EMPLOYMENT TRIBUNALS (SCOTLAND)

5 **Case No: 4106407/2019**

Held in Glasgow on 17 October 2019

Employment Judge M Kearns

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Mr A Higgins	**Claimant** **Represented by:** **Mr W McParland** **Solicitor**

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White House Products Limited	**Respondent** **Represented by:** **Mr N MacDougall** **Advocate**

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30 **JUDGMENT OF THE EMPLOYMENT TRIBUNAL**

The Judgment of the Employment Tribunal is that the claimant has not established that he was disabled as defined in the Equality Act 2010 at the relevant times.

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REASONS

1. The claimant was employed by the respondent as an order processor from 29 September 2008 until his dismissal on 20 December 2018. On 2 May 2019, having complied with the early conciliation requirements he presented an

application to the Employment Tribunal in which he claimed unfair dismissal and disability discrimination.

Issue for determination at Preliminary Hearing

5 2. The claimant's disability status is in dispute. The case was accordingly set down for a Preliminary Hearing on the following issue: *"Whether the claimant was disabled according to the definition in section 6 of the Equality Act 2010 at the relevant times."*

3. The recent events set out in the ET1 spanned a period between 11 July 2018 and 10 15 March 2019. However, during discussions at the outset of the hearing Mr McParland helpfully focused the 'relevant times' for today's purposes as the period between October and 20 December 2018.

Evidence

15 4. The parties each lodged a bundle of documents ("C" and "R" respectively) and referred to them by page number. The claimant gave evidence on his own behalf.

Findings in Fact

5. The following material facts were admitted or found to be proved:-

20 6. The respondent is a family business engaged in the distribution of hydraulic equipment. The claimant was employed by the respondent as an order processor from 29 September 2008 until 20 December 2018.

7. In or around 2008 the claimant's father died after a fall. The claimant experienced 25 low mood after his father's death but used various coping mechanisms such as walking, physical exercise and talking to his partner. On 13 September 2011 the claimant attended his general practitioner. The entry in his GP notes (C9) reads as follows: *"History - thinks he is getting depressed again, doesn't know why, had had a holiday at the start of July, didn't feel good going back to work, in work for* 30 *hydraulic company in PG, off alcohol for 3 years now, is very busy at work and*

pretty stressed at work, feels as if gives everything at work then has nothing to give at home, tired and can't be bothered and often can't see the point but never considers DSH, often thinks of father's death, tired and no energy and drinking a lot of fluids ie about 2-3 litres of water daily, long discussion, scored 13 on phq -9, has been depressed in the past and recognises that this is how he felt, wouldn't go back to alcohol but has antabse in house just in case. Examination O/E - BP reading affect ok today". [I was not referred to any previous entries relating to depression or mental health problems, nor were any referred to in the impact statement.] This visit on 13 September 2011 was recorded as a "depressive episode" in the claimant's GP record (C3). It is not clear how long the episode lasted. The claimant was prescribed the antidepressant fluoxetine hydrochloride for 28 days. However, there was no record of any repeat prescriptions and no further entries in his GP notes regarding depression or associated mental health problems again until 12 October 2018.

8. On 13 May 2018 the claimant suffered a head injury after slipping on grass outside his partner's house. He was off work for two months.

9. In July 2018 the claimant returned to work, but he began to experience difficulties in his relationship with his manager. The claimant's perceived workplace stressors began to cause him anxiety. His sleep became disturbed leading to tiredness and fatigue. The claimant's appetite diminished. He suffered panic attacks. These involved pins and needles, palpitations and erratic breathing.

10. On 2 September 2018 the claimant took a deliberate overdose of Co-codamol with alcohol while at home with his partner after an argument with his partner whilst he was intoxicated (C15). He was taken to hospital.

11. On Friday 12 October 2018 the claimant was late back from his lunch break. On his return, he went into the kitchen to heat up his food. His manager came into the kitchen and told him off robustly for his timekeeping. The claimant had a panic attack and left the building. He telephoned his partner and had an argument with her about what he had just done. The claimant consumed alcohol and formed an

intention to throw himself into the Esplanade in Greenock. He walked out of his house dressed in a T shirt, shorts and a pair of slippers. The claimant's partner telephoned the police who intercepted him at 18:35 pm and took him to the Emergency Department at Inverclyde Royal Hospital (C12) where he reported that he felt suicidal. A nursing assessment was made: *"Patient c/o depression, now feeling suicidal, has not made plans. Hx overdose of co-codamol 1/12 ago".* The claimant was discharged at 22:25 hours the same night into the care of his partner with follow up by the primary care team.

