



# EMPLOYMENT TRIBUNALS

**Claimant** David Ketley

**Respondent** No Looking Back Solutions Limited

**HEARD AT:** Watford (by Cloud Video Platform)

**ON:** 7 December 2021 and 26 January 2022

**BEFORE:** Employment Judge J Lewis

## Representation

**For the Claimant:** In person

**For the Respondent:** Karen Moss (Counsel)

## JUDGMENT

1. The correct name of the Respondent is No Looking Back Solutions Limited.
2. The Claimant's mother was at all material times a disabled person within the meaning of the Equality Act 2010 ("EqA") by reason of her condition of depression.
3. The Claimant was a disabled person within the meaning of the EqA from March 2017, but not before.

## REASONS

1. This was a preliminary hearing directed by Employment Judge Eeley on 4 August 2021 to determine whether the Claimant and his mother were at the material time disabled persons within the meaning of the EqA and to consider the correct name of the Respondent. The Claimant acted in person and Karen Moss of Counsel represented the Respondent. I heard evidence

from the Claimant, and oral and written submissions from both parties.

**Name of the Respondent**

2. It was agreed by the parties at the outset of the hearing that the correct Respondent is No Looking Back Solutions Limited.

**Procedural issues addressed on 7 December 2021**

3. At the outset of the hearing the Claimant made an application to strike out the Response or that the Respondent should not be permitted to contest the disability issue on the basis of its non-compliance with case management orders. The Claimant had been required to provide particulars and medical evidence relating to his disability by 15 October 2021. He provided a response on around 15 October 2021, and a further response on 28 October 2021 having noted that some of the points had not been fully answered. By way of context, the Claimant had explained when sending the response on 15 October 2021 that it had been rushed as he had only been able to obtain his medical records on the afternoon of 12 October 2021.
4. The directions required that the Respondent write to the Tribunal by 5 November 2021 confirming whether or not it accepted that the Claimant and/or his mother had a disability and if not, to explain why. If adjusting to allow for the Claimant's further response on 28 October 2021, that would indicate a response by 18 November 2021. However the Respondent did not provide its response to this direction until an email sent at 9.02pm on 6 December 2021, on the evening before the preliminary hearing was to be heard.
5. There was also a delay by the Respondent in providing a copy of the bundle for the hearing. A hard copy should have been sent to the Claimant by 19 November 2021 and an electronic copy to the tribunal by 30 November 2021. The Claimant wrote to the tribunal and the Respondent on 28 November 2021 in relation to the failure to provide either a hard or electronic copy of the bundle and the failure to comply with the order in relation to whether disability was disputed and why. He explained that he would not be around over the following week.
6. I was told that the Respondent sent the electronic bundle on 2 December 2021. He had not received a hard copy bundle. As he had said in his earlier email he had been away when the bundle was sent, and he explained that he turned his emails off due to suffering from anxiety.
7. The Claimant said that something similar had occurred before the previous preliminary hearing. The Respondent had also been late in filing its ET3.
8. For the Respondent Ms Moss stated that she did not have instructions as to why the deadlines had been missed. I allowed her time to take instructions. Having done so I was informed that it was an oversight for which her solicitor apologised. As Ms Moss accepted, there was therefore no satisfactory

explanation.

9. In addition on the morning of the hearing the Respondent produced a further document, which was a printout from an NHS webpage relevant to the issue of whether stress is a cause of stomach ulcers. Again, there was no satisfactory explanation as to why this had been produced so late.
10. For reasons which I gave orally at the hearing on 7 December 2021 I declined to strike out the Response or to refuse to permit the Respondent to contest the disability issue. I concluded that neither would have been the proportionate course. I made clear that I would have been willing to consider a postponement of the hearing if the Claimant sought this in the light of any prejudice caused by the Respondent's non-compliance. The Claimant confirmed that he was able to deal with the documents, which other than the NHS print out he had seen before and wished to continue.

### **The Claimant's mother's disability**

11. For reasons I gave at the hearing on 7 December I did accede to a request to postpone the hearing in relation to whether the Claimant's mother, Olive Maunder, was disabled to allow further evidence to be obtained. In the event, since the hearing was not completed on 7 December, there was further time for the material to be obtained prior to the resumed hearing. That evidence was provided by way of an impact statement from her in a letter dated 6 January 2022 and in a letter from her GP of 18 January 2022. By an email of 21 January 2022 the Respondent accepted that the Claimant's mother was a disabled person, and I have made an Order to that effect. There remains an issue for the final hearing as to the Respondent's knowledge of the disability to the extent relevant to the claim.

### **Further issue as to additional documents produced by the Claimant**

12. The Claimant gave oral evidence at the hearing on 7 December 2021, and was cross-examined in relation to it. The hearing was not completed on that day and was listed to be completed on 26 January 2022. Subject to whether there was further evidence to be addressed in relation to the Claimant's mother, the matters expected to be addressed at that hearing were oral submissions, judgment and consequential case management issues.
13. By an email of 18 January 2022, the Claimant provided further evidence in relation to his disability. The Respondent objected to the admissibility of those documents. The documents included a consultant psychiatrist's report dated 11 January 2022 which included a current diagnosis of GAD. There had been no permission previously sought or given for an expert report, the Respondent had had no opportunity to put questions to the expert or to cross-examine the expert, or to instruct on a joint expert or put in its own expert report in response and the Claimant had already completed his evidence, been cross-examined on it and seen the Respondent's closing written submissions. For reasons which I gave at the hearing I did not permit the Claimant to put in the expert report, but permitted the other

documents to be admitted on the basis that the weight to be given to them would be a matter for submissions.

