Case Numbers: 2302208/2020 and 2302349/2021

EMPLOYMENT TRIBUNALS
BETWEEN

Claimant		***Respondent***
Mr T Allan	**AND**	Churchill Retirement Living Limited

OPEN PRELIMINARY HEARING

HELD BY CVP **ON** 20 and 21 September 2021

EMPLOYMENT JUDGE TRUSCOTT QC

Appearances

For the Claimant: Ms H Platt of Counsel

For the Respondent: Mr S Wyeth of Counsel

JUDGMENT on PRELIMINARY HEARING

The claimant has not established that he was disabled on account of high blood pressure and/or anxiety and depression at the relevant time in accordance with section 6(1) of the Equality Act.

REASONS

Preliminary

1. At a preliminary hearing on 19 March 2021, this Open Preliminary Hearing was listed to address whether the claimant is disabled in terms of the Equality Act in respect of high blood pressure and/or anxiety and depression. A more detailed list of issues for this hearing was agreed between the parties and is set out at paragraph 4. The respondent accepted that the claimant is disabled by reason of his back condition and that the respondent knew about this condition at the material time and from May 2019.

2. Other matters for consideration at this hearing have been dealt with in Case Management Orders which have been issued separately.

3. The claimant was represented by Ms H Platt, barrister. He confirmed that his disability impact statements [1-11, 34-41 and 42-44] constituted his evidence. The respondent was represented by Mr S Wyeth, barrister. Both counsel made submissions to the Tribunal, the legal submissions made by Mr Wyeth were accepted as legally accurate and applicable by Ms Platt. Ms Platt provided written submissions in addition to her oral submission. There was a bundle of documents to which reference will be made where necessary. The references in this judgment are to page numbers in the electronic bundle.

4. **Issues for this hearing**

Was the Claimant disabled at the material time pursuant to section 6 Equality Act 2010 by reason of:
high blood pressure;
mental health condition of anxiety and depression.

More specifically at the material times stated below:
were these conditions impairments?
did either impairment separately or cumulatively have a substantial adverse effect on the Claimant's ability to carry out normal day-to-day activities?
If so, is that effect long term? In particular when did it start and has it lasted or was it likely to last at least 12 months?
What measures were being taken to treat the impairments and but for those measures would the impairment be likely to have a substantial adverse effect on the claimant's ability to carry out normal day-to-day activities?

The Claimant says the material time in respect of his said disability of high blood pressure is January 2020 to his dismissal on 8 April 2021.

The Claimant says the material time in respect of his said disability of anxiety and depression is January 2020 to his dismissal on 8 April 2021.

It is accepted that the Respondent had knowledge of the Claimant's conditions:
high blood pressure since November 2019; and
anxiety and depression since November/December 2019.

5. In relation to his high blood pressure, the claimant relies on the following as part of his evidence:

Date	Event	Page (pdf)
1989	Hypertension	65
6.04.1989	Hypertension	80
12.04.1989	Hypertension	69
22.01.2004	Angina	61
23.01.2004	Chest pain on mild exertion / moderate exercise	84

28.01.2004	Hypertensive disease	60
13.02.2004	Tensipine MR causes reduction in blood pressure Hypertension	59
7.04.2004	Chest pain on moderate exercise	83
27.05.2004	Tensipine MR causes reduction in blood pressure	59
16.08.2004	Tensipine MR causes reduction in blood pressure	64
15.06.2007	Tensipine MR causes reduction in blood pressure	57
18.10.2007	Tensipine MR causes reduction in blood pressure	57
20.11.2007	Tensipine MR causes reduction in blood pressure	57
28.03.2008	Tensipine MR causes reduction in blood pressure	56
25.06.2008	Tensipine MR causes reduction in blood pressure	56
12.11.2008	Tensipine MR causes reduction in blood pressure	55
17.02.2009	Tensipine MR causes reduction in blood pressure	55
18.06.2009	Tensipine MR causes reduction in blood pressure	54
19.08.2009	Tensipine MR causes reduction in blood pressure	54
16.10.2009	Tensipine MR causes reduction in blood pressure	54
23.10.2009	Tensipine MR causes reduction in blood pressure	54
15.12.2009	Tensipine MR causes reduction in blood pressure	53
22.12.2009	Tensipine MR causes reduction in blood pressure	53
16.03.2010	Tensipine MR causes reduction in blood pressure	53
4.06.2010	Tensipine MR causes reduction in blood pressure	53
27.08.2010	Tensipine MR causes reduction in blood pressure	52
12.10.2010	Tensipine MR causes reduction in blood pressure	52
2.12.2010	Tensipine MR causes reduction in blood pressure	52
15.12.2010	Tensipine MR causes reduction in blood pressure	52

