms of his obsessive behaviours related to driving and checking doors and that his main focus was driving but he disputed the use of the term ' quickly' to describe the resolution of the other symptoms . His evidence is that those other issues had never gone away but he had been given solutions he could use with support. He confirmed he was able to drive again by about April or March 2018 albeit he had to be accompanied. By May 2018 he was able to control his OCD and drive on his own.

67. The claimant gave evidence that before the counselling he would not get in a car because he was so anxious. After the counselling he will now drive but he must prepare and drive to familiar places. The respondent, when he was back at work from May 2018 would not send him anywhere more than an hour away and before he had to go, he would drive there once or twice with his partner to familiarise himself and he would perhaps his mother if he becomes anxious.

68. This is consistent with an entry in his GP records on 4 August 2020 (p.70);

"*anxious when driving long distances, saw OH who advised not to drive > one hours.."*

And the OH report itself (p.97 and 98) dated **14 April 2018;**

"This gentleman reports feeling much improved since his last OH consultation. He tells me he told all advice given during his consultation in preparation for his specialist counselling support, He has attended 9 support sessions with a very positive effect and Chris described and gave examples of approaches and coping mechanism learned. Chris has recommenced driving, he does however still report some anxiety associated with driving, which he is trying hard to manage with the tools given to hm

by his anxiety counsellor and by increasing his driving and distances gradually This gentleman's episodes and symptoms of anxiety have significantly reduced. He is eating and sleeping as normal and carrying out general daily living activities with some small restrictions such as limitations with driving. …He is due to have a further 3 sessions of CBT and will then be placed on a treatment maintenance programme to prevent potential relapse…"

And

"It is important that Chris does not work alone initially as he will require some support, which will be required through to the duration of his phased return to work plan. I would recommend a 4-week phased return to workplace, extending to 6 weeks if indicated…. Please give consideration to site location due to this gentleman's anxiety associating with driving, the shorter distance, the better initially*…"*

69. Reference is made in this report to the coping strategies and I note that even with 100mg of anti-depressants, the recommendation at this stage is that he "*does not work alone"* and needs support during the phased return.

70. It was put to the claimant in cross examination that from end of May 2018 to August 2020, he had no periods off work directly referable to anxiety or OCD however, the claimant gave evidence that he had periods off work due to those conditions but he did not report them as connected at the time because it did not occur to him that the symptoms were due to OCD or anxiety.

71. The MediWright/OH report on 19 April 2018 refers to the "*approaches and coping mechanisms learned".*

72. I find that the OCD had not been 'cured' by the counselling however the claimant had been given tools to manage or ameliorate the symptoms. The claimant does not allege that the behavioural management tools that he now had would not be reasonable strategies for him to continue to use to help control the behaviours.

73. Although the claimant felt in a better state of mind to return to work in May 2018, as of 24 September 2018 was still taking 100mg of anti- depressant medication. He had made no attempts to reduce his medication by this stage. His doctor was continuing to give regular monthly prescriptions of this same amount.

November 2018 - April 2019 attempts to reduce Sertraline dosage

74. Around November 2018 the claimant's evidence is that he tried reducing the amount of Sertraline he was taking, not that he stopped taking it.

75. The GP notes from November 2018 record the same 100mg prescriptions of Sertraline. This is consistent with the claimants' evidence that it was his decision to attempt to reduce the dosage and not the doctors, and I accept his evidence on this.

February 2019

76. In February 2019, the claimant gave evidence in response to questions from the tribunal, that he was involved in a car crash and as a result he resumed taking the full dose of 100mg.

77. It was put to the claimant under cross examination that he tried to reduce his dose on two occasions; the first from November 2018 to April 2019 and then again from early 2020 which the claimant accepted, however that does not quite tie in with his earlier evidence which is that he tried to come off in November 2018, went back on the full dose due to a car accident in February 2019 and then attempted to reduce his dose again in April 2019. This more detailed account of events appears to be supported by the documentary evidence. There is an entry in the GP records on 10 February 2019 which refers to "*Emergency dept"* which would appear to support his account of an accident in February and the respondent's own absence record include an entry about time taken off work from 9 February to 11 February due to a car accident (p.101). His evidence about going back on 100mg following this incident was not directly challenged in cross examination. I find therefore that were three periods; the first attempt from November 2018 was interrupted by an event in February 2019 but that he then resumed the attempt to reduce the dose in April 2019 and then he would reduce it again in early 2020.

78. The GP records show that during **February, March and April, May 2019** the claimant was still prescribed Sertraline at 100mg (p.66 and 67).

April 2019: resumed attempt to reduce his Sertraline dosage

79. The claimant's oral evidence was that from April 2019 he attempted to reduce his dose again to 50mg however, this led to periods of nausea, sickness and diarrhoea and therefore he went back on the full dose. The GP records include an entry on 1 June 2019 which refers to the claimant reporting vomiting and refers to the claimant having been on holiday (p. 68);

"partner has had similar symptoms and she also went to Egypt"

Absence from work: 1 – 3 June 2019

80. The entry on 3 June 2019 (p.68) reads; " ..*sickness and diarrhoea for more than two weeks, had some symptoms when in Egypt, took some meds from pharmacy while there for sickness and Imodium*" and " *Plan: for faeces culture to check for food poisoning*"

81. There is no record in the GP records of these symptoms being due to a reduction in Sertraline however there is a report from Dr Stuart Pavey at Weavers medical dated 24 May 2021 which states that (p.78);

" *I can confirm that Mr Meithbauer has symptoms consistent with OCD and GAD according to his Changing Minds letter and assessment. He has had this since 2017.*

After various tests in mid-2019, ***it was accepted that the most likely cause of the nausea/sickness/ diarrhoea he had was due to the attempted reduction/ withdrawal of Sertraline medication.*** *He has continued to take his Sertraline and has not had the same symptoms since*".