### The Claimant's case as to disability

14. The Claim Form stated that the Claimant was complaining of "Discrimination in regard to Mental Health". [7]<sup>1</sup> In the particulars of his claim he alleged that the Respondent's director, Rupinder Sagar, constantly stated that "Mental Health" does not exist and that when the Claimant was off sick due to panic attacks, Mr Saggar held that against him. He added that he did not take time off as Mr Saggar stated that he would not pay his "as Mental Health does not exist". Although not further identified, the complaint raised in the ET1 was therefore in relation to a mental health condition.
15. By an Order made on 1 February 2021, EJ R Lewis required the Claimant to provide further particulars of his harassment and discrimination claims [39-40]. The response was set out in two schedules, one relating to discrimination and one in relation to harassment [272-279], and the nature of the claims was further clarified at the preliminary hearing on 4 August 2021 (as set out in the case management summary for that hearing). In relation to discrimination, items 3 to 18 and 21 to 24 and 29 assert claims of harassment and direct (or in relation to items 10, 18) indirect disability discrimination and item 20 is a claim of disability harassment. There is reference in each case (other than item 24) to the employer's response to or comments about mental health issues or stress and anxiety or depression or therapy. In the harassment table items 3 to 5, 7 to 10 and 12 to 25 are claims of disability harassment, including in relation to items 21 to 23 associative disability harassment relating to the Claimant's mother. Again, in so far as these identify the impairment, the reference is to mental health.
16. The Claimant was required to provide further particulars by an Order made at the preliminary hearing on 4 August 2021, including identifying the mental impairment relied upon [71]. The Claimant's response did not directly answer this but stated (in a follow up response of 28 October 2021 [183]) that the Claimant was first diagnosed in 2016 and that his stomach issues were caused by stress, panic and anxiety.
17. In submitting his medical evidence on 15 October 2021, the Claimant stated:

"Please note, I never hid any of my diagnosis from the defendant and was in constant communication. I indicated that the undue stress placed upon me caused many of the issues however due to their beliefs no adjustments were made and if anything it was made almost impossible for me to seek further treatment. There is a clear, consistent, diagnosis of anxiety and physical effects of this anxiety. This includes ulcers for which I am still on medication as well as chest pain, palpitations, arm pain, headaches, panic attacks and paraesthesia."  
[81]

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<sup>1</sup> References in bold and square brackets are to the Bundle for the Preliminary Hearing.

18. The Claimant's case was therefore put on the basis of a disability consisting of "anxiety and the physical effects of anxiety". Those effects were said to include "ulcers ... chest pain, palpitations, arm pain, headaches, panic attacks and paraesthesia.
19. In the Claimant's oral evidence in chief he stated that he was relying on two impairments: (a) stress and anxiety and (b) his ulcers. However in cross-examination he clarified that the impairment he is relying upon is stress and anxiety and that the other matters, including the ulcers and paraesthesia are said to have been caused by or were symptoms of the anxiety. That remained his position in closing submissions.
20. That is consistent with the case advanced in the ET1 that the claim is of discrimination in relation to a mental health condition. On that basis the Respondent has disputed the connection with anxiety and made submissions to the effect that even if there was an effect on day to day activities, the evidence does not show that it arises from the stress and anxiety rather than from other matters such as the ulcers.

### Relevant legal principles

21. Section 6(1) EqA provides:

"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."

22. Further provisions are set out in schedule 1 to the EqA. I am also required to take into account relevant guidance in statutory codes of practice (para 12 of Schedule 1). I have therefore had regard to relevant provisions of the Government's 2011 "Guidance on matters to be taken into account in determining questions relating to the definition of disability" ("the Guidance") and the EHRC Code of Practice on Employment ("the EHRC Code").
23. Section 212(1) EqA provides that "substantial" means more than minor or trivial. Paragraph B1 of the Guidance provides that the requirement for a substantial effect on normal day to day activities reflects the general understanding of disability as meaning "a limitation going beyond the normal differences in ability which may exist among people."
24. Appendix 1 of the EHRC Code of Practice states of normal day to day activities that:

"14. They are activities which are carried out by most men or women on a fairly regular and frequent basis. The term is not intended to include activities which are normal only for a particular person or group of people, such as playing a musical instrument, or participating in a sport to a professional standard, or performing a skilled or specialised task at

work. However, someone who is affected in such a specialised way but is also affected in normal day-to-day activities would be covered by this part of the definition.

15. Day-to-day activities thus include – but are not limited to – activities such as walking, driving, using public transport, cooking, eating, lifting and carrying everyday objects, typing, writing (and taking exams), going to the toilet, talking, listening to conversations or music, reading, taking part in normal social interaction or forming social relationships, nourishing and caring for one's self. Normal day-to-day activities also encompass the activities which are relevant to working life.”

25. Paragraph D3 of the Guidance is to similar effect. Illustrative examples of what might be regarded as or not regarded as day to day activities are set out in the Appendix to the Guidance.
26. It is necessary to focus on what the Claimant could not do, or only do with difficulty, rather than on what he could do (Guidance at B9).
27. Paragraph 2 of Schedule 1 provides, so far as material:

**“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.  
...”

28. “Likely” in this context means that it is something that “could well happen” (Guidance at C3); ***All Answers Ltd v W*** [2021] IRLR 612 (CA) at para 25. This is to be assessed by reference to the facts and circumstances at the time of the alleged discrimination (Guidance at C4). It is not permissible to have regard to what in fact subsequently transpired: ***All Answers*** at para 26.
29. In relation to the meaning of impairment, the Guidance provides:

“A3. ... 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.  
...”

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. ... What it is important to consider is the effect of an impairment, not its cause – provided that it is not an excluded condition.” (my emphasis)

30. Those provisions therefore direct attention to the effect of an impairment rather than its cause. However causation was an issue before me in connection with the issue of whether, given the way the Claimant’s case was pleaded and advanced, he could place reliance on any effect on day to day activities caused by peptic ulcer disease (“PUD”) or paraesthesia. The Claimant’s case was that these were caused by or symptoms of his anxiety. The Respondent accepted that if this was so then it was permissible to take them into account. Ms Moss also accepted that it would be sufficient if anxiety caused an “episode” of PUD. However Ms Moss disputed that the evidence supported such a causative link, and contended that it would not be sufficient if PUD or paraesthesia was simply exacerbated by anxiety.
31. In support of this position, Ms Moss placed reliance on paragraph C2 of the Guidance which provides:

“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.