11.02.2011	Tensipine MR causes reduction in blood pressure	51
2013	been looked after by Dr Patel. History of hypersensitive heart disease – heart muscle has maladapted secondary to blood pressure	24
5.12.2013	Letter Kent and Canterbury Hospital – uncontrolled hypertension	62
20.05.2014	Tensipine MR causes reduction in blood pressure	181
22.05.2014	C seen by Dr Nicholas Moran, Consultant Neurologist	129
12.05.2017	Tensipine MR causes reduction in blood pressure	50
26.06.2017	Tensipine MR causes reduction in blood pressure	50
1.08.2017	Tensipine MR causes reduction in blood pressure	50
15.11.2017	*Hypertens monitor*	50
13.12.2017	*Make appointment for a BP check*	50
30.10.2019	*Nifedipine*	49
7.11.2019	Blood pressure reading 139/89. Hypertension. *Nifedipine* is a medicine used to treat high blood pressure.	49
17.02.2020	Referred to Dr Patel, warrants further assessment in light of blood pressure and clinical profile	87
16.03.2020	*Med 3 – blood pressure – not fit for work*	132
19.03.2020	*Dr Patel appointment – shows hypertensive changes*	89; 133
13.01.2021	*Dr Patel – stress and anxiety negatively impact on blood pressure control*	98
12.02.2021	*Dr Patel, change meds - Olmesartan*	100
2.06.2021	*Dr Patel appointment – BP high – not quite there with reducing BP*	159

6. In relation to his anxiety disorder / depression, the claimant relies on the following as part of his evidence:

Date	Event	Page (pdf)
3.09.1982	Anxiety. Very depressed	70
6.09.1982	Depressed	69

15.08.1986	Depressed	69
19.08.1986	Psychiatric care – admitted in emergency ward	79
8.02.1995	Counselling	81
14.02.2000	Medical report Dr Sharmala Moodley Panic attacks, anxiety disorder	71
28.02.2000	Seeing counsellor, concentration still bad. Anxiety disorder.	67
15.01.2001	Seeing Dr Paul Mallett, consultant psychiatrist	68
28.01.2001	Anxiety Depressive illness	68
22.03.2001	Seeing Dr Paul Mallett, consultant psychiatrist	66
22.05.2014	Amitriptyline (drug for anxiety and depression). Trial of Pregabalin (used to treat anxiety)	63
20.04.2017	Stress at work related – patient has made appointment with consultant psychiatrist who he has seen several years ago (Dr Mallett)	50; 175
20.02.2020	Feels bullied exhausted and harassed. Idea self harm, asking for counselling	167
16.03.2020	Med 3 - work related stress – not fit for work	132
16.03.2020	Work related stress	167
28.04.2020	Work related stress	166
June 2020	Seen by Dr Mallett as escalating work difficulties, - over arousal and anxiety – blood pressure gone up. Further psychological treatment	157
20.10.2020	Work related stress GP entry	164
January 2021	Seen by Dr Mallett – range of depressive symptoms and anxiety and clear that focus and concentration were affected. CBT recommended.	157
4.03.2021	GP entry – stress – sleep hygiene given and avoid caffein	161
10.03.2021	Dr Mallett – anxiety is escalating and sleep disturbed	104
21.04.2021	Dr Mallett – issues with sleep and anxiety	156
26.04.2021	Dr Mallett letter	157

Findings

1. On 14 February 2000, Dr Moodley summarises the claimant's then mental health condition saying that his condition is likely to be short lived [69]. Up until 22 March 2001, the claimant is recorded as having a number of episodes of depression. The causes are noted in the medical records [63-67].