[Tribunal stress]

82. The claimants evidence in chief (supplemental questions) was that his doctor had told him he did not want him to stay on the medication long term and that he had felt in a good state of mind to take ½ a tablet and start to withdraw from the medication . The claimant then reduced his table to 50mg, there was no change for a couple of weeks and then his evidence is that he kept feeling nauseous, but he did not link it to the

reduction in the medication. His new GP (there was change to another GP practice in March 2019 and change of registered GP to Dr Pavey) thought the sickness may be thyroid related and he underwent tests for that, there was he says; "*no resolution, nothing conclusive but that the Dr had said that the most likely reason was medication withdrawal".* The claimant's evidence is that after the results of the thyroid check he immediately went back on a dose of 100mg from June 2019. There is a record of him requesting Sertraline 100mg on 10 June 2019 (p.69).

83. I accept based on the oral evidence of the claimant and Dr Pavey's letter, that the claimant was informed that the most likely cause of his sickness was the reduction in his medication reduction. I also accept his evidence that he then resumed taking the full dose. There was no evidence that his GP considered that the claimant was ready to reduce or withdraw from the medication. There is no entry in the GP records of the claimant being advised to reduce or withdraw from the medication at this point and records ongoing prescriptions for Sertraline from June 2019 through to April 2020.

January 2020 – April 2020.

84. The GP records confirm further prescriptions for Sertraline at 100mg in January 2020 March and April 2020 but no further prescriptions until after the relevant date i.e. no further prescription after April 2020 until 4 August 2020 (p.70).

Early 2020 – August 2020: reduction in Sertraline

85. The claimant gave evidence, in response to a question from the tribunal, that he cut down his medication to 50mg in early 2020, "*in around* ***April, May, June, July 2020*****"**. However, in cross examination when asked when in early 2020 he tried to reduce his Sertraline he gave evidence that he could not recall the date. This timescale of cutting back on the medication in around April 2020 is consistent however with the medical records which show the last prescription which the claimant had requested had been requested on 4 April and given to him on the 6 April 2020. I accept the claimant's evidence that he tried again to reduce his medication and that on a balance of probabilities, I find that this was from the beginning of April 2020.

86. His evidence about why he decided to reduce his medication at this time was that;

"*Coping yes, I was in a good state of mind, I had good colleagues who were understanding, very supportive, I was doing ok and had a routine , helps with anxiety, it calmed down and I was managing it a lot more – it motivated me to try and come off the medication."*

87. It was put to the claimant in cross examination that during the gap in the prescriptions (from April to August 2020) he was not just reducing the amount of medication he was taking but he was not any taking medication.

88. Counsel referred to the GP records which showed no requests for Sertraline after April 2020. However, the claimant's evidence is that because he had taken only half a tablet when he had tried to reduce his dosage before, he had some in reserve. It was put to the claimant that this alone would not have provided him with sufficient medication to cover this period. However, the claimant maintained that he had sufficient medication to reduce his dosage to 50mg.

89. There is an entry in the GP records in August 2020 (p. 70) which includes the following;

"*2 years ago had episode of anxiety &OCD, referred to changing minds & found this v*

helpful…"
…

"now feels anxiety is worse"

"Sertraline not issued since April, states is trying to reduce, was having tablet and 50mg
…

Pt states ***had lots leftover*** *from previous as wasn't taking it*"

[Tribunal Stress]

90. The GP notes in August 2020 that the claimant has leftover tablets and the claimant's evidence is that he reduced his medication from November to February and then from April until the results of the thyroid results in June, which would I find leave him with circa 56 tablets left over, potentially sufficient medication to take 50mg/ ½ a tablet from April 2020 through to the end of July 2020. I therefore accept the claimant's evidence that he did not stop taking ant-depressants but had reduced his dosage.

Submissions

Respondent's submissions

91. The respondent submits that the relevant period in respect of determining whether the claimant was disabled, is mid 2018 to early or mid-2020 and that there is no dispute that over that period the respondent appears to have taken into account some absences from work but not it is submitted, absences prior to those set out at page 101.

92. It is submitted that there is only 1 period during the whole piece, from end of 2017 to June/early May 2018 when the claimant was absent from work continually because of the impairments.

93. Mid 2018 to mid-2020, he was not absent for reasons related to the impairments it is submitted. He called the respondent and gave the cause for his absences as sickness or nausea, he was not off directly due to OCD or GAD and he was ready to be discharged from Changing Minds from June 2018. He could now drive again which was the major impact of the OCD.

94. The Changing Minds report (p.46) refers to the treatment being focussed on OCD. There is no mention of GAD. The claimant says CBT was very useful and by the end of it, he was back driving and back to functionality.

95. There is medical evidence from June 2018 which refers to OCD.

96. The claimant has various medical practitioners, but from June 2018 it is submitted that the issue can only be GAD as OCD has fallen away – it has been treated so only the GAD may be in play now.

97. There is no absence correctly attributable to the GAD. The only medication was Sertraline and there are gaps in the medication in the prescriptions. The claimant's own evidence is that he had reduced his dosage (p.72/73) between November 2018 and April 2019 and in early 2020 up to end of July /August 2020. His evidence was he felt

good and he felt appropriate time to ween himself off it. The respondent submits that while it is right to consider he was on medication, the tribunal is in a position to conclude over the 2 specific periods, that he was able to function without medication. He had no other symptoms and no other time off expressly due to OCD.

98. The respondent argues that a continuous period of 12 months of affects is not established.

99. The onus is on the claimant to pass the section 6 test and he has failed to discharge the burden of proof. The documents to not support that beyond June 2018 he was disabled by OCD.

100. The respondent submitted that the period up to dismissal was a period when the claimant stopped taking prescribed medication, he felt good and happy with himself and there was no impact by reason of GAD or OCD.

101. On the issue of likelihood of recurrence, counsel submits that it is difficult when looking back but by July 2020 it, he submits the conditions were not likely to recur and by July the claimant's evidence was, he was in much better shape and able to move forward

Claimants submissions

102. The claimant submits that the respondent did not put to the claimant in cross examination any issues from his witness statement with respect to the benefit of the medication or treatment and he submits the tribunal has the ability to accept the submissions of the claimant. The claimant submits that the claimant was not challenged on the alleged impact of the conditions without treatment and his evidence is that when he stopped taking the medication, he would suffer chronic anxiety.