'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.” (my emphasis)

32. Drawing on this guidance, Ms Moss submitted that no doubt it would be possible to find evidence that stress exacerbates almost any condition, but that it could not be right that to treat that as a sufficient basis to conflate anxiety with two separate conditions. Nor is it sufficient if the Claimant perceived that the PUD and paraesthesia were brought on by his anxiety. She submitted that it would be sufficient if, but only if, those conditions were caused by or likely to have developed from the anxiety.
33. The Guidance in C2 addresses whether it is possible to consider the combined effect of two or more impairments without addressing any issue as to whether reliance on each of those impairments is part of the claim as pleaded. However I accept the Respondent's concession that this does not prevent reliance on other conditions if they arise from anxiety. That is a realistic concession. If ulcers and paraesthesia were properly to be regarded as physical effects of, or developments from, anxiety then their inclusion can in my view properly be regarded as consistent with the substance of, and encompassed by, the pleaded case which of "Discrimination in regard to Mental Health".
34. As to whether the line is properly drawn in the place contended for by the Respondent, it is relevant in my view to consider two aspects. First there is the question of whether the cumulative or combined aspects of two or more conditions can be considered together (which is the focus of C2). There is then, secondly, the question of limits arising from the way the case was pleaded or advanced (which, by way of shorthand only, I refer to as the "pleading point").
35. As to the first of these, I do not accept one condition can only be regarded as "related to" another, or that it is only permissible to consider their combined or cumulative effect, if one was the cause of the other. That would in my view be too narrow and technical an approach. Nor would it be consistent with the spirit of the Guidance set out in A3, A6 and A7.
36. Turning to the pleading point, for ease of discussion I address this by reference to the conditions of anxiety and PUD (but the same applies if considering paraesthesia). If the only relation between the two is that PUD exacerbates anxiety, then I accept that it would only be permissible to take into account the effect on day to day activities of the (exacerbated) anxiety. I do not however accept that if anxiety exacerbated the effects of PUD that those effects have to be left out of account. It seems to me wholly consistent with the substance of the Claimant's pleaded case to take into account all the effects of the mental health condition including its impact on other conditions. Further, in her closing submissions Ms Moss accepted that it would be sufficient if anxiety was not the original cause of PUD, it nevertheless caused an "episode" of PUD. I see no bright line in principle between that and causing or contributing to an incident of PUD related reflux or otherwise exacerbating the effects of PUD. I do not accept that either the pleaded case, or the Claimant's contention that PUD (and paraesthesia) were physical effects of the anxiety, prevent such an approach.



37. Reliance was also placed by the Respondent on the EAT's decision in **Herry v Dudley Metropolitan Council** [2017] ICR 610, and its reference to guidance given by Underhill J in **J v DLA Piper UK LLP** [2010] ICR 1052. The relevant propositions addressed in that decision include the following:
- 37.1 It is good practice for the Tribunal to state conclusions separately on the questions of impairment, adverse effect, substantiality and long term nature (para 57).
- 37.2 However in reaching conclusions on those issues the tribunal should not proceed by rigid consecutive stages. Where the impairment is in dispute, the tribunal might start with questions about the whether the claimant's ability to carry out normal day to day activities was impaired (and on a long term basis) and to consider the question of impairment in the light of those findings. (paras 58,59). However there is no rigid rule that the tribunal must consider the issues in any particular order (para 69).
- 37.3 A valid distinction can be drawn between a mental impairment and symptoms which are simply "a reaction to adverse circumstances (such as problems at work) or ... 'adverse life event' (para 55). Underhill J in **DLA Piper** stated that if the effect on day to day activities was long term in most cases a tribunal would be likely to conclude that the claimant was suffering from clinical depression rather than simply a reaction to adverse circumstances. But in **Herry** (at para 56) the EAT added that experience shows that there is a class of cases where a reaction to circumstances becomes entrenched where the person will not give way or compromise and return to work even though in other circumstances there is no or little effect on day to day activities, and that a tribunal is not bound to find that there was a mental impairment in such a case. The question of whether there is a mental impairment is one for the tribunal to assess.
- 37.4 There is no requirement for a clinically well-recognised condition.
- 37.5 The effect on day to day activities encompasses activities which are relevant to participation in professional life (para 64).
38. In relation to the effect of medical treatment, paragraph 5 of Schedule 1 provides:
- “(1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day 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.
- ...”
39. An issue was canvassed in closing argument as to what falls within the scope of “measures ... taken to treat or correct” a condition. In particular there was an issue as to whether, having had a course of CBT in 2016, the steps taken to put into practice the steps or techniques learnt from then when

dealing with an anxiety attack fall within the scope of measures taken to treat or correct the impairment. Ms Moss placed reliance on the decision of the **Metroline Travel Ltd v Stoute** [2015] IRLR 465. The EAT rejected an argument that in considering whether the claimant, who had Type 2 diabetes, had a disability, it was permissible to consider the deduced effect of the claimant ceasing to avoid sugary drinks. The EAT emphasised that it was relevant to have regard to B17 of the Guidance which provides that:

“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.

For example, a person who needs to avoid certain substances because of allergies may find the day-to-day activity of eating substantially affected. Account should be taken of the degree to which a person can reasonably be expected to behave in such a way that the impairment ceases to have a substantial adverse effect on his or her ability to carry out normal day-to-day activities. (See also paragraph B12.)”