2. On 23 January 2004, the claimant was referred to the rapid access chest pain clinic [81]. The claimant commenced medication for high blood pressure on 27 May 2004 [56]. This is a different date to that provided by the claimant's counsel which was 13 February 2004.

3. The medical notes for 8 August 2014 narrate:
"Medication requested He would like amitriptyline added to repeat prescription. Takes for migraine."

4. On 20 April 2017, the claimant is noted a suffering stress at work [172]. He was employed by the respondent from 2 October 2018 until 8 April 2021 as a sales executive at its Maidstone site.

5. At paragraph 2 of his first impact statement [1], the claimant says, in relation to his back:
"f. More generally, my movement is restricted, and at times painful, which does impact on all day to day activities.
g. I take medication for pain management and, on advice, attend pilates, yoga and fit classes."

6. At paragraph 3 [1] he says:
"I have a history of hypertensive heart disease…This results in high blood pressure: I have to be careful with physical exertion: for example I cannot run up and down stairs."

7. At paragraph 4ii, he says he suffers from poor sleep [2]. In paragraph 8, he says that in October 2019 he had to lie down in the office because of his blood pressure [3].

8. Paragraph 4 of the impact statement says the claimant has had anxiety since 2017. This was related to the breakup of a relationship [19].

9. On 24 May 2019, the claimant is prescribed what is called a low dose of amitriptyline [for an issue which appears related to his back] [168]. He had previously been prescribed amitriptyline for migraine.

10. On 7 November 2019, he self certified a 3-hour period of sick leave in order to see his GP.

11. The claimant was seen as an outpatient on 2 January 2020 [26]. On 6 January 2020, Mr Jonathan Bull the consultant spine surgeon reported [26]:
"I think it would not be unreasonable as per his suggestion to consider undertaking repeat injection…which gave him significant relief previously…"

12. The claimant was signed off from 14 January to 11 February 2020 with back pain awaiting facet joint injections [10] and did not return to work thereafter.

13. On 27 January 2020, he had a facet joint injection [30]. His next certificate was from 11 February 2020 to 16 March 2020 with back pain under specialist undergoing facet joint injections.

14. On 20 February 2020, the GP notes show history low mood …idea self harm [164]. The reference to work related stress first arises in this discussion.

15. On 6 March 2020, according to the claimant's ET1 [305] at paragraph 3.44 while the narrative is not entirely clear the ambulance crew referred him to hospital. This is not shown on the relevant page of the GP records [164] nor in the GP letter dated 19 March 2020 [86].

16. On 12 March 2020, Mr Jonathan Bull, wrote [31]:

> I saw Mr Allan in outpatient at The Shard on 12th March 2020.
> He has been doing well in terms of his lower back pain, although he still has some pain, which is particularly exacerbated by episodes of driving, which again sounds musculoskeletal in nature, but he has made some improvements following the injections and undertakes regular exercises, but he has not seen any physio at present as he has sufficient experience to undertake things independently. I am delighted with his progress, although I think he will need a phased return to work given the persistent nature of this pain and its intrusion into his activities of daily living and I think this is in hand with an occupational health assessment.

17. The medical certificate from 16 March 2020 to 27 April 2020 narrates cardiology-high blood pressure, work related stress and recovery from facet joint injections [12].

18. On 15 April 2020, the claimant appears to make no mention of work-related stress to his GP [164] but on 24 April 2020 he requests a 3-month medical certificate due to cardiology issues and stress [163]. The GP is only prepared to issue a certificate for a month unless the cardiologist says otherwise. It is not clear why but the GP extends the length of the certificate to 20 July so from 27 April 2020 to 20 July 2020 the certificate narrates work related stress, under cardiology, high blood pressure.

19. On 20 July 2020, the claimant emailed his GP [102] as follows:

> "I'm just emailing in for your attention as I'm not sure whether or not you are doing appointments. My current doctors certificate that you did for me on the 28th of April for three months from the 27th of April to the 20th of July expires today. I am still under the care of Dr Paul Mallett consultant psychiatrist, regarding the effects of work related stress & bullying and am undergoing another counselling session on Tuesday the 31 July. I am awaiting to see Dr Patel, Cardiologist at the BMI Blackheath Hospital now that I believe it has reopened regarding my blood pressure."