12. On Monday 15 October 2018 the claimant was seen by his GP. The GP's notes record: *"History - in with partner - see previous hospital admission with OD and A&E letter from weekend. Work problems - issues with boss ongoing.....going through divorce proceedings and has had no access to child in a year, and potential that moving to Ayrshire with mum. ongoing issues at work and feels given the problems with boss can't return at present, walked out of work on Friday after an incident. On Saturday left the house with the intent to go to the Clyde, had had a few drinks, partner called the police, no current active suicidal plans but still has thoughts and can remain safe with partner.....says mood been low for a while now and inc anxious but reluctant to get help in case was used against him at work, sleep terrible just now and appetite variable. No suicidal ideation at present but given hx HI ask for CRS* [Community Response Service] *involvement. Aware to contact ourselves/ooh* [Out of Hours service] *etc if situation changes before sb CRS."* The record showed that the claimant had been prescribed Citalopram Hydrobromide Tablets 20mg, one tablet to be taken per day. Sleeping tablets were also prescribed. The claimant gave permission for his GP to discuss matters with his partner when required. The claimant was signed off sick until 29 October 2018 with a diagnosis of low mood and anxiety (C5).

13. The following day, on 16 October 2018 the claimant was referred urgently by his GP to the Inverclyde Community Mental Health Team Community Response Service ("CRS"). On the referral letter (C15) the claimant's presenting complaint was described as: *"low mood anxiety and suicidal ideation".* The comment section

reported the claimant's deliberate Co-codamol overdose on 2 September 2018 and described how during the previous weekend (12 October 2018) he had been taken by the police to Inverclyde Royal Hospital Emergency Department having been intercepted by them intending to jump in the Clyde. His personal and work circumstances were referred to. It was reported that he denied any current suicidal ideation but that he was concerned as to whether he could remain safe. His sleep was reported to be "awful" and his appetite "varied". The GP stated that she had given the claimant a short course of Zopiclone to help improve his sleep and started him on Citalopram 20mg.

14. On 17 October the GP telephoned and spoke to the claimant's partner. The records state: *"History - spoke with Jeanette - Alastair had said this was fine at consultation on Monday. Has CRS review tomorrow at Crown House at 3pm. Received a letter from work today re disciplinary action. Commenced on tabs and no sfes. Taking one zopiclone - knows can take 2 if not effective at low dose. No further suicidal ideation reported. Await CRS review and plan".*

15. On 18 October 2018 the Community Response Service ("CRS") Mental Health Team saw the claimant for an assessment. In a letter dated 19 October 2018 (C18) they reported: *"He has been abstaining from alcohol since the 12th October and appears to be willing to remain abstinent at this time. His [sic] is aware of the detrimental effects of alcohol on his mood and impulsivity. His partner is supporting him with this. He has commenced on antidepressant medication and is concordant with this. On assessment there was no role at this time for the Community Response Service. He denied any ongoing suicidal ideation or intent. He has been given contact details for Breathing Space and Samaritans should he require urgent support. He is aware that he can be re-referred to CRS should he require intensive support in future. He was also advised that he can self-refer to the Primary Care Mental Health Team for input in future if he requires support."*

16. During this period, the claimant suffered from low mood, panic attacks and anxiety. If he was In the house on his own, he would stay in bed late. Sometimes he would not eat, wash or get dressed. He was not sleeping properly and this

affected his motivation. He would have good days and bad days. On a bad day the claimant would not get out of bed or talk to friends or family. On a good day, he would get up in the morning and try and get himself into a routine. If he succeeded in having a shower and getting himself something to eat, this would take longer than usual. For example, motivating himself to have a shower might take up to an hour. Even if he managed to get to sleep using sleeping tablets, the claimant would wake at 2 or 3am and be unable to get back to sleep. The claimant was experiencing between 2 and 6 panic attacks per day.