40. Paragraph B12 refers to Sch 1 Para 5(2) and adds that 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.
41. It is important however not to lose sight of the statutory wording in Sch 1 para 5(2) which focuses on measures taken “to treat or correct” the impairment. On the facts in **Metroline** it is unsurprising that avoiding sugary drinks was not regarded as treating or correcting the condition. The EAT noted “a perfectly normal abstention from sugary drinks” was not medical treatment and nor was the abstention itself an impairment of day to day activities. The position is different in my view in relation to the application of CBT techniques, including to relax and concentrate on his breathing, so as to cope in the context of an anxiety attack. That directly involved treating or correcting the impairment to be able to alleviate the impact of it. I see no reason to construe the reference to “measures” in Schedule 5 so narrowly as to exclude such steps, implementing CBT techniques.

### **Material facts**

42. The Claimant was employed by the Respondent, a recruitment business, as Group Business Manager from 3 January 2015 until his dismissal with effect from 29 June 2020.
43. The Claimant placed his evidence as to his anxiety in the context of a familial history of depression and poor mental health, such that his grandfather was sectioned, his mother suffers from depression and his brother was on anti-

depressants and the Claimant was in counselling as a child. The Claimant's medical records refer to low mood in 2013 [136].

**(1) Anxiety attacks in 2016**

44. The Claimant started having panic attacks in 2016. He had been having palpitations. A GP entry of 5 October 2015 records that he had been getting intermittent episodes of arm shooting pains and that when he starts to get pain he worries about his heart and his chest gets tight. [108] His first serious panic attack (though there were less serious ones previously) was on 21 March 2016. He attended hospital having woken up with a panic attack. A GP entry of 29 March 2018 records [106]:

“Constant SOB [shortness of breath] for 1 week, not able to exert self, intermittent L[eft] sided chest pain – like being hit by an elastic band, pleuritic [ie sharp, stabbing pain in chest], some associated pains in L[eft] arm – like a trapped nerve. .. Feeling dizzy, prone to anxiety in the past ... Anxious since had sx [symptoms], normally more relaxed ... Likely anxiety related but ongoing sx and marginally raised di dimer. ... Declined trialling beta blocker ...”

45. A referral letter (to Watford General Hospital) from the Claimant's GP [170] recorded that the Claimant had been suffering from troubling chest pains and palpitations for about 3 to 4 weeks with no obvious precipitant. It added that:

“He has some symptoms of anxiety and does have a history of anxiety but feels that this is not the cause of his symptoms on this occasion, as he has no current stresses and symptoms occur when he is relaxing. ... I think the most likely cause for his symptoms is anxiety and I have explained this to him on a number of occasions ...”

46. Although at that stage the note records that the Claimant felt that this was not anxiety related, the GP expressed the view that anxiety was the most likely cause. His evidence, which I accept, is that he did not want to admit that there was anything mentally wrong with him. Upon going to counselling (involving CBT) the connection with anxiety became apparent to him.

47. A GP entry of 7 April 2016 [105], records that:

“Feeling nervous all the time. On edge. Struggling to relax. No impending sense of doom. Takes a while to drop off but sleeping and eating OK. Mood Ok. No SI. No stresses” and

“No ppt for sx – no panic attacks, feels not anxiety related as occur when driving when is usually relaxed”

48. The Claimant was sent for an ECG to check on his heart [105,170]. In addition on 26 May 2016 he was referred by the NHS Wellbeing Service, As One, for a course of individual face to face CBT treatment “focussing on addressing ... symptoms of health anxiety” [167]. The course of CBT continued for 10 weeks.

49. The Claimant's evidence was that at around this time he was having panic attacks most days or nights. There is a tension between this and the GP entry of 7 April 2016 recording "no panic attacks". I accept that the most likely explanation is that at that time the Claimant was reluctant to accept that the symptoms amounted to a panic attack. The episodes included him suddenly becoming short of breath and unable to focus. He was suffering from symptoms of anxiety at this time (as the GP records reflect) and his evidence that he was suffering panic attacks derives support in the entry made when the Claimant again attended A&E after a panic attack on 20 June 2016. A GP entry of 7 July 2016 records [103]:

"End up in A&E after waking at night with a panic attack. Multiple tests for chest pains – all normal. Last episode triggered by stomach pains, ... Pains every day, in the morning, waking at night – hard to breathe, panicky, pains in the chest. ... Undergoing CB, declined medication for anxiety. Likely anxiety and dyspepsia . Continue CBT – may consider SSRI in future. Undiagnosed dyspepsia." [103]

50. A further entry, on 15 July 2016 records that the Claimant was feeling very anxious, and in constant agony with pains in his stomach and chest. [102,152]. It recorded that the Claimant was highly anxious because his father had stomach cancer the previous year. A referral form for a referral on 4 August 2016 records [147] that the Claimant continued to have chest pain which made his feel breathless and was unable to lie on his left side and woke up at night with night sweats, and had a racing heart and tired legs and:

"His anxiety stems from the fact that his paternal grandfather had a heart attack at the age of 52 and his paternal grandfather had AF. [Atrial fibrillation] His paternal cousin died age 24. Often feels faint prior to chest pains. Health anxieties re extremely heightened."

51. The Claimant was prescribed anti-depressants in April 2016 (Diazepam) and then in July and August 2016 (Citalopram) for anxiety symptoms [112], and was referred for cognitive behavioural therapy. He stopped the antidepressants in October 2016 [333] and was not prescribed them after that because he asked not to be. He felt he could manage better with CBT and did not like the effect of the anti-depressants. He explained that he felt "rubbish" when taking Citalopram and did not know if he was happy or sad. He therefore decided to come off it.
52. At around the same time there were tests conducted on the Claimant's heart. The medical records indicate that there was a delay in providing the test results from August 2016 when they were conducted, until November 2016. All investigations were reassuring including ECG and bloods [144-145,333].
53. At the start of the Claimant's CBT he had a "GAD7 start score" of 10 The GP letter of 24 December 2021 explains that the start score was from a test on 26 May 2016 and indicates moderate anxiety. That date ties in with the date

of an As One letter of 26 May 2016 [167]. As set out in the As One letter of 23 September 2016 he had a "GAD7 end score" of 0. In the Claimant's evidence he explained the end score as reflecting that at the time he was able to better control his anxiety but that this was just a snapshot at that time.