20. The claimant is provided with a medical certificate for 20 July 2020 for 3 months narrating work related stress, under cardiology, blood pressure recovering from spinal and orthopaedic treatment and surgery [15]. On 20 October 2020 his GP notes that "…has taken work to court due to work related stress and tribunal is not for 5-6 months and unable to work because of this." [161]. The certificate provided on 20 October 2020 for 6 months narrates work related stress, under cardiology consultant for blood pressure, recovering from spinal and orthopaedic treatment and surgery.

21. On 13 January 2021, Dr Patel wrote [95]:
"To recap. he has a history of hypertensive heart disease where his heart muscle has maladapted secondary to blood pressure. I have looked after him since 2013."

22. On 13 January 2021, Dr Mallett said [16-17] that:
"He contacted me because of an escalation in his background physical health problems, mainly high blood pressure and spinal pain and ongoing difficulties in the work situation in that he had attempted to put some distance between him and his HR Department as far as direct communication was concerned. but he indicated they have continued to contact him directly to a degree that he considered harassing and needed to involve the police… Symptomatically he has poor sleep. constant ruminations about the work situation, associated poor concentration and persistent tiredness. He is anxious and angry at the thought of returning to work to the extent that he considers it would be easier to talk to a complete stranger about his personal problems, than anyone in his work environment. I consider from discussing this with him that he would simply be too overwhelmed. aroused. angry and anxious to return to his previous employers at the current time…The diagnosis therefore is one of a generalised anxiety state with some phobic anxiety features in relation to returning to the specific work place. I am optimistic that with resolution of the difficulties with his current employer and with the continued support of Steve Lynch. he will be able to resolve his anxiety symptoms without the need for long term psychological treatment or medication…"

23. The GP notes for 21 January 2021 record [159]:
Medication Amitriptyline 25mg tablets One To Be Taken Each Day 28 tablet

24. On 6 February 2021, Dr Patel wrote [147]:
"His echocardiogram shows that his heart is structurally and functionally unremarkable with no left ventricular hypertrophy now and normal left atrial size."

25. On 10 March 2021, Dr Mallett reported seeing the claimant and makes reference to him being stressed in relation to tribunal proceedings [101].

26. On 19 April 2021, the claimant requested a 6 month medical certificate [102]:
"I'm contacting you regarding the email that sent to you.
I'm on Mirtazapine & Olmersatan. I've a consultation with Dr Mallett 21/4/21 & Dr Patel May
I'd like my doctor certificate to include latest diagnosis from Dr Mallett:-
Depression anxiety, work related stress. Awaiting Facet Joint Injection. Under Cardiologist for Blood Pressure.
I'm having further facet joint injection Jonathan Bull consultant neurosurgeon at London Bridge Hospital end of May."

27. On 21 April 2020, Dr Mallett noted some improvement in the mood of the claimant [39] and said:

> "…he should have no problems with his day to day functioning or self- care and certainly his capacity to make day to day decisions is not affected, but he is likely to struggle with high level or demanding situations that require for example, multitasking and decisiveness by virtue of his depressive symptoms, which have had an adverse impact on his concentration and motivation. These impairments are unlikely to last for more than 12 months accumulatively, as long as he stays away from the direct involvement with his difficult work situation. and as indicated above they do not affect his capacity to undertake normal day to day activities."

Relevant Legal Framework

28. A person with hypertension is not deemed to be disabled under paragraph 6, Part 1 of Schedule 1 to the Equality Act 2010 (EqA 2010) or the Equality Act 2010 (Disability) Regulations 2010, SI 2010/2128 and whether or not such a person has a disability will therefore be determined in accordance with the definition in EqA 2010, s 6(1), ie whether there is a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. This also applies to anxiety/depression.

29. In these circumstances, disability has to be established in accordance with the provisions of section 6 of the Equality Act 2010 which are not repeated here. These provisions are analysed in great detail in **Igweikw v. TSB Bank plc** [2020] IRLR 267 upon which analysis the Tribunal placed considerable reliance. This case was not referred to by counsel but was drawn to their attention by the Tribunal. The case refers to a number of authorities which were cited to the Tribunal. These are not repeated here.