17. The claimant next consulted his GP on 29 October 2018. The record stated: *"History - with wife - remains very anxious and poor sleep but mood no worse. No further self-harm attempts. Fleeting negative thoughts but supportive partner. Work stress ongoing and has meeting today. Sleeping tabs not helping sleep and making drowsy in moms so will reduce back to x1 node prn. Good compliance with citalopram. Examination - anxious but good rapport and no TSH* [thoughts of self-harm]. *Comment - c/t hopefully will start to reduce anxiety and reduce sleep, tel consult/appt 2 weeks re symps + for rx.Additional - eMED3 (2010) new statement issued, not fit for work FitNote.pdf, (Diagnosis: low mood and anxiety; Duration: 29/10/2018 - 12/11/2018)/* He was signed off with a further fit note until 12 November 2018.

18. Also on 29 October 2018 the claimant was referred to the respondent's Occupational Health provider (C5). The 'reason for the referral' section explained the background and stated: *"We are suffering an increasing level of absence, a poorer level of productivity. We therefore are needing to see whether Alasdair Higgins can undertake the role expected for him in the long term. If not why not and what can be done to rectify the weaknesses if they are medically related."* (R6)

19. The claimant next consulted his GP on 12 November 2018 and was signed off again until 26 November. The record stated: *"History - with wife - had a bad weekend with low mood and tsh* [thoughts of self-harm] *but no tsh today, triggered by work meeting with his boss who is not acknowledging the bullying*

allegations, taking citalopram nocte instead of mane. Examination - anxious and low but good rapport with no tsh. Comment - try to increase citalopram to 30mg and take mane - see 2 weeks, sooner if worse and partner has CRS team contacts. Medication - Citalopram Hydrobromide tablets 10mg 28 tablet ONE TO BE TAKEN EACH DAY IN ADDITION TO 20MG Additional - eMED3 (2010) new statement issued, not fit for work FITNote.pdf (Diagnosis: low mood and anxiety; Duration: 12/11/2018 - 26/11/2018)"

20. The respondent's Occupational Health Advisor issued his report (R13) on 19 November 2018. Under the heading 'problem', the advisor stated: *"Alasdair comments that he is experiencing anxiety, low mood, sleep disruption, fatigue and poor motivation that he attributes to conflict with his manager. I understand that there is a disciplinary issue ongoing. At present Alasdair is receiving appropriate medication from his GP for his symptoms and this was increased one week ago. He comments that he is beginning to feel some improvement in his symptoms and he is being reviewed by his GP every 2 weeks."* In the 'Recommendation' section the advisor had written that the claimant was not fit for work as at the date of the letter, but that he would expect to see an improvement over the next 2 - 3 weeks that would allow the claimant to return to work should the perceived workplace conflict be resolved.

21. The claimant was seen again by his GP on 26 November 2018. The record stated: *"History -r/v mood a little better, ongoing work issues although hr meeting went better than expected last week. His bullying allegations may lead to tribunal but awaiting outcome, not ready for return... .thinks citalopram 30 mg helping more. Examination - slightly less anxious, mood slightly brighter, no negative thoughts... Medication - Citalopram Hydrobromide Tablets 20mg".* The claimant was again signed off sick. His GP continued to sign him off with consecutive fit notes until 10 June 2019.

22. On 29 November 2018 the claimant took an overdose of citalopram and was admitted to Inverclyde Royal Hospital. He was seen by the Psychiatric Liaison Service, Liaison Psychiatric Nurse Ann Weir on 30 November 2018. She reported

by letter dated 6 December as follows: *"Thank you for referring the above gentleman to the Psychiatric Liaison Service. I met with him at J North on 30.11.18 following his admission the previous evening with an overdose of Citalopram taken whilst heavily under the influence of alcohol. Alasdair said that he has been struggling with a variety of stresses recently including currently being on sick leave from work following an altercation with his manager. He reports being very badly bullied at work and currently has an employment advisor assisting him with the situation. Unfortunately whilst he is off work, he is only receiving statutory sick pay and is struggling to make ends meet. Finally he is also in the process of getting divorced and this will hopefully be finalised in the next week or so. On the day of the overdose he had been home alone and thinking about all his issues. He had had a recent appointment with Occupational Health and was not entirely satisfied with the content of the report. He began to worry about this and realising he had some alcohol at home decided to drink it. This led to an argument with his girlfriend over the telephone and he admitted that he was feeling very sorry for himself. He impulsively took overdose and as soon as he had taken the tablets, he regretted his actions. He told his girlfriend who phoned an ambulance and he was happy to come to hospital and accept treatment. Today he described relieved to be alive and hopes that this will 'draw a line under things".*