103. The claimant has been on anti- depressants since 2017 and is still now, in 2021.

104. With respect to the periods when the respondent submits the claimant stopped taking the medication, the claimant has given evidence in relation to both periods that he was attempting to reduce the amount of medication rather than stopping the medication. He had taken half a tablet and accumulated a stock of medication as a result which he could use later. There is no evidence it is submitted, to contradict his evidence on that point.,

105. From November 2017 until now, it is submitted that the claimant has been regularly taking anti- depressants. Mr Morris referred to the NHS Website stating that one of the treatments for OCD is anti- depressant medication which is why the only prescription was for Sertraline. However, Mr Morris accepted that the information he was referring to as existing on the NHS Website, was not in the bundle and nor did the claimant refer to the NHS guidance in his evidence. Mr Morris informed the tribunal that he was not applying to add this evidence and it is therefore disregarded.

106. It is submitted that the claimant is someone reliant on mediation and all his evidence on the impact of the impairments went unchallenged.

107. The effect of the impairments must be judged it is submitted, on the effects of the medication however, Mr Morris referred to this involving the tribunal in some degree of speculation but that the best evidence is the claimant's about the impact of his conditions before he took the medication in 2017 and the impacts are clearly substantial, he referred to his conditions making him in effect a recluse.

108. Mr Morris was invited to make submissions on how the tribunal should approach the issues of which affects arise from which conditions. Mr Morris submitted, largely on the content of claimant's evidence, that the claimant has sought to differentiate between the two conditions, but his evidence is that (in terms of the OCD) without the medication he would catastrophise and it becomes a cycle of negative thoughts, he would not be able to "*move forwarded or do anything* ", he would be in an unbroken cycle of obsessing and worrying. In terms of GAD, he has dealt with it in his witness statement and the test is how he would be affected if he stopped taking the medication. He has given evidence on how he was before he received medication and that evidence is unchallenged.

109. It is submitted that the claimant is not sure if the medication was prescribed for one condition or the other. He was referred to CBT because of the OCD but there is no evidence that Sertraline had nothing to do with the OCD and he referred to the claimant's witness statement (para 14) where he referred in the section dealing with OCD, to having 20 sessions of CBT and taking medication Sertraline. Thus it is submitted he has given evidence that for OCD he was both receiving counselling and taking medication.

110. In response to the submissions, the respondent disputes that there has to be a challenge by the respondent to what the claimant has said in evidence about the medical evidence and the claimant has not discharged the burden on him to establish that he was disabled at the material time.

111. Neither party made specific reference to parts of the Code or Guidance which may be relevant.

The Law

Disability

112. The definition in section 6 (1) Equality Act 2010 (EqA) is the starting point for establishing the meaning of 'disability. The supplementary provisions for determining whether a person has a disability are set out in Part 1 of Schedule 1 to the EqA.

113. The Government has issued 'Guidance on matters to be taken into account in determining questions relating to the definition of disability' (2011) ('the Guidance') under S.6(5) EqA. The Guidance does not impose any legal obligations in itself but courts and tribunals must take account of it where they consider it to be relevant para 12, Sch 1, EqA and ***Goodwin v Patent Office 1999 ICR 302, EAT*.**

114. The Equality and Human Rights Commission (EHRC) has published the Code of Practice on Employment (2015) ('the EHRC Employment Code'), which provides some guidance on the meaning of 'disability' under the EqA and this also does not impose legal obligations but must be taken into account where it appears relevant to any questions arising in proceedings.

115. The Equality Act 2010 contains the definition of disability and provides:

Section 6. Disability

(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.

(2) A reference to a disabled person is a reference to a person who has a disability.

(3) In relation to the protected characteristic of disability—

(a) a reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability;

(b) a reference to persons who share a protected characteristic is a reference to persons who have the same disability.

(4) This Act (except Part 12 and section 190) applies in relation to a person who has had a disability as it applies in relation to a person who has the disability; accordingly (except in that Part and that section)—

(a) a reference (however expressed) to a person who has a disability includes a reference to a person who has had the disability, and

(b) a reference (however expressed) to a person who does not have a disability includes a reference to a person who has not had the disability.

(5) A Minister of the Crown may issue guidance about matters to be taken into account in deciding any question for the purposes of subsection (1).

(6) Schedule 1 (disability: supplementary provision) has effect.

Schedule 1 sets out supplementary provisions including:

Part 1: Determination of disability

Impairment

Long-term effects

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.

(7) If an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day-to-day activities, it is to be treated as continuing to have that effect if that effect is likely to recur.

(8) For the purposes of sub-paragraph (2), the likelihood of an effect recurring is to be disregarded in such circumstances as may be prescribed.

(9) Regulations may prescribe circumstances in which, despite sub-paragraph (1), an effect is to be treated as being, or as not being, long-term.

Effect of medical treatment

5(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 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.

(10) "Measures" includes, in particular, medical treatment and the use of a prosthesis or other aid.

Past disabilities

9(1)A question as to whether a person had a disability at a particular time ("the relevant time") is to be determined, for the purposes of section 6, as if the provisions of, or made under, this Act were in force when the act complained of was done had been in force at the relevant time.

(2)The relevant time may be a time before the coming into force of the provision of this Act to which the question relates.

PART 2 GUIDANCE

Preliminary

10 This Part of this Schedule applies in relation to guidance referred to in section 6(5).

Examples

11 The guidance may give examples of—

(a)effects which it would, or would not, be reasonable, in relation to particular activities, to regard as substantial adverse effects;

(b) substantial adverse effects which it would, or would not, be reasonable to regard as long-term.

Adjudicating bodies

12(1) In determining whether a person is a disabled person, an adjudicating body must take account of such guidance as it thinks is relevant.

The 'Guidance on matters to be taken into account in determining questions relating to the definition of disability' (2011)

116. Relevant provisions which I have considered include the following and I have emboldened certain parts which I consider to be particularly pertinent;

A3. The definition requires that the effects which a person may experience must arise from a physical or mental impairment. The term mental or physical impairment should be given its ordinary meaning. It is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness. In many cases, there will be no dispute whether a person has an impairment. Any disagreement is more likely to be about whether the effects of the impairment are sufficient to fall within the definition and in particular whether they are long-term. Even so, it may sometimes be necessary to decide whether a person has an impairment so as to be able to deal with the issues about its effects.

A4. Whether a person is disabled for the purposes of the Act is generally determined by reference to the effect that an impairment has on that person's ability to carry out normal day-to-day activities....