**(2) Continued panic attacks after 2016**

54. So far as concerns 2016 there was an apparent explanation for the anxiety attacks in terms of health anxiety and assurance had been given. However the Claimant's evidence, which I accept, was that he continued to suffer panic attacks though less frequently than in 2016 when he had all the health anxiety in relation to the matters investigated at that time. This would happen about once a week in 2017 and 2018, rising to twice to three times a week in the Summer of 2018. For much of 2019 it would be less frequent, which he estimates at about once every three weeks, but more frequent towards the end of 2019 when it would be two to three times a week. Then in January 2020 there was an incident when he had a complete breakdown and had to leave the office.
55. When the anxiety attacks happened at night the Claimant would wake up unable to breathe but they could also come at other times when he suddenly found it difficult to breathe. One example was in Spring 2017 when standing outside in the queue for a nightclub.
56. When the panic attacks first started in 2016 he could not do much at all whilst having an attack. He could not eat or sleep and had trouble breathing. He could just about operate a phone to dial 999 but found it difficult even to call his mother and had to save her number of speed dial to be able to do so. He would lie on the sofa for two to three hours to try to get some normality and normally make a phone call to his mother to calm himself down. He would put on what he describes as "white noise" and not work or read or watch TV. If an attack happened at work he would go to his car and just sit in his car for a time.
57. In the immediate aftermath he would try to recover by cooking something or watching TV or focussing on something. He could not go out to gym or go out with friends. A coping mechanism was to cook some things to eat on the Sunday that he could work up during the week. He could not drive as far as seeing his mother (who was 40 miles away) and could not drive to the gym through fear. He was scared to go to sleep.
58. Before he had a particular enjoyment of driving. He had modified cars and would enjoy going out driving on A and B roads for one to three hours. He could not do that any more in 2016 and 2017 due to the fear of anxiety and panic.
59. During the period in 2016 he avoided having relationships as he did not want to put someone through seeing him at that time (though he did start a relationship in 2018). He socialised much less than he had before. Before he would go out with friends every week more than once. In 2016 he would

go out only about once every two to three weeks and had to push himself to do that. He lived in a state of constant anxiety as to when an attack would come.

60. During 2016 he found it difficult to wake up in the morning and difficult to go to sleep which had not been a problem in the past. As a result he became tired and more short-tempered. This also affected his work life as he would snap more quickly. He would tend not to pick up the phone as much. He felt more comfortable emailing because if anxiety crept in whilst on the phone he could not keep up a proper conversation. Once he had got past the worst he would try to cook a meal but could not eat all of it.
61. In 2018, until about the Summer, the Claimant was much better. He attributes this to not having been in the office as much. However in the Summer he relapsed and would have panic attacks two to three times a week usually in the evenings. As set out below, it was also around that time that he started to suffer from the paraesthesia and migraines.
62. As a result of the techniques learnt through his course of CBT, and knowing following the investigations in 2016 that he was not suffering a heart attack, the Claimant found that he was able to manage the attacks better so that the impact would be for a shorter period. He would lie down if in the evening or sit in the car or on the wall outside the office if during the day and go through the CBT methods he had learnt. It would take anything from half an hour to an hour and there was little else he could do during that time. One example was when he was driving home with his partner and in mid-conversation an attack came on. He sat in the car in a petrol station with his partner next to him and could manage to say yes or no or response to questions such as if he was OK, but not hold a conversation.
63. When an attack came on he would go through the procedures learnt from CBT for about 15 to 20 minutes. He would then slowly get back to normal, typically after about 45 minutes. After that he would carry on "pretty much as normal". There was less anxiety about it as he knew how to manage the situation and did not have the health anxieties of 2016.
64. The Claimant's evidence, which I accept, was that when he was subject to the anxiety attacks he did not want to eat or drink or see people or be in front of a screen when at work. He did want he had to do but could not do them well at all. He points to 2018 as being the proof of this when he could not manage people, did not want a team or to make money and did the minimum to survive.
65. The Claimant grouped together 2016 and 2017 when describing the impact of anxiety attacks upon him. In my judgment that is unlikely to be correct, not only because he no longer had the health anxieties of 2016 but also because he had learnt the coping mechanisms from CBT which he says in relation to 2018 assisted him in coping with an attack. I also note that there was some confusion as between 2017 and 2018 in relation to the Claimant's evidence in relation to the onset of paraesthesia. In the course of his evidence he

made some reference to this occurring in 2017, whereas the medical records indicate that it was in 2018. In all, whilst I accept that he continued to experience anxiety attacks in 2017 (including the instance whilst waiting in the nightclub queue) I consider it more likely that the position in 2017 was more similar to that described in the first part of 2018 at least in relation to how the Claimant coped with anxiety attacks.

66. After 2016 there was no mention of anxiety in the Claimant's medical records until after the termination of his employment despite numerous GP consultations in relation to other conditions. The Claimant contended that although not recorded in his notes there was some discussion of anxiety in relation to paraesthesia. I address that further below. Other than that, the Claimant explained that he did not wish to raise his anxiety with his GPs in this period. He had lost trust in his doctors because he felt that he had had to push them to send him for tests in 2016 which had ultimately come back positive and so provided reassurance. Whilst he did still visit his GP that was for other specific issues such as issues with his eyes. He did not need to go back and discuss anxiety because in his mind it was not in doubt (and so did not need a diagnosis) and there were more appropriate people to discuss this with who he trusted more. He had also learnt techniques as to how to act through his course of CBT. He continued to speak to the "As One" service or Mind over the following years at time of particular stress, but these were confidential calls and there was no record kept of them. For the period he was with his partner from 2018 he was able to speak to her father who was a cognitive behaviour therapist, and he could also speak to his mother who had 33 years' experience of dealing with depression. Whilst the absence of any reference to anxiety is surprising given the number of GP consultations, I accept the Claimant's evidence as to the explanation for this.