Alasdair had recently been assessed by CRS and also by Out of Hours psychiatric services. At both those assessments it was identified that he did not have any real plans for suicide however he did appear to me misusing alcohol. Today Alasdair admits he has always been a heavy drinker and there have been periods in his life when he has misused alcohol. He said that he actually stopped drinking about six weeks ago when the situation at work arose and would not have touched alcohol had it not been available in his house. He said that his girlfriend has since removed all the alcohol from his house.

Today at assessment he presented as euthymic and reactive. He made good eye contact and a rapport was easily established. He did not appear to be depressed

significantly but instead under a significant amount of stress due to the situation at work. He does however appreciate the help he is receiving with his situation. We discussed what support might be useful to him on discharge from the medical ward. Although he was not very keen to engage with alcohol services today, he has been involved with them in the past and is aware of the procedure for self-referring. He is hopeful that he can maintain abstinence without their support but may contact them in the future if this does not prove possible. He stated that he would like to access one to one counselling and I therefore provided him with the contact details for Primary Care Mental Health Team and also advised him about Mind Mosaic, a counselling service available in Greenock. I said that I would copy the PCMHT into this letter but did advise him that they would be unlikely to see him if he was still drinking in a hazardous way.

I was satisfied that he was no longer a risk to himself. He has arranged to stay with his girlfriend on discharge and describes her as extremely supportive. I was happy for him to be discharged when deemed medically fit."

23. The next entry in the claimant's GP record was on 3 December 2018 and stated: *"note ~ overdose of citalopram - review appt please".* On 4 December the claimant was seen at his GP surgery. His GP wanted his citalopram dispensed weekly because of his previous overdose.

24. The claimant made a call to the Greenock Out of Hours GP service on 9 December 2018. The details are not in his record. On 17 December 2018 he was seen again by his GP. The note states: *"History - with partner, see recent events - attempted overdose and then drank at weekend. NO alcohol since, no TSH. Not on citalopram and feels a bit better as no side effects. Has not phoned alcohol clinic yet as advised by psychiatry. Has disciplinary meeting this week, they are not supporting his claims of bullying. Examination - anxious but no tsh, good rapport".* The notes commented that the claimant should be seen as an emergency if any 'TSH'.

25. On 19 December 2018 the claimant went to see his GP again ahead of his disciplinary hearing the next day. The record states: *"attending again, wishes letter for work tribunal tomorrow to support chronic depression and recent symps. Clinically no worse today - hand written letter given, copy to notes, thanks. Has alcohol clinic tomorrow and awaits PCMHT input"* His GP, Dr Brogan gave him a hand-written letter (C11) in the following terms: *"Re Alasdair Higgins 23-5-67 ...I am writing with regards to the above named patient. He is suffering from Depression & has recently been admitted with attempted overdose. He has been suffering from Depression since 2011. He is under the care of the primary care mental health team & we are closely monitoring him in the community."* The claimant was referred to the Primary Care Mental Health Team and remained on a waiting list for counselling until February 2019. Since February 2019 the claimant has had counselling every two weeks.

26. The claimant was dismissed at the disciplinary hearing on 20 December 2018. The claimant next attended his GP on 7 January 2019. It was recorded that the claimant had been dismissed and that another fit note had been issued stating that he was not fit for work. The diagnosis given was low mood and anxiety. The claimant was signed off from 7 January to 4 February 2019. The claimant was seen again by his GP on 28 January and then on 8 April 2019. On 28 January the claimant indicated that he still wished to have counselling/CBT and was on a waiting list. He was reported as having poor sleep but not tsh. On 8 April it was reported that his mood was a bit brighter. On 7 May 2019 the GP notes show that the claimant attended for inter alia “Review of Depression”. The note recorded that he had *"tried Citalopram for Depression but history of taking too much”.* He was accordingly prescribed Sertraline Hydrochloride Tablets 50mg one to be taken each morning.