A5. A disability can arise from a wide range of impairments which can be:

- *impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy;*
- ***mental health conditions with symptoms such as anxiety, low mood, panic attacks, phobias,*** *or unshared perceptions; eating disorders; bipolar affective disorders;* ***obsessive compulsive disorders****; personality disorders; post-traumatic stress disorder, and some self-harming behaviour;*
- *mental illnesses, such as depression and schizophrenia; • produced by injury to the body, including to the brain.*

*A6****. It may not always be possible, nor is it necessary, to categorise a condition as either a physical or a mental impairment. The underlying cause of the impairment may be hard to establish. There may be adverse effects which are both physical and mental in nature.*** *Furthermore, effects of a mainly physical nature may stem from an underlying mental impairment, and vice versa. A7. It is not necessary to consider how an impairment is caused, even if the cause is a consequence of a condition which is excluded. For example, liver disease as a result of alcohol dependency would count as an impairment, although an addiction to alcohol itself is expressly excluded from the scope of the definition of disability in the Act. What it is important to consider is the effect of an impairment, not its cause – provided that it is not an excluded condition. (See also paragraph A12 (exclusions from the definition).)*

Section B Meaning of 'substantial adverse effect'

B1. The requirement that an adverse effect on normal day-today activities should be a substantial one reflects the general understanding of disability as a limitation going beyond the normal differences in ability which may exist among people. A substantial effect is one that is more than a minor or trivial effect. This is stated in the Act at S212(1).

B2. ***The time taken by a person with an impairment to carry out a normal day-to-day activity should be considered when assessing whether the effect of that impairment is substantial.*** *It should be compared with the time it might take a person who did not have the impairment to complete an activity.*

The way in which an activity is carried out B3.

Another factor to be considered when assessing whether the effect of an impairment is substantial is the way in which a person with that impairment carries out a normal day-to-day activity. ***The comparison should be with the way that the person might be expected to carry out the activity compared with someone who does not have the impairment.***

The guidance gives the following example;

A person who has obsessive compulsive disorder (OCD) constantly checks and rechecks that electrical appliances are switched off and that the doors are locked when leaving home. A person without the disorder would not normally carry out these frequent checks. The need to constantly check and recheck has a substantial adverse effect.

Cumulative effects of an impairment B4.

An impairment might not have a substantial adverse effect on a person's ability to undertake a particular day-to-day activity in isolation. However, it is important to consider whether its effects on more than one activity, when taken together, could result in an overall substantial adverse effect.

B5. For example, a person whose impairment causes breathing difficulties may, as a result, experience minor effects on the ability to carry out a number of activities such as getting washed and dressed, going for a walk or travelling on public transport. But taken together, the cumulative result would amount to a substantial adverse effect on his or her ability to carry out these normal day-to-day activities.

The guidance gives the following example:

A man with depression experiences a range of symptoms that include a loss of energy and motivation that makes even the simplest of tasks or decisions seem quite difficult. He finds it difficult to get up in the morning, get washed and dressed, and prepare breakfast. He is forgetful and cannot plan ahead. ***As a result he has often run out of food before he thinks of going shopping again. Household tasks are frequently left undone or take much longer to complete than normal.*** *Together, the effects amount to the impairment having a substantial adverse effect on carrying out normal day-to-day activities.*

Effects of behaviour B7.

Account should be taken of how far a person can reasonably be expected to modify his or her behaviour, for example by use of a coping or avoidance strategy, *to prevent or reduce the effects of an impairment on normal day-to-day activities. In some instances, a coping or avoidance strategy might alter the effects of the impairment to the extent that they are no longer substantial, and the person would no longer meet the definition of disability. In other instances, even with the coping or avoidance strategy, there is still an adverse effect on the carrying out of normal day-to-day activities.*

B9. Account should also be taken of where a person avoids doing things which, for example, cause pain, fatigue or substantial social embarrassment, or avoids doing things because of a loss of energy and motivation.

It would not be reasonable to conclude that a person who employed an avoidance strategy was not a disabled person. In determining a question as to whether a person meets the definition of disability it is important to consider the things that a person cannot do or can only do with difficulty.

In order to manage her mental health condition, a woman who experiences panic attacks finds that she can manage daily tasks, such as going to work, if she can avoid the stress of travelling in the rush hour. In determining whether she meets the definition of disability, consideration should be given to the extent to which it is reasonable to expect her to place such restrictions on her working and personal life.

Effects of treatment B12.

The Act provides that, where an impairment is subject to treatment or correction, the impairment is to be treated as having a substantial adverse effect if, but for the treatment or correction, ***the impairment is likely to have that effect. In this context, 'likely' should be interpreted as meaning 'could well happen'****. The practical effect of this provision is that the impairment should be treated as having the effect that it would have without the measures in question (Sch1, Para 5(1)). The Act states that the treatment or correction measures which are to be disregarded for these purposes include, in particular, medical treatment and the use of a prosthesis or other aid (Sch1, Para 5(2)). In this context, medical treatments would include treatments such as counselling, the need to follow a particular diet, and therapies, in addition to treatments with drugs.*

B13. This provision applies even if the measures result in the effects being completely under control or not at all apparent. ***Where treatment is continuing it may be having the effect of masking or ameliorating a disability so that it does not have a substantial adverse effect.*** *If the final outcome of such treatment cannot be determined, or if it is known that removal of the medical treatment would result in either a relapse or a worsened condition, it would be reasonable to disregard the medical treatment in accordance with paragraph 5 of Schedule 1.*

The following example if given in the guidance:

A person with long-term depression is being treated by counselling. The effect of the

treatment is to enable the person to undertake normal day-to-day activities, like shopping and going to work. If the effect of the treatment is disregarded, the person's impairment would have a substantial adverse effect on his ability to carry out normal day-to-day activities.

B16. ***Account should be taken of where the effect of the continuing medical treatment is to create a permanent improvement rather than a temporary improvement.*** *It is necessary to consider whether, as a consequence of the treatment, the impairment would cease to have a substantial adverse effect. For example, a person who develops pneumonia may be admitted to hospital for treatment including a course of antibiotics.* ***This cures the impairment and no substantial effects remain.***

B17. However, if a person receives treatment which cures a condition that would otherwise meet the definition of a disability, the person would be protected by the Act as a person who had a disability in the past.