30. The essence of the enquiry to be carried out was summarised by Langstaff P in **Aderemi v. London and South Eastern Railway Ltd** [2013] ICR 591 EAT:

> 'It is clear first from the definition in section 6(1)(*b*) of the Equality Act 2010, that what a Tribunal has to consider is an adverse effect, and that it is an adverse effect not upon his carrying out normal day-to-day activities but upon his ability to do so. Because the effect is adverse, the focus of a Tribunal must necessarily be upon that which a Claimant maintains he cannot do as a result of his physical or mental impairment. Once he has established that there is an effect, that it is adverse, that it is an effect upon his ability, that is to carry out normal day-to-day activities, a Tribunal has then to assess whether that is or is not substantial. Here, however, it has to bear in mind the definition of substantial which is contained in section 212(1) of the Act. It means more than minor or trivial. In other words, the Act itself does not create a spectrum running smoothly from those matters which are clearly of substantial effect to those matters which are clearly trivial but provides for a bifurcation: unless a matter can be classified as within the heading "trivial" or "insubstantial", it must be treated as substantial. There is therefore little room for any form of sliding scale between one and the other'. (paragraph 14, p 591).

31. A number of additional points arise. If an impairment is being treated or corrected, the impairment is deemed to have the effect it is likely to have had without

the measures in question (EqA 2010 Sch 1 para 5). Faced with evidence of medical treatment, the tribunal has to consider how the claimant's abilities had actually been affected at the material time, whilst being treated, and then to decide the effects which they think there would have been but for the treatment. The question is then whether the actual and deduced effects on the claimant's abilities to carry out normal day-to-day activities are clearly more than trivial (see **Goodwin v. The Patent Office** [1999] ICR 302, per Morison J). **Sussex Partnership NHS Foundation Trust v. Norris** UKEAT/0031/12, concerned the correct approach to the proper consideration of 'deduced effects' of an impairment disregarding medical treatment. The claimant had a physical impairment of Selective IgA Deficiency, a defect of the immune system rendering her susceptible to recurrent infections, but not in itself having any effect on her ability to carry out normal day to day activities. Medication was prescribed to prevent her from getting infections. Absent medication she would be more susceptible to infection. Slade J stated (at para 40) that the EqA:

> 'requires a causal link between the impairment and a substantial adverse effect on ability to carry out normal day to day activities. In many cases that link will be direct. However in our judgment the EqA does not require that causal link to be direct. If on the evidence the impairment causes the substantial adverse effect on ability to carry out normal day to day activities it is not material that there is an intermediate step between the impairment and its effects provided there is a causal link between the two'.

In this case, the EAT said that the ET ought to have asked whether the deduced effect of the claimant's impairment, of suffering more frequent infections, would itself have a substantial adverse effect on her ability to carry out normal day to day activities.

32. In **Woodrup v. London Borough of Southwark** [2003] IRLR 111 CA, Miss Woodrup claimed that if her medical treatment for anxiety neurosis were to stop, her condition would deteriorate and she would be a 'disabled person' for the purposes of the DDA. The Court of Appeal, upholding the decision of the employment tribunal, was of the view that she had not done enough to prove that stopping her treatment would have the relevant adverse effect. The CA made a point of emphasising the 'peculiarly benign doctrine under para 6' and Simon Brown LJ commented 'In any deduced effects case of this sort the claimant should be required to prove his or her alleged disability with some particularity. Those seeking to invoke this peculiarly benign doctrine under para 6 of the schedule should not readily expect to be indulged by the tribunal of fact. Ordinarily, at least in the present class of case, one would expect clear medical evidence to be necessary'.'

33. 'Treatment' can include counselling with a qualified professional: **Kapadia v. London Borough of Lambeth** [2000] IRLR 699 CA.