Applicable Law

27. Section 6(1) of the Equality Act 2010 is in the following terms:

"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. "

28. Section 6 is supplemented by Schedule 1. Part 1 of that Schedule deals with the determination of disability and provides, so far as relevant as follows:

"2. Long-term effects

(1) The effect of an impairment is long-term if -

(a) It has lasted for at least 12 months,

(b) It is likely to last for at least 12 months, or

(c) It is likely to last for the rest of the life of the person affected.

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

29. Schedule 1 paragraph 5 provides:

'"Effect of medical treatment

(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.

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

30. Under the Equality Act (Disability) Regulations SI 2010/2128 addiction to alcohol is deemed not to amount to an impairment for the purposes of the statutory definition of disability. However, in considering what amounts to an impairment it is its effect and not its cause that is important, thus, for example, depression or liver disease as a result of alcohol dependency would still count as an impairment.

31. Section 6(5) Equality Act 2010 (“EqA”) empowers a Minster of the Crown to issue guidance on matters to take into account in deciding any question under subsection (1). In 2011 the Secretary of State issued 'Guidance on matters to be taken into account in determining questions relating to the definition of disability'. The Guidance does not impose any legal obligations in itself, nor is it an authoritative statement of the law. However, Schedule 1, paragraph 12 to the Act requires that a tribunal which is determining a person is disabled as defined must take into account any aspect of this Guidance which appears to it to be relevant. I therefore take it into account where relevant below.

Discussion and Decision

32. The definition of disability in Section 6 of the Equality Act 2010 (as supplemented by Schedule 1) raises the following four questions. In Goodwin v Patent Office [1999] IRLR 4 the EAT made clear that these must be considered separately and sequentially.

    (1) Does the claimant have a physical or mental impairment?

    (2) Does that impairment have an adverse effect on his ability to carry out normal day-to-day activities?

    (3) Is the effect substantial?

    (4) Is the effect long-term?

33. Goodwin also emphasised that tribunals and courts should give a purposive construction to the legislation, which is designed to confer protection rather than restrict it. I address each of these questions in turn.

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(1) Does the claimant have a physical or mental impairment?

34. Mr McParland submitted that in the Act the words 'mental impairment' carry their natural meaning and that the important consideration is their effect and not their cause. He submitted that it was obvious that the claimant was suffering from a mental impairment. He said that it was not normal for someone to attempt suicide as a reaction to arguments at work or with a partner. That was the result of an unhealthy mind. The medical issues in the present case are somewhat complicated. The claimant's medical records contained numerous references to difficulties he had experienced with alcohol. Whilst accepting that it is the effect and not the cause of an impairment that matters, both the Community Response Service and the Psychiatric Liaison Service commented on the detrimental effects of alcohol abuse on the claimant's mood and impulsivity. On the basis of the written medical records before me it was impossible, without expert medical assistance to tease out whether the symptoms and effects the claimant suffered at the relevant times were the adverse effects of a mental impairment; a reaction to the extraordinarily stressful situations taking place in his work and personal life; a result of alcohol abuse or some combination of all three. All these matters were covered in the medical records and correspondence.

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35. Mr MacDougall said in his supplementary oral submissions that whether someone suffering from depression is suffering from a mental impairment was a matter of fact and degree. He accepted that depression could be a mental impairment, but submitted that it would not automatically be so. He is clearly correct about that. The onus is on the claimant to establish that he was suffering from a mental impairment at the relevant time.

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36. Mr MacDougall referred me to the section on 'Mental Impairments' in the IDS Employment Law Handbook on 'Discrimination at Work' (IDSEMPL 458633486 (2019)). As observed at paragraph 43, and as Mr McParland reminded me, the original provision that a mental illness would only amount to a mental impairment if it was "clinically well-recognised" was removed by the Disability Discrimination Act 2005. As stated by the IDS authors: *"The effect of this was to put mental illness on a par with physical impairments and other mental impairments, a parity now reflected in the EqA. It means, in practical terms, that the focus of the tribunal's inquiry is on the effect the mental impairment has on the employee's day-to-day activities."*