Section C: Long-term

The cumulative effect of ***related impairments*** *should be taken into account when determining whether the person has experienced a long-term effect for the purposes of meeting the definition of a disabled person.* ***The substantial adverse effect of an impairment which has developed from****, or is likely to develop from, another impairment should be taken into account when determining whether the effect has lasted, or is likely to last at least twelve months, or for the rest of the life of the person affected.*

The guidance provides two examples:

A man experienced an ***anxiety disorder****. This had a substantial adverse effect on his ability to make social contacts and to visit particular places. The disorder lasted for eight months and then* ***developed into depression****, which had the effect that he was no longer able to leave his home or go to work. The depression continued for five months. As the total period over which the adverse effects lasted was in excess of 12 months, the long-term element of the definition of disability was met.*

A person experiences, over a long period, adverse effects arising from two separate and unrelated conditions, for example a lung infection and a leg injury. These effects should not be aggregated.

Meaning of 'likely' C3.

The meaning of 'likely' is relevant when determining: • whether an impairment has a long-term effect (Sch1, Para 2(1), see also paragraph C1);

- *whether an impairment has a recurring effect (Sch1, Para 2(2), see also paragraphs C5 to C11);*
- *whether adverse effects of a progressive condition will become substantial (Sch1, Para 8, see also paragraphs B18 to B23); or*
- *how an impairment should be treated for the purposes of the Act when the effects of that impairment are controlled or corrected by treatment or behaviour (Sch1, Para 5(1), see also paragraphs B7 to B17).*

In these contexts, 'likely', should be interpreted as meaning that it could well happen.

Recurring or fluctuating effects C5.

The Act states that, if an impairment has had a substantial adverse effect on a person's ability to carry out normal day-to-day activities but that effect ceases, the substantial effect is treated as continuing ***if it is likely to recur****. (In deciding whether a person has had a disability in the past, the question is whether a substantial adverse effect has in fact recurred.) Conditions with effects which recur only sporadically or for short periods can still qualify as impairments for the purposes of the Act, in respect of the meaning of 'long-term' (Sch1, Para 2(2), see also paragraphs C3 to C4 (meaning of likely).*

The guidance sets out the following examples:

C6. For example, a person with rheumatoid arthritis may experience substantial adverse effects for a few weeks after the first occurrence and then have a period of remission. See also example at paragraph B11. ***If the substantial adverse effects are likely to recur, they are to be treated as if they were continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term.*** *Other impairments with effects which can recur beyond 12 months, or where effects can be sporadic, include Menières Disease and epilepsy as well as mental health conditions such as schizophrenia, bipolar affective disorder, and certain types of depression, though this is not an exhaustive list. Some impairments with recurring or fluctuating effects may be less obvious in their impact on the individual concerned than is the case with other impairments where the effects are more constant.*

A young man has bipolar affective disorder, a recurring form of depression. The first episode occurred in months one and two of a 13-month period. The second episode took place in month 13. This man will satisfy the requirements of the definition in respect of the meaning of long-term, because the adverse effects have recurred beyond 12 months after the first occurrence and are therefore treated as having continued for the whole period (in this case, a period of 13 months).

Meaning of 'normal day-to-day activities' D2.

The Act does not define what is to be regarded as a 'normal day to-day activity'. It is not possible to provide an exhaustive list of day to-day activities, although guidance on this matter is given here and illustrative examples of when it would, and would not, be reasonable to regard an impairment as having a substantial adverse effect on the ability to carry out normal day-to-day activities are shown in the Appendix.

D3. In general, day-to-day activities are things people do on a regular or daily basis, and examples include ***shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities.*** *Normal day-to-day activities can include general work-related activities, and study and education-related activities, such as interacting with colleagues, following instructions, using a computer, driving, carrying out interviews, preparing written documents, and keeping to a timetable or a shift pattern.*

Adverse effects on the ability to carry out normal day-to-day activities D11.

This section provides guidance on what should be taken into account in deciding whether a person's ability to carry out normal day-today activities might be restricted by the effects of that person's impairment. The examples given are purely illustrative and should not in any way be considered as a prescriptive or exhaustive list.

D12. In the Appendix, examples are given of circumstances where it would be reasonable to regard the adverse effect on the ability to carry out a normal day-to-day activity as substantial. In addition, examples are given of circumstances where it would not be reasonable to regard the effect as substantial. In these examples, the effect described should be thought of as if it were the only effect of the impairment. Equality Act 2010 Guidance on matters to be taken into account in determining questions relating to the definition of disability 38

Appendix

An illustrative and non-exhaustive list of factors which, if they are experienced by a person, it would be reasonable to regard as having a substantial adverse effect on normal day-to-day activities.

Whether a person satisfies the definition of a disabled person for the purposes of the Act will depend upon the full circumstances of the case. That is, whether the substantial adverse effect of the impairment on normal day to-day activities is long term. In the following examples, the effect described should be thought of as if it were the only effect of the impairment.

[the following examples appear relevant to this case]

- ***Difficulty going out of doors unaccompanied,*** *for example, because the person has a phobia, a physical restriction, or a learning disability;*

Difficulty using transport; for example, because of physical restrictions, pain or fatigue, a frequent need for a lavatory or as a result of a mental impairment or learning disability;

- *Difficulty entering or staying in environments that the person perceives as strange or frightening;*
- *Behaviour which challenges people around the person, making it difficult for the person to be accepted in public places;*
- ***Persistent general low motivation or loss of interest in everyday activities;***
- *Frequent confused behaviour,* ***intrusive thoughts****, feelings of being controlled, or delusions;*
- *Persistently wanting to avoid people or significant difficulty taking part in normal social interaction or forming social relationships, for example because of a mental health condition or disorder;*
- ***Compulsive activities or behaviour****, or difficulty in adapting after a reasonable period to minor changes in a routine.*

Case Authorities

117. The time at which to assess the disability is the date of the alleged discriminatory act: **Cruickshank v VAW Motorcast Limited 2002 ICR 729** EAT.