34. In **McDougall v. Richmond Adult Community College** CA 2008 ICR 431 CA, the Court of Appeal confirmed that the employment tribunal should have determined whether the impairment existed at the time of the acts of alleged discrimination and in **All Answers Ltd v. W and anor** [2021] EWCA Civ 606 CA, the Court of Appeal held that an employment tribunal erred in failing to consider whether the adverse effect of a disability discrimination claimant's mental impairment was likely to last for at least 12 months as at the date of the alleged discriminatory acts. The tribunal is not entitled

to have regard to events occurring after the date of the alleged discrimination to determine whether the effect was likely to last for 12 months. The Court of Appeal allowed the appeal, confirming that following McDougall, the key question is whether, as at the time of the alleged discriminatory acts, 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 the date of the alleged discriminatory acts and the tribunal is not entitled to have regard to events occurring later.

35. In **Elliott v. Dorset County Council** UKEAT/0197/20, the EAT held that the ET did not sufficiently identify the day-to-day activities, including work activities, that the claimant could not do, or could only do with difficulty, to found a proper analysis.

Discussion and decision

36. The Tribunal noted that the parties agreed the issues for the hearing which confirm that there should be concentration on the evidence of disability at the "material time" which was also specified however, the oral submission for the claimant was that he qualified as a disabled person at an earlier stage and remained disabled. The Tribunal noted this submission as relating to depression and considered the evidence in that regard in addition to the identified issues.

37. The evidence for the claimant was provided by his disability impact statements, some supplementary questions, the answers to cross examination questions and re-examination. The respondent attacked the credibility of the claimant. The Tribunal did not consider his evidence to be reliable for reasons set out later.

38. It was repeated several times that the claimant has to establish disability and it is a low threshold. The Tribunal kept these mantras in mind as it tried to gain an understanding of the past and recent medical history of the claimant. The Tribunal was aware that it should consider the evidence relating to hypertension and anxiety separately but also together. It also seemed to the Tribunal that it should not ignore the evidence relating to the claimant's back issue notwithstanding that it was conceded by the respondent as a disability.

Past disability

39. In relation to anxiety and depression, the claimant claimed that disability had been established by the report from Dr Moodley of 14 February 2000 [68] which shows a good prognosis in relation to the panic attack he was experiencing. It was submitted that things did not turn out that way by reference to a note on 28 July 2001, referring to the claimant having anxiety and depression [65] from which it could be concluded that the effect was long term. However, the GP note of 15 January 2001 [65] makes reference to a court hearing, a stressful event. The Tribunal did not consider that these entries without more was sufficient evidence to establish that the claimant had a mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities

40. It was submitted that the prescription for amitriptyline on 22 May 2014 together with his trial of pregabalin and his self referral to Dr Mallett on 20 April 2017 were

relevant. While the Tribunal accepted that amitriptyline is an anti-depressant and pregabalin was prescribed [60], it did not accept the claimant's submission that the latter was for anxiety, it seems to have a wide range of uses including pain relief which might have been related to back pain as indeed does amitriptyline which was prescribed in relation to his back. The Tribunal accepted that the claimant had received counselling but did not consider that such evidence as there was of this added anything to the consideration.

Impairment at the material time commencing in January 2020

41. Counsel for the claimant submitted that high blood pressure, hypertension and hypertensive heart disease were all one and the same. The Tribunal was not confident of this in that control of high blood pressure/hypertension is effected by a drug which relaxes and expands the blood vessels. The effect of the drug is to reduce the high blood pressure which if it was allowed to persist might result in damage to the health of the patient. Hypertensive heart disease, as described by Dr Patel, in paragraph 20 hereof, might suggest that some damage has already been done to the claimant. However, the contents of Dr Patel's report, set out at paragraph 24 hereof, indicates otherwise. On the basis of the available evidence, the Tribunal is unable to find that there is an impairment.

42. The claimant's evidence narrated at paragraphs 5 and 6 attribute the impact on normal day to day activities to high blood pressure. There is reference in the medical records which are not specifically identified here to diet and lifestyle advice in order to reduce his weight which would reduce his blood pressure. If this evidence is taken into account, the impact may not be because of his high blood pressure. Additionally, he is noted as carrying out exercise for his back without difficulty. The Tribunal did not ignore the subsequent events of referral to the chest pain clinic but concluded that it did not have the evidence to determine that the claimant's hypertension was a physical impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities. The Tribunal is not in a position to say what the position of the claimant would have been had he not taken the drug Tensipine or equivalent over the years.