37. In his written submissions Mr MacDougall quoted paragraph 52 of the same handbook where, under the heading 'Depression' the IDS authors say this: *"In many cases, however, employees fail to establish that their depression is serious enough to constitute a disability. It may be that their symptoms are not severe enough to amount to a physical or mental impairment; or that the depression does not have a substantial effect on their ability to carry out normal day-to-day activities; or that the illness does not last or is not likely to last, for at least 12 months."* In the same paragraph (52) the IDS authors continue with reference to J v DLA Piper UK LLP 2010 ICR 1052 EAT that *"when considering the question of impairment in cases of alleged depression, tribunals should be aware of the distinction between clinical depression and a reaction to adverse circumstances. While both can produce symptoms of low mood and anxiety, only the first condition should be recognised by the DDA. In practice, the requirement that any impairment must have long-term effects if it is to amount to a disability for the purposes of the EqA should assist in drawing a line between the two (particularly given the EAT's acknowledgement that clinical depression can also be triggered by adverse circumstances or events)."*

38. As set out in paragraph 31 above, in 2011 the Secretary of State issued 'Guidance on matters to be taken into account in determining questions relating to

the definition of disability'. The Guidance states at paragraph A4 that whether a person is disabled for the purposes of the Act is generally determined with reference to inter alia the effect the impairment has on their ability to carry out normal day-to-day activities. At A5, under the heading 'Meaning of 'impairment' the guidance gives a non-exhaustive list of the range of impairments from which a disability can arise. These include:

- *"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;"*

39. Taking Mr MacDougall's point, there were indications in the medical records that some of the claimant's symptoms were a reaction to circumstances rather than indicative of an underlying mental impairment. For example, on 12 November the claimant's GP recorded that the claimant had had a bad weekend with low mood and thoughts of self harm and that these had been *"triggered by work meeting with his boss who is not acknowledging the bullying allegations".* On 19 November the claimant was examined by the respondent's OH provider who recorded: *"Alasdair comments that he is experiencing anxiety, low mood, sleep disruption, fatigue and poor motivation that he attributes to conflict with his manager. I understand that there is a disciplinary issue ongoing."* Similarly, the Psychiatric Liaison Nurse stated in her report of the assessment on 30 November 2018: *"He did not appear to be depressed significantly but instead under a significant amount of stress due to the situation at work".*

40. In the absence of expert medical testimony, I have found it impossible to resolve this question. The medical records are not entirely consistent with the claimant's evidence and it is difficult to work out what relevance, if any alcohol problems might have. I accept that from at least September until 20 December 2018 the claimant suffered from symptoms such as anxiety, low mood and panic attacks. However, in the absence of medical testimony it is difficult to work out whether these amounted to a mental impairment or a reaction to stress at work and in the claimant's personal life or some combination of both.

(2) Does that impairment have an adverse effect on his ability to carry out normal day-to-day activities?

41. Paragraph A7 of the Guidance makes clear that *"What it is important to consider is the effect of an impairment, not its cause."* Had I concluded that the claimant's symptoms amounted to a mental impairment I would have found that from around September 2018 there was an adverse effect on the claimant's ability to carry out the normal day to day activities of sleeping, concentrating normally and relating to colleagues, family and friends; and that from 12 October 2018 there was an additional adverse effect on the claimant's ability to get up in the morning, wash, dress, concentrate and attend work.

(3) Is the effect substantial?

42. "Substantial" is defined in Section 212(1) Equality Act 2010 as *"more than minor or trivial".* The Act does not create a spectrum. Rather, unless the adverse effect can be classified as "minor or trivial" it must be treated as substantial. That is a relatively low standard. I would have concluded that the effect was substantial during that period in the sense that what the claimant could not do was not trivial or insubstantial.

(4) Is the effect long term?

43. As set out above, an impairment will have a long term effect only 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. "*

5 44. On the evidence before me the claimant's most recent episode of low mood/anxiety had not, considered in isolation, lasted 12 months at the relevant time. The relevant period was October to December 2018. The claimant's evidence was that the effect of his mental impairment on his ability to carry out normal day-to day activities had become steadily worse over the time from his
10 return to work in July 2018 until his sick leave which began on 12 October.