### **(3) Ulcers**

67. The Claimant was diagnosed with duodenal ulcers in 2016. He was prescribed medication which he has continued to take for this since then to reduce the amount of acid in his stomach. He said that he was told by one of his GPs that this was to do with stress, but this is not mentioned in his medical notes.
68. The ulcers cleared up in 2016 but he continued to have further episodes of symptoms related to them despite having reduced his alcohol intake, and changed his diet and lifestyle. It causes severe acid reflux and a lot of pain. It makes it difficult to eat and if it came on at night it affected his sleep and bowel movement. He could continue working when it came on but would avoid picking up the phone. He was able to reduce his medication for two out of four years from 2016. However his experience is that it is likely come on when he reduces his prescription or is otherwise triggered by stress. He explained, and I accept, that the ulcers and reflux are only prevalent when his anxiety levels are heightened.

### **(4) Paraesthesia**

69. A GP note of 29 August 2018 records that the Claimant started noticing “paraesthesia” in June 2018. [95] This had the effect that he could not feel his hands and the left side of his face goes numb. A GP entry of November 2018 records:

“suffering with headaches, nausea, occasional facial numbness. Pain starts at left jaw, feels like face has ‘no power’ and is dropping, tends to happen with headaches”

70. In January 2019 he was referred for a Cat scan in relation to this, which took place in February 2019. The outcome is described in the GP notes as “normal”, whilst recording the history of “ongoing headaches, paraesthesia to left side of his face”.
71. I accept the Claimant’s evidence that the paraesthesia would come on around once a week. His understanding from the position outlined to him by his doctors is that the paraesthesia is likely to be a physical symptom of anxiety in that when anxiety or panic comes on it can set off a migraine reaction. The migraine may be felt as a headache or other symptoms of the paraesthesia.
72. The notes prior to termination of the Claimant’s employment do not make reference to the paraesthesia being a symptom of anxiety. There is however support for this in an entry of 19 May 2021. This noted a history of intermittent parathesis and referred to the Cat scan. The note records: “could be migraine aura and anxiety” and that the Claimant was speaking to a therapist and he was advised to reduce caffeine, drink plenty of water and sleep more [84]. Whilst the note itself does not make clear whether this is recording something that was said in May 2021 or had been said previously, it provides some corroboration for the Claimant’s evidence that he had been told by his doctor that the condition was likely to have arisen as a symptom of anxiety. The absence of any other obvious causes would appear to be supported by the normal Cat scan and a GP note of 29 August 2018 that there were no obvious triggers.
73. Consistently with the view that the paraesthesia was related to anxiety, the Claimant explained that the migraines occurred at times when he was more stressed. I accept that was his perception and is likely to have been the case. In terms of timing it is also consistent with his evidence that he had experienced a relapse in relation to the frequency of panic attacks in the Summer of 2018. In closing submissions the Claimant stated that the paraesthesia did not happen unless he had an anxiety attack or anxiety prior to it. I put that to one side in reaching my conclusions because it was not put in quite that way in the Claimant’s oral evidence. But it is consistent with his evidence as to the connection between stress and the onset of paraesthesia.
74. When the paraesthesia came on it would usually take between a half hour and 1.5 hours to clear up although sometimes it could be a whole day. When this happened he could just manage to drive to his girlfriend who was 20 minutes away but couldn’t drive for 30 minutes. He would drive on roads



that were not busy or at night and would ask his partner to come to him. He could not look at a screen whilst this was occurring. If in the office he would place himself so that he could look out of the window. He could not hold a full conversation but could give answers or responses without having an informed discussion or focus fully.

75. On the occasions when the affect was more long lasting, up to a whole day, he felt he had no alternative but to “crack on”. He could not focus on work to the full degree but was able to move to emails, and instead of looking at a screen for up to two hours, he would look for 15 minutes and then move away. If it occurred when he was at home, if he was doing DIY or gardening he would have to stop as he was not able to focus.
76. Over the Summer of 2018 the episodes of the symptoms of paraesthesia on most days. In 2019 they occurred once or twice a week. They then became more common in 2020.

#### **(4) Breakdown in 2019**

77. In November 2019 the Claimant had a breakdown. He had separated from his partner in September 2019, which he attributes to his anxiety but also other issues. His mental health deteriorated to the point that by November he did not want to be at work or around anyone. He had stopped going to the gym, and did not want to socialise or answer the phone or look at a screen and did not want to be alive. He stopped eating or drinking much. He took annual leave (please some additional days leave) to take time off work and went overseas to try to relax. After about two weeks away from the office in late November and early December he started to feel better.

#### **(5) 2020**

78. Matters came to a head again on 29 January 2020. The Claimant’s case as to the events which precipitated this are set out items 12 to 14 of the particulars of discrimination and paragraph 20 of the statement provided on 15 October 2021. The Claimant states that he told Mr Sagar that he needed to consider all aspects of his future due to his mental health. He states that in response Mr Sagar blocked him from critical information about his job and sought to manipulate his management team against him. He states that Mr Sagar stated that every member of the team was upset with him and created a hostile environment and blames him for all the companies’ faults.
79. It is not necessary for the purposes of the matters before me to make findings as to whether the Claimant’s perception of events was well-founded. I accept that the Claimant had a mental breakdown. He could not work and left the office and then wrote an email to Mr Sagar. Over the following five to six weeks he went in to work but had severe anxiety about what was going on and what was going to occur. Over that period he could not focus on his job or on life and was thinking about what was going to happen tomorrow, would the business survive and would he get paid. Over that time he was not able to relax, or have time on his own or list to music, watch TV or do DIY

or work in the garden as the anxiety was too high.

80. In an email to Mr Saggar of 23 February 2020 set out concerns as to his perception of what was going on at work. He stated that work was “majorly playing on my mind”. He complained of time being taken up in training new members of the team and being required to get involved in other areas outside his remit that was taking him away from billing with the effect, he said, that he was being required to do 2.5 jobs and that he was left feeling undervalued. He introduced the email by noting that he was so down every evening that he needed to say something, and that:

“I am not in a good place now personally, mentally or with family and its very difficult for me to admit that to anyone right now – but I am trying my best to put a brave face on when in the office.”