118. **Goodwin v Patent Office 1999 ICR 302 EAT**; The EAT set out guidance on how to approach such cases;

"Section 1(1) defines the circumstances in which a person has a disability within the meaning of the Act. The words of the section require a tribunal to look at the evidence by reference to four different conditions.

(1) The impairment condition
Does the applicant have an impairment which is either mental or physical?

(2) The adverse effect condition.
Does the impairment affect the applicant's ability to carry' out normal day to day activities in one of the respects set out in paragraph 4(1) of Schedule 1 to the Act, and does it have an adverse effect?

(3) The substantial condition
Is the adverse effect (upon the applicant's ability) substantial?

(4) The long-term condition
Is the adverse effect (upon the applicant's ability) long-term?

Frequently, there will be a complete overlap between conditions (3) and (4) but it will be as well to bear all four of them in mind. Tribunals may find it helpful to address each of the questions but at the same time be aware of the risk that dis-aggregation should not take one's eye off the whole picture.

119. In **J v DLA Piper (2010 ICR 1052) the Employment Appeal Tribunal ,** presided over by Underhill P, gave important guidance as to the approach to the determination of disability which Employment Tribunals should adopt; at paragraphs 39 and 40 of their judgment the EAT said: –

"39 …. Both this tribunal and the Court of Appeal have repeatedly enjoined on tribunal's the importance of following a systematic analysis based closely on the statutory words, and experience shows that when this injunction is not followed the result is too often confusion and error."

"40. Accordingly, in our view the correct approach is as follows: –

(1), it remains good practice in every case for a tribunal to state conclusion separately on the questions impairment and other adverse effect (and in the case of adverse effect, the questions of substantiality and long-term effect arising under it), as recommended in Goodwin v Patent Office (1999 ICR 302)

(2), however, in reaching those conclusions the tribunal should not proceed by rigid consecutive stages. Specifically, in cases where there may be a dispute about the

existence of an impairment it will make sense, for the reasons given in paragraph 38 above, to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adverse to be affected (on a long-term basis), and to consider the question of impairment in the light of those findings.

(3) These observations are not intended to, and we do not believe that they do, conflict with the terms of the Guidance or with the authorities referred to above…"

120. In **All Answers Ltd v W 2021 IRLR 612, CA, t**he Court held that the EAT was wrong to decide that the tribunal's failure to focus on the date of the alleged discriminatory act was not fatal to its conclusion that the claimants satisfied the definition of disability. The Court held that, following **McDougall v Richmond Adult Community College 2008 ICR 431, CA,** the key question is whether, as at the time of the alleged discrimination, the effect of an impairment has lasted or is likely to last at least 12 months. That is to be assessed by reference to the facts and circumstances existing at that date and so the tribunal is not entitled to have regard to events occurring subsequently.

121. The impairments do not need to be related or interact with each other for their combined effect to be considered: **Ginn v Tesco Stores Ltd EAT 0197/05.** In **Brown v Beth Johnson Foundation ET Case No.1304755/15 B** relied upon the collective effects of the conditions of chronic fatigue syndrome, myalgic encephalopathy, fibromyalgia, hypothyroidism, anxiety and depression. The employment tribunal inferred from the evidence that both the depression and hypothyroidism would affect B's ability to carry out day-to-day tasks '*to some degree'* in the absence of medication, and that she experienced aches and pains which substantially affected her mobility and concentration. The tribunal concluded that the aches and pains — whether by themselves or together with the deduced effects of depression and hypothyroidism — had a substantial adverse effect on B's ability to carry out day-to-day tasks.

Conclusions

122. The claimant presented his case, as set out in the claim form and in his witness statement, on the basis of him having with two conditions; namely Generalised Anxiety Disorder (GAD) and Obsessive Compulsive Disorder (OCD).

The impairment condition

123. As set out in my findings, the claimant experienced a deterioration in his mental health leading up to and culminating in the incident on 24 September 2018. He had always worried, but his anxieties had escalated.

124. There is no need to establish what caused the episode on the 24 September 2017, however I have no reason to doubt the claimant's belief (which was not dismissed by the OH nurse) that several traumatic events may well have been the trigger or been factors.

125. I am satisfied that the claimant suffered with symptoms as set out in paragraph 23 of my findings through to 26, which included panic attacks. I have accepted his account of sweating, shaking, not being able to focus and of the physical pain of those attacks. As described, they are distressing and debilitating.

126. I accept his account of when he says 'it all started' on the 24 September and

how he was unable to drive to work that day, felt sick and gripped with fear and his description of other effects as set out in my findings (paragraph 42 and 43), of his cycle of irrational thoughts, of catastrophising and how his anxiety would spiral out of control such that he would not have the concentration or motivation to activities such as cooking a meal, going shopping, driving or washing himself.

127. The claimant also suffered from obsessive behaviours, which included checking that the door to his home was locked repeatedly when he left and on some occasions did not leave to avoid the anxiety this cause.

128. The claimant would also take longer to travel when driving because he would become anxious about having caused an accident, he would get into a cycle of returning to where he had already driven to check.

129. His GP diagnosed Chronic Anxiety on 25 September 2017. By 1 December 2017 he was referred to counselling services for his obsessive behaviours. By15 February 2018 there is a report referring the main issues reported by the claimant as being consistent with OCD.

130. Based on my findings about the symptoms he was displaying from 24 September until those were controlled by medication and counselling, I am satisfied that the claimant suffered mental impairments (which manifested into mental and physical symptoms) namely GAD and OCD.

131. Mental health conditions with symptoms such as anxiety, low mood, panic attacks and obsessive-compulsive disorders are listed in the Guidance as examples of *impairments* which may give rise to a disability (A5).

132. I am satisfied therefore that the claimant had an **impairment** for the purposes of section 6 EqA namely GAD (or Chronic Anxiety) and OCD and the Impairment Condition is therefore met.

133. The respondent in its submissions, although not formally conceded, did not seek to argue that the claimant did not have those impairments (albeit the respondent does not accept that they had a long term adverse effect onnormal day to day activities).

Adverse effects condition

134. Did the impairment have an adverse effect on the claimant's ability to carry out *normal day to day activities* ?

GAD

135. The claimant's mental health condition is diagnosed as Chronic Anxiety by his GP and referred to as GAD in the pleadings, however the respondent does not take issue with the name given to what is clearly an anxiety condition. This condition had a number of effects.