45. In the absence of expert medical evidence, it was not possible to determine whether the claimant's symptoms, which began in July 2018 were likely to last for at least 12 months. As paragraph C3 of the Guidance makes clear, "likely" in this
15 context should be interpreted as meaning that 'it could well happen'. The Guidance also states at C4:

> *"C4. In assessing the likelihood of an effect lasting for 12 months, account should be taken of the circumstances at the time the alleged discrimination*
> 20 *took place. Anything which occurs after that time will not be relevant in assessing this likelihood. Account should also be taken of both the typical length of such an effect on an individual, and any relevant factors specific to this individual (for example, general state of health or age). "*

25 46. It is not what actually later occurred but what could earlier have been expected to occur which is to be judged. The fact that a condition has, since the date of the alleged discrimination, lasted for 12 months is not relevant to the question whether these eventualities were likely at the time of the discrimination. A tribunal must determine the hypothetical question of what the prognosis would have been
30 in the light of the information available at the time of the alleged act or acts of discrimination. Where a tribunal is asked to make a judgement of this nature in

relation to a mental illness, it needs an evidential basis for doing so, and it is normal for expert medical evidence to be led.

47. As discussed above, Mr MacDougall submitted that because the claimant had not led expert medical evidence in this case the Tribunal did not have a sufficient evidential basis to find him disabled in terms of the Act. This affected not only the issue of whether there was a mental impairment, but also the issue of whether it was long term as defined.

48. In support of his submission Mr MacDougall cited Royal Bank of Scotland pic v Morris EAT 0436/10. In that case the claimant had, by his own choice, not led expert evidence to support his argument that his illness constituted a clinical depression satisfying the requirements of the Act. The EAT held that the contents of the contemporary medical notes in that case did not permit conclusions to be drawn on essential elements in the definition of disability, including the duration, or likely duration of the claimant's impairment. In Morris, a psychiatric registrar's report on 19 October 2006 had indicated that the claimant was having a "severe depressive episode" which clearly amounted to a mental impairment substantially affecting his ability to carry out normal day-to-day activities. However, the claimant in that case was only seen on one subsequent occasion by the registrar on 16 November 2006 at which point he was improving and was advised to stay on antidepressant medication for a further 6 months. The EAT (Underhill P) commented that no safe inferences could be drawn from the continuation of antidepressant medication for six months as this might only have been precautionary. There had been no explicit evidence on the point. They stated: *"This is just the kind of question on which a tribunal is very unlikely to be able to make safe findings without the benefit of medical evidence. The same applies to any potential reliance on* [the likelihood of recurrence]. *Dr O'Donovan did indeed in his letter of 6 December 2006 refer to the risk of recurrence; but it would be difficult for the Tribunal to assess the likelihood of that risk, or the severity of the effect if it eventuated, without expert evidence."*

49. With regard to whether the effect was long-term, the EAT continued: 7'f *follows from our conclusions in the previous paragraph that the evidence before the Tribunal did not establish that the Claimant at any time in the relevant period suffered from a (serious) impairment which had lasted for at least twelve months... The Claimant could in principle still argue that the (serious) impairment from which he did unquestionably suffer in October 2006 was - judged at that date (as required by* [Richmond Adult Community College v McDougall [2008] IRLR 227 CAI) *likely to last for at least twelve months.. But again, the evidence did not in our view justify such a conclusion. Dr O'Donovan's contemporary note simply diagnoses a "severe depressive episode", with no prognosis of any kind.... The Tribunal could not without expert evidence form any view on the likelihood of that impairment (at the necessary level of seriousness) continuing for at least a year."*

50. In Morris the EAT observed: *"The fact is that while in the case of other kinds of impairment the contemporary medical notes or reports may, even if they are not explicitly addressed to the issues arising under the Act, give a tribunal a sufficient evidential basis to make common-sense findings, in cases where the disability alleged takes the form of depression or a cognate mental impairment, the issues will often be too subtle to allow it to make proper findings without expert assistance. It may be a pity that it is so, but it is inescapable given the real difficulties of assessing in the case of mental impairment issues such as likely duration, deduced effect and risk of recurrence which arise directly from the way the statute is drafted."*

51. In this case the claimants recent mental episode put at its highest, began in July 2018. By the end of the relevant period it had lasted a maximum of 5 months. The issue of whether it was, at that point, likely to last at least 12 months and the likelihood of recurrence going forward were guestions I was unable to determine in the absence of expert medical evidence.