81. The migraines/ paraesthesia became a lot more frequent in 2020. As before when it occurred, the Claimant could not look at a screen or hold telephone calls.
82. The Claimant was placed on furlough on or about 23 March 2020. His depression heightened at that point and on one occasion he had suicidal thoughts. In the period up until lock down the panic attacks had been less as he had learnt how to manage them, and instead stomach problems were more prevalent. He would have a panic around every couple of weeks up to the point when he was put on furlough, but then 2 to 3 times a week.
83. The Claimant’s position became particularly bad from 18 April 2021 to a point when he moved in with his mother for a week in mid-June 2021. He did not do anything but lie in his garden thinking about his situation and did not socialise or do any exercise other than walk the dog on the odd occasion. His sleep was mixed and he did not eat other than if he had to.
84. He started taking CBD oil in March 2021 and eventually found this helped him to relax better. He also started weekly psychodynamic counselling, but this was not until after the termination of his employment, on 7 January 2021 [176].
85. One consequence of both the stomach cramps from ulcers and anxiety attacks was tiredness. If it affected him overnight there would be a direct effect the next day. It would not stop him from working, but he would have to focus on menial tasks. Focussing on a screen was more of a struggle as he would not want to be at work or doing anything but sleep. It would affect how he reacted with other people, being more short-tempered and not as forgiving, and not wanting to build relationships.
86. When anxiety struck it also affected his ability to relax. He describes there being always something on his mind.
87. Throughout the period from 2016 the Claimant avoided taking sick leave. This was despite the fact that, in the Claimant’s own words, in his email of 23

February 2020, he had a demanding job which indeed added up to 2.5 jobs. I accept that the Claimant avoided taking time off because his perception was that he could not do so because Mr Saggar was unsympathetic to mental health issues. (I make no finding as to whether that perception was well-founded, it being unnecessary to do so for this hearing). He instead found coping mechanisms such as sitting in his car when he had a panic attack. About 10 days of time off was taken as holiday leave in 2017 and 2018 rather than taking sick leave. Even when he had his breakdown in November 2019 he took the time off as annual leave and additional leave.

**Are the ulcers properly to be regarded as a symptom of stress and anxiety**

88. The Respondent's contention is that any effect or deduced effects on day to day activities arising from the Claimant's ulcers must be disregarded as it is not established that it is a symptom of or linked to the Claimant's anxiety. That is supported by the NHS print out, produced on the morning the first day of the hearing. This stated that ulcers are usually the result of either *Helicobacter pylori* (*H.pylori*) or taking non-steroidal anti-inflammatory drugs such as ibuprofen or aspirin, particularly if taken for a long time or in high doses. However the Claimant was tested in 2016 for *H.pylori* (a bacterial infection of the gut) and this was not found (as indicated in his GP record for 24 June 2016 [128]), and I accept his evidence that he does not take either ibuprofen or aspirin.
89. The NHS print out also stated that that it used to be thought that stress or certain foods might cause stomach ulcers but that there was little evidence to suggest that this is the case. However the Claimant produced a number of academic articles indicating that this view is controversial. Whilst I have carefully considered that material, it is not necessary to refer to it in detail in these reasons. In overview there is acknowledgement of the line of thinking that had focussed on *H. Pylori*, whilst noting that this does not adequately explain the incidence of ulcers (Goodwin et al (2013)). There is also reference to several studies indicating a link between anxiety disorders and peptic ulcers, and the articles provide further evidence of studies to this effect (see eg Goodwin et al (2013), Lee et al (2017); Kim et al (2020). There is also a recognition of the need for further study, and a question raised as to whether the data is indicative of anxiety/ stress causing the ulcer disease, or that pain associated with the ulcer disease causes anxiety (Goodwin et al (2013)).
90. I was also referred to guidance by the National Institute for Health and Care Excellence which, whilst stating that the most common risk factors for ulcers and *H pylori*, or nonsteroidal anti-inflammatory drugs or aspirin, states that initial treatment includes assessment for stress, anxiety and depression. That might indicate a view that control of these elements is regarded as relevant to treatment, though again it might point to the risk of the condition impacting on mental health.
91. I also take into account that the ulcers were discovered at a time when the Claimant was suffering substantial stress in 2016. As against that however I

do not have evidence of how long the condition would have been present as compared to the period when the Claimant was suffering substantial stress. It may be on the contrary that it was the symptoms associated with the ulcers that were in substantial part responsible for the health anxieties.

92. Taking the evidence together, I am not satisfied that it has been shown that it is more likely than not that the PUD was caused by anxiety. The academic literature, and the exclusion of the most common causes referred to in the NHS document, supports the hypothesis that anxiety *may* have played a part. But in the absence of any direct medical evidence relating to the Claimant's case, and having considered the academic literature, I am not able to say that is more likely than not to be the case.
93. I do accept however that it is more likely than not that anxiety and stress has an exacerbating effect and has been at least a substantial influence in episodes where the symptoms associated with PUD have flared up since 2016. I take into account in particular the Claimant's evidence, which I accept, that his own experience has been that flare ups have been associated times at which his stress levels have been heightened.

#### **Migraines/ paresthesia**

94. I accept on the evidence before me that the Claimant's paraesthesia/migraines are more likely than not to be symptoms of his stress and anxiety. I accept that this was the view expressed to him by his GP as evidenced by the note of May 2021 and it appears that, despite investigation including a Cat Scan, no other cause has been identified. It is consistent with the Claimant's own perception that the migraines occurred at times when he was more stressed.
95. The medical records also indicate that the Claimant first noticed the symptoms of paraesthesia in June 2018 which was around the time when, on his evidence, he suffered a relapse in the frequency of the anxiety attacks. Whilst that begs a question as to whether the anxiety was causative of paraesthesia, or anxiety as to paraesthesia contributed an exacerbation of anxiety, or each impacted negatively on the other. However it at least indicates a correlation between the two conditions, and as above I accept the Claimant's evidence as to the medical opinion expressed to him.