136. The claimant suffered with low moods and low motivation such that before the medication alleviated his symptoms, he would suffer from a cycle of anxious thoughts which lead him to catastrophise. On a more practical level his irrational thoughts and low mood resulted in a lack of concentration and motivation to do normal activities including cooking and shopping , driving and washing himself. I accept his evidence

about the effects and all those are normal day to day activities .

137. The claimant was not deemed well enough to work for a period of about 8 months during which time he tried medication to deal with the panic attacks, but the medication did not help. The claimant had panic attacks initially on almost a daily basis, they became less frequent but he continued having them until about early 2018 . Those panic attacks were painful and left him shaking and sweating.

138. There were other symptoms which were treated by Changing Minds specifically as symptoms of OCD; the obsessive behaviours including checking doors and driving.

139. His anxieties meant that he had trouble leaving his home. Leaving the house is a normal day to day activity and not being able to or taking a substantially longer time to do so than someone without the condition would take, because of repeatedly checking and rechecking the doors is an adverse effect on what is a normal day to day activity. The MediWright report (para 50 above) referred to the claimant *"constantly returning to carry out checks"* when he does leave the house but that he was fearful of leaving.

140. When he did go out in the car, journeys would take him longer because he would retrace part of his journey to check he had not caused an accident, creating a cycle of anxiety and irrational thoughts and extending the length of his journey and ultimately leading him to avoid driving altogether.

141. I am satisfied that the impairments, both OCD and GAD had an adverse effect on the claimant's normal day to day activities both as separate conditions and together ; persistent low mood, catastrophising/intrusive thoughts, difficulty going out of doors, difficulty driving, loss of interest in every day actives such as shopping and panic attacks.

Were the effects substantial and long term ?

Composite approach/ cumulative effect

142. While the claimant suffers from both conditions it is not necessary to establish they they are related or interact with another for their combined effect to be considered : **Ginn v Tesco Stores**. However, for the reasons set out in my findings (paras 52 a to 55 above) , the impairments I am satisfied, are related, the OCD being the expression or result of his anxious mind. The cumulative effect of related impairments should (Government guidance C2) be taken into account when determining whether the person has experienced a long-term effect.

143. Between 24 September 2017 and 17 November 2017, the claimant had been prescribed medication for panic attacks which did not work and his condition had deteriorated by November 2017 such that he was then prescribed Sertraline, an anti-depressant medication at a dose of 50mg. His anxiety slightly improved a couple of weeks after taking Sertraline.

144. The EqA provides that where an impairment is subject to treatment or correction, the impairment is to be treated as having a substantial adverse effect if, **but for** the treatment or correction, the impairment is likely to have that effect.

145. In this context, 'likely' should be interpreted as meaning 'could well happen'

146. The claimant described how without his medication he would find it difficult to leave the house because of the fear of what may happen. How he would not be able to have a rational thought, the difficulty of preparing food because of the obsessive behaviour over hygiene, how he would find it difficult to drive because of his fears of what may happen. He describes how without his medication he has low mood such that he had general low motivation or loss of interest in everyday activities such as shopping, cooking a meal, washing himself or driving. He describes frequent intrusive thoughts about hygiene and contaminating things and how he cannot think rationally and catastrophises, feeling that his thoughts are out of control.

147. His condition was then brought under control to the extent that he returned to work after **28 May 2018**. By this stage he has been absent from work for 8 months. He would not attempt to reduce his mediation until November 2018.

148. The claimant gave evidence that he was diagnosed with OCD by Changing Minds around February 2018. However, he had presented to his doctor earlier on 25 September 2017 with behaviours which lead them to refer him to Changing Minds for counselling and their diagnosis .

149. During the period from about February 2018 the claimant was undertaking counselling and the effects of that counselling also need to be considered. The claimant was also taking medication which was addressing his underlying anxiety and the claimant's evidence which is accepted, is that without the medication his anxiety would become out of control and his obsessive behaviours would return (see para 45 to 49 above)

150. The treatment (medication and counselling) was successful in treating the obsessive behaviours. The most significant impact of the condition was the restriction on his driving but this had been resolved by **May 2018** when he could by that stage, drive unaccompanied. There continued to be restrictions on his driving, (which is a normal day to day activity), in that he was still anxious. As referred to in the OH report in March 2018 (p.98) his condition was not preventing him driving, but it was recommended that his driving be limited to an hour and consideration given to sites because of his anxiety and the "*shorter the distance the better*". The claimant does not complain that this ongoing limitation caused him any serious difficulties, he does not complain about the restriction in terms of its effects on his daily life, although if required to travel further afield his evidence is that he would drive the journey once or twice in advance, to manage his anxiety.

151. I conclude that from May 2018 therefore, the impact of OCD as a stand-alone condition was no longer such that it was having a significant impact on his normal day to day activities following the counselling, however what I need to go on to consider is what the position would be **but for** the medication. Whether without the anti-depressant medication the OCD impairment was 'likely' from June 2018 (when he was discharged by Changing Minds) to have a substantial effect on his day to day activities.

152. There is no evidence that the counselling which ended in June 2018 had cured the OCD.

153. As set out in my findings, I have heard and accepted the claimant's own evidence about what the impact of stopping the medication would be on not only his GAD but on the OCD symptoms which he considers, and I accept, are 'interlinked'.

Medication/ Counselling

154. The claimant had been given coping mechanisms by Changing Minds and I have found that it was reasonable for him to continue to employ them to manage any OCD symptoms. He did not give evidence that those coping strategies caused him any difficulties or that there were circumstances in which they failed to assist. While the behavioural tools helped to manage they did not provide a permanent solution, to his OCD.

155. I have considered the report from Ms Gale of OH and her observations about the escalation of the anxiety and this **resulting** in the obsessive behaviours (para 51).

156. The Guidance C6, provides that if the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term.

157. The first effects of the OCD, if taken to be 24 September 2017, would need to have recurred after 24 September 2018 to qualify as long term. There is no evidence of the OCD itself causing a significant adverse effect on the claimant's day to day activities **after** the **24 September 2018.**

158. By May 2018 the claimant was reducing his medication, was back at work and had tools to assist with managing the OCD and by June 2018 had been discharged by Changing Minds after they had helped him to control the anxieties and fears which had prevented him from driving . He was told however that for the next 6 months he needed to consolidate the treatment before any referral back to them.