52. However, Mr McParland submitted that the 2018 episode was a continuation or recurrence of a previous depressive episode, which was diagnosed in 2011. It was the claimant's evidence that his conditions had persisted since 2011, but that he had used various coping strategies when necessary. I did not accept his 5 evidence on that because there was no support for it whatsoever in his GP records. After the single visit in 2011 the claimant did not go back to his GP with any mental health issue until October 2018 when he was experiencing problems at work and personal stressors such as divorce.

10 53. Turning to Mr McParland's submission on recurrence of an earlier impairment, the following extracts from the section of the Guidance headed: *'Recurring or fluctuating effects'* are relevant:

> *"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 15 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 20 the meaning of 'long-term' (Sch 1, Para 2(2), see also paragraphs C3 to C4 (meaning of likely).)*
>
> *C6 For example, a person with rheumatoid arthritis may experience substantial adverse effects for a few weeks after the first occurrence and then have a period of remission. See also example at paragraph B11. If 25 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 Meniere's Disease and epilepsy as well as 30 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.

5 *'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).*

10 *In contrast, a woman has two discrete episodes of depression within a ten-month period. In month one she loses her job and has a period of depression lasting six weeks. In month nine she experiences a bereavement and has a further episode of depression lasting eight weeks. Even though she has experienced two episodes of depression she will not*

15 *be covered by the Act. This is because, as at this stage, the effects of her impairment have not yet lasted more than 12 months after the first occurrence, and there is no evidence that these episodes are part of an underlying condition of depression which is likely to recur beyond the 12-month period.*

20 *However, if there was evidence to show that the two episodes did arise from an underlying condition of depression, the effects of which are likely to recur beyond the 12-month period, she would satisfy the long term requirement. '*

C7 It is not necessary for the effect to be the same throughout the period

25 *which is being considered in relation to determining whether the 'long-term' element of the definition is met. A person may still satisfy the long-term element of the definition even if the effect is not the same throughout the period. It may change: for example activities which are initially very difficult may become possible to a much greater extent. The effect might even*

30 *disappear temporarily. Or other effects on the ability to carry out normal*

day-to-day activities may develop and the initial effect may disappear altogether.

'A person has Meniere's Disease. This results in his experiencing mild tinnitus at times, which does not adversely affect his ability to carry out normal day-to-day activities. However, it also causes temporary periods of significant hearing loss every few months. The hearing loss substantially and adversely affects his ability to conduct conversations or listen to the radio or television. Although his condition does not continually have this adverse effect, it satisfies the long-term requirement because it has substantial adverse effects that are likely to recur beyond 12 months after he developed the impairment.'

54. Section 6(4) and Schedule 1(2) EqA and Paragraph C12 of the Guidance concern the assessment of whether a past disability was "long-term". Paragraph C12 includes the following guidance: *"…In deciding whether a past condition was a disability, its effects count as long-term if they lasted 12 months or more after the first occurrence, or if a recurrence happened or continued until more than 12 months after the first occurrence..."* In this case, as mentioned above, the evidence of the claimant that his condition had continued from 2011 until October 2018 was at odds with his medical records. Furthermore, I was unsure in the absence of expert medical evidence whether the depressive episode the claimant experienced in 2011 had a substantial adverse effect on his ability to carry out normal day to day activities and amounted to an impairment. For example, it was not suggested that the claimant had been absent from work at that time. I did not find the handwritten GP letter issued the night before the disciplinary hearing to be of much assistance. GPs are often prevailed upon to advocate for their patients in employment disputes. The letter contained no reference to supporting detail and in the absence of the doctor her evidence could not be tested. I have come to the conclusion on balance that the claimant has not established that the difficulties he suffered at the relevant times amounted to a long term mental impairment as defined in the absence of medical evidence to that effect and I

have therefore concluded that he has not established that he was disabled at the relevant times.

55. Date listing letters will be sent to parties to list a hearing in his unfair dismissal claim.

Employment Judge: Mary Kearns
Date of Judgment: 25 October 2019
Entered in register: 05 November 2019
and copied to parties