43. The Tribunal considered the evidence in relation to anxiety and depression and what was said in **Herry v. Dudley Metropolitan Council** (set out at paragraph 42 of **Igewige**) in relation to stress. The medical evidence is contained in the fitness to work notes dated 16 March 2020 and 20 July 2020 which refer to "work related stress and anxiety". The Tribunal did not accept that these fit notes alone were sufficient to establish that he had a mental impairment the effect of which was substantial. The medical certificates, after 14 January 2020, were obtained when the claimant was not at work. While he explained why he had work related stress when he was off work, the Tribunal had difficulty in accepting his evidence. The Tribunal also noted that the fitness to work notes narrate work related stress because that is what he reported. Indeed, in relation to the 19 April 2021 request for a medical certificate, he sets out a diagnosis of Dr Mallett which is not discernible from the letters of Dr Mallett.

44. The fact that the absence is described as work related would ordinarily indicate that it is likely that it will cease upon the claimant not attending work and not at all likely

that it would last 12 months or longer. The Tribunal was unable to conclude that the claimant had a mental impairment which has a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities

45. Considering both high blood pressure and anxiety together, the Tribunal got no further in its deliberative process. The certificate provided on 20 October 2020 for 6 months narrates work related stress, under cardiology consultant for blood pressure, recovering from spinal and orthopaedic treatment and surgery. In relation to Dr Mallett's report dated 13 January 2021, it is not clear from this that Dr Mallett understands that the claimant has not been at work for about a year.

46. The Tribunal noted the evidence about the claimant's back issues and could understand, from a common-sense perspective, how this might impact hypertension and anxiety, however the Tribunal was not in a position to draw any conclusion other than the submission by the claimant's counsel that hypertension and anxiety were circular was not correct because it left out of account back pain. Neither counsel spent any time on the effects of the claimant's back problems presumably because disability on this ground was admitted but the consequences of the back problems and the impact on the claimant's day to day activities are substantial and have to be understood in order to identify what effect is attributable to which potential disability.

47. The Tribunal considered the period of absence because of back pain from 14 January 2020 to 16 March 2020. This is a lengthy absence if the facet joint injections have been effective and, if not, the absences are indicative of serious back problems which would be expected to impact substantially on day to day activities. The Tribunal reminded itself of what Dr Bull had said on 12 March 2020, set out at paragraph 15 hereof. It found itself unable to identify the effect of either high blood pressure or anxiety or both on the claimant when there is such a substantial effect from the back pain.

48. The Tribunal has concentrated on the high blood pressure, anxiety and spinal issues but the medical records show that the claimant has a more complicated medical history than solely those issues and it might have been that those issues impacted one or more of the matters the Tribunal is considering.

49. In **Igweike**, at paragraph 36, the EAT narrates the contents of paragraph 38 in **J v. DLA Piper** EAT, it continues and sets out that (at paragraph 41 of DLA): "We have to rely primarily on the inference that can be drawn from such medical evidence as there is, together with the Guidance and the case law and the general knowledge acquired from our own experience of depressive illness in the field of employment law and practice." This Tribunal has long experience in this area and is not in a position to compare itself with the depth of experience of the Tribunal in DLA but this Tribunal tended to the view that the outcome of a claim should not be dependent on the knowledge a Tribunal brings to the issue of depressive illness, the evidence should be adduced and be comprehensible by any Tribunal in order to provide a basis upon which to draw an inference. The Tribunal considered that it would have benefited from an analysis of the records by a medically qualified person. The respondent proposed this but the claimant did not agree. The respondent's application to the Tribunal for

such a report was rejected for reasons this Tribunal is unaware of. The claimant was content that this issue was determined on the basis of the available evidence.

50. The Tribunal found that the claimant had not established that he was disabled because of hypertension and/or anxiety/ depression. It considered that what was said at paragraph 50 of **Igweige** was apposite to this case, as it was for the claimant to establish disability, it was his obligation to provide such evidence to establish the disability or disabilities claimed.

EMPLOYMENT JUDGE TRUSCOTT QC

Date 20 October 2021