159. Counsel for the respondent submits that as there is no mention of OCD from June 2018, from this date the OCD is "no longer in play". If that is correct, the effects of the OCD are not long term and counsel would invite me to therefore discount OCD as a disability under section 6. However, I do not accept that this can be correct. I do not accept that when dealing with two conditions so closely connected, the OCD being (as set out in my findings) a result of the escalation of the anxiety disorder, that the OCD and its effects have no relevance to the disability question after June 2018.

160. It is correct that there is no medical evidence which deals specifically with OCD from June 2018 and that OH refers to the tools the claimant now has to manage OCD and that they were proving successful however, the claimant was also during the period up to June 2018 regularly taking 100mg of anti- depressant medication to control his underlying anxiety.

161. I have found that the OCD and the GAD are related conditions on the evidence and on a balance of probabilities, symbiotic in the sense that the OCD **results** from an escalation of the anxiety condition if not controlled.

162. The effects of the OCD itself, the claimant describes as compulsive behaviours which relieve the anxiety he feels, but without treatment quickly consume his life and result in him doing the same thing for hours or not being able to stop checking something.

163. As with all such cases where there is unfortunately an absence of medical evidence from the claimant to cover all the salient matters to be considered by the tribunal, I need to consider carefully whether there is sufficient evidence from which to make a finding .

164. What I have been presented with is a credible and thoughtful witness, who I accept was giving his honest account of his condition and its effects. His evidence is that he knows how he feels when he takes his medication at different times of the day and he gave evidence about what the effects of not taking the medication would be. His evidence about the effects was not limited to any particular period in time but the ongoing situation from the date he started taking the medication up to the date of the hearing.

165. There is no medical evidence to support his oral evidence on the effects of not taking the medication, and I have considered that he was reducing the medication for several months from April to August 2020 with a view to at some time coming off the medication, however he was still taking a daily dose of 50mg for many months (April to August) even in circumstances where he was working in a supportive environment. I accept that this was because he felt he still needed it.

166. The claimant is someone who was concerned about remaining on medication and attempted to reduce the amount he was taking but who had nonetheless felt the need to continue taking it following his return to work. He engaged actively with counselling and found the sessions helpful and was employing the management tools given to him. The effects of not taking the medication completely he describes as thought patterns which escalate into obsessive behaviours. I have accepted his evidence that if his anxiety is not controlled, he cannot think rationally and cannot for example employ the behavioural tools to manage his panic attack, which he would otherwise be able to do . He describes suffering some symptoms even with medication but these are far worse without medication.

167. I have no reason not to accept the claimant's evidence that if he had stopped taking the medication, he would suffer the effects he described (see para 41-48) based not only on his symptoms before the medication but on the symptoms he still experiences when he takes his medication later in the day. There was nothing in the cross examination of the claimant that gave me cause to doubt the veracity of his evidence on this point.

168. I do not accept the respondent's submission that the tribunal is able to conclude that over the 2 periods when he *reduced* his dose of medication, he was able to function *without* medication. There is no basis for such a finding on the medical evidence as presented or on the claimant's own evidence.

169. The first occasion he reduced his medication was in November 2018, but he resumed the full dose in February 2019 after an upsetting life event. This was a car accident in which he does not allege he was seriously hurt and only had a couple of days off work. As a result of this incident, he clearly felt he could not cope on only 50mg of anti-depressants and immediately doubled the dose back to 100mg.

170. There is no medical evidence to suggest that the claimant was able to function with no medication at all and that is not consistent with the doctor still prescribing 100mg of anti- depressant medication. It is also not consistent with the claimant's own evidence. The GP records confirm that the doctor was still prescribing the full dose of Sertraline to the claimant up to April 2020 and it was not prescribed after that date, not because the doctor did not consider he required them but because he was trying himself to reduce the amount he was taking.

171. I am satisfied that the specific obsessive behaviours, if they were treated as effects of the OCD as a separate condition from GAD, had a significant adverse effect on normal day to day activities in their own right as are the other effects as set out in

my findings, associated with the GAD . However, it is also appropriate to consider the cumulative effect of both conditions (GAD and OCD) given the nature of the conditions and the symbiotic relationship between them. For completeness I have addressed in my conclusions the position treating the conditions both as separate conditions and taking into account the cumulative/ composite approach.

172. I conclude therefore as follows;

- That the substantial adverse effects of the GAD and the OCD started on 24 September 2017.

- That as at 1 July 2018; (the start of the relevant period), the substantial adverse effects of the GAD and OCD had not lasted 12 months however, it was *likely* at that time (in that it could well happen), that the total period which the claimant would continue to suffer the substantial adverse effects of;

  i) GAD as a standalone condition
  ii) GAD including the cumulative effects of the symptoms associated with the related condition of OCD; and
  iii) OCD as a stand-alone condition

  Were likely to be at least 12 months i.e. the substantial adverse effects would continue to at least to 24 September 2018 (when discounting the effects of the medication) which would mean that the conditions qualify under the long-term condition.

- As at 24 September 2018; the substantial adverse effects of i), ii) and iii) above, had lasted for 12 months, when discounting the effects of the medication.

- The substantial adverse effects of i) ii) and iii) above, continued throughout the relevant period i.e. continued to 30 June 2020 when discounting the effects of the medication.

- I am satisfied the impairments, had a substantial adverse effect on the claimant's day to day activities (when discounting the effect of the medication) such that he qualified as a disabled person due to both conditions (separately and considering the cumulative effect of the two), throughout the entire duration of the relevant period.

173. The claimant was a disabled person throughout the relevant period by reason of Generalised Anxiety Disorder and Obsessive-Compulsive Disorder.

174. The claimant's claim that he disabled person for the purposes of section 6 of the Equality Act 2010 is well founded and succeeds.

175. I make no finding on whether the periods of absence during the relevant period were arising out of the disability. There was insufficient evidence before me to make that finding and in any event, that is a matter which should be determined at the liability hearing.

Orders

176. The case will be set down for a 90-minute telephone preliminary hearing to

make case management directions.

Employment Judge Broughton

27 August 2021