#### **Substantial effect on normal day to day activities and impairment**

96. I take into account that the Claimant was able to continue working in a demanding job. However it is important to focus on what the Claimant could not do or only do with difficulty. Further, at times he was only able to avoid taking sickness absence by using his annual leave entitlement.
97. I am satisfied that the Claimant's anxiety involved a substantial effect on day to day activities. That was the case at least whilst the Claimant was having panic or anxiety attacks and in the immediate aftermath, and clearly at least as time went on after 2016 and the panic attacks continued, these were likely

to recur notwithstanding that the particular health anxieties in 2016 had ceased. During the panic attacks the Claimant had to stop doing other things and either lie down or go out and sit in his car or on a wall. Once he had learnt CBT he had to stop to go through that process. Whilst in the midst of a panic attack he was unable to eat or sleep and had limited ability to dial a number (other than speed dialing a pre-set number) and was unable to read or watch TV. Even when better able to cope, he had to take himself out of operation for the period whilst he went through the process of dealing with the attack and slowly getting back to normal. During that time he was unable to hold a conversation, rather than just responding to some basic questions during an attack. He was less able to drive in the aftermath of an attack, compared to his normal abilities. He was also less able to socialise and to interact with others in his usual manner without being snappy, his sleep was affected and focussing on a screen was more of a struggle. Whilst there were clearly periods of particular stress both in the Claimant's personal life when he split from his partner, and in relation to work, I accept that this went far beyond the range of normal reactions to adverse life events.

98. As set out above, I consider that the CBT techniques applied by the Claimant to deal with panic attacks fall within the scope of measures to treat or correct the impairment within paragraph 5 of Schedule 1 EqA. It follows from the fact that he was better able to cope when applying those techniques, that the impact on of the attacks on the Claimant would have been more severe if they were not applied. It is not necessary to quantify precisely what difference this would have made in the light of my conclusion as to the substantial effect on day to day activities even without having regarded to the deduced effect of stopping CBT.
99. Equally I have reached my conclusion as to the effect of the Claimant's anxiety without taking into account the combined effect with paraesthesia or flare ups of the symptoms of PUD. In both cases they further reinforce the conclusion I have reached as to the substantial impact on day to day activities. When there were flare ups in the symptoms of paraesthesia, the effect included that the Claimant found it more difficult to focus on a computer screen. He was unable to hold a full conversation though he could give direct answer or responses. He diverted attention to tasks such as dealing with emails rather than tasks which required conversation. It impacted on his ability to drive longer distances (more than 30 miles) and only on less busy roads and not at night and he suffered a loss of appetite.
100. As to the flare ups of PUD and reflux, this had a substantial impact in relation to difficulty in eating without pain, difficulty in sleeping or relaxing and the knock on impact such as that the Claimant would avoid picking up the phone. Further all this would have become much more acute if the medication that was taking had been stopped.

## **Impairment**

101. In relation to anxiety there is a closely related issue of whether these effects were due to an impairment or were simply a reaction to adverse life events.

There were indeed life events that appear to explain the points of greatest impact. First there were the health anxieties in 2016. Later there was the impact of the separation from the Claimant's girlfriend, and also the work related stresses. I accept however that the impact on the Claimant went beyond a normal response to ordinary life events. He continued having episodes of anxiety attacks, albeit less frequently, throughout the period such as the attack when driving home with his girlfriend when he needed to pull into a garage for an hour. Further the response went beyond the normal bounds of reaction to adverse events both in relation to the period of time over which they continued and the severity of the impact.

102. My conclusions in this respect are reinforced by the development of further manifestations of the impact of the stress and anxiety in relation to the migraines/ paresthesia. Again, this went beyond a normal reaction to adverse life events, both in relation to the symptoms and the period over which it lasted. However I would have reached the same conclusion without this aspect.

### **Long term**

103. The Claimant evidence, which I accept, was that the first severe panic attack was on 21 March 2016. I am not satisfied that in the 12 months after this it could yet be said that there was a long term effect on day to day activities. Initially in 2016 there were still health investigations and I have not seen evidence that it could be said that, viewed at that point, there was reason to believe that it could well happen that the condition would last for more than 12 months notwithstanding that the Claimant was discharged by the As One service on 23 September 2016.
104. However the position is different from the time when the Claimant had continued having panic attacks more than 12 months later. At that point it was apparent that these were likely to continue to occur beyond the period of intense health anxiety in 2016. In practice the specific dates pleaded in the Claimant's claim within that period are in April and May 2016 so nothing would seem to turn on fixing the precise point at which it was likely that the condition would continue for 12 months. It is not appropriate to specify a particular date in March 2017 by when the Claimant was a disabled person, given that realistically there must have come a point in advance of 21 March 2017 when, since the anxiety attacks were continuing, it was apparent that they were likely to continue to recur beyond the 12 months anniversary of 21 March 2016.
105. Equally in so far as the peptic ulcer condition can be taken into account, in association with the stress and anxiety, I have not seen evidence that it could have been known in 2016 that it could well be the case that this would recur rather than having been resolved. I have not found that the ulcers were caused by anxiety and nor do I have evidence as to the specific dates on which there were flare ups that can be regarded as brought about by stress and anxiety such as to indicate an earlier point at which the Claimant should be regarded as having been a disabled person.

**Conclusion**

106. I conclude therefore that, although the Claimant was not yet a disabled person within the meaning of the Equality Act during the period of his acute health anxieties in 2016 (including April and May 2016), he was a disabled person from March 2017.

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**Employment Judge J Lewis**

Date: 2 March 2022

SENT TO THE PARTIES ON:

7 March 2022

FOR THE TRIBUNAL OFFICE: