EMPLOYMENT TRIBUNALS

Claimant: **Mr A Thompson**

Respondent: **Hanson Quarry Products Europe Ltd**

Heard at: Bristol **On:** 14 March 2022

Before: **Employment Judge Midgley**

Representation
Claimant: Mr J Duffy, Counsel
Respondent: Mr Humphreys, Counsel

JUDGMENT having been sent to the parties on 28th February 2022, and written reasons having been requested in accordance with Rule 62(3) of the Employment Tribunals Rules of Procedure 2013, the following reasons are provided:

REASONS

Introduction

1. The issue to be determined at this preliminary hearing is whether the claimant was at the material time disabled as a consequence of Ischaemic Heart Disease and Superventricular Tachycardia within the definition contained in Section 6 and Schedule 1 of the Equality Act.

Procedure, Hearing and Evidence

2. In preparation for the hearing the parties had agreed a bundle of 345 pages, consisting of relevant medical evidence. I only read and considered the pages I was referred to by the parties. In addition, I had the benefit of the following:
   2.1. A disability impact statement from the claimant
   2.2. A witness statement from the claimant

3. The claimant had prepared the witness statement in addition to his disability impact statement and served it on the respondent shortly before the preliminary

hearing. The respondent objected to the claimant relying on the later statement as there was no Order for witness evidence. Having heard argument from both counsel, I permitted the claimant to rely on the statement: the respondent had had sufficient time to read, consider and respond to it, and was not therefore prejudiced by its admission, and the content of the statement was relevant to the issue I had to determine, and merely covered in written form what the claimant was likely to say in answer to questions from Mr Humprhey.

4. The claimant gave evidence by affirmation and answered questions from counsel and from me. I found the claimant to be an honest, credible, and straightforward witness. I accepted his evidence.

5. I heard concise verbal submissions from both counsel before giving Judgment.

The Issues

6. The relevant issues were as follows

6.1. Did the claimant have a disability as defined in section 6 of the Equality Act 2010 at the time of the events the claim is about? In particular:
6.1.1. Did the claimant have a physical or mental impairment. The claimant argues that he had a x impairment, namely x.
6.1.2. Did it have a substantial adverse effect on the claimant's ability to carry out day-to-day activities?
6.1.3. If not, did the claimant have medical treatment, including medication, or take other measures to treat or correct the impairment?
6.1.4. Would the impairment have had a substantial adverse effect on her ability to carry out day-to-day activities without the treatment or other measures?
6.1.5. Were the effects of the impairment long-term? In particular:
6.1.5.1. did they last at least 12 months, or were they likely to last at least 12 months?
6.1.5.2. if not, were they likely to recur?

Factual Background

7. I made the following findings on the balance of probabilities on the basis of the evidence which I heard and from that contained in the agreed bundle.

8. The claimant has been employed by the respondent as a rail operative since 1987.

9. He has suffered from the condition of Superventricular Tachycardia ("ST") for approximately twenty years. He describes the symptoms of that condition as follows: when he suffers an attack, he has a sudden missed breath and then has a very rapid shallow pulse. If he remains standing, he begins to feel faint and needs to sit down, although he prefers to lie on his back and raise his legs. He will remain in that position until his pulse returns to normal. The attacks can last from a few minutes to up to an hour. When he suffers an attack, he cannot walk, work, or drive until his pulse has stabilised. He has found drinking ice cold water or eating an ice lolly can help his pulse return to normal quicker.

10. The claimant did not go to his doctor every time that he had a heart palpitation, but largely sought to self-manage it by lying down, raising his feet, and the taking steps detailed above.

11. In June 2014, the claimant was diagnosed with Ischaemic Heart Disease ("IHD"), following an angiogram. As a result on 28 October 2014 he underwent a double heart bypass. He takes medication to manage the IHD, ST and hypertension conditions. I accept his evidence as to details and periods over which he has taken that medication: in brief he has taken the five separate medications detailed on page 81 of the bundle. In particular, atenolol was prescribed in relation to the SVT and its dosage was increased in March 2020.

The OH reports

12. After the claimant's bypass operation, the respondent obtained three occupational health reports in respect to determine whether he was fit to return to work. The first was on 25 June 2014. That report identified the following:

    12.1. In October 2014, just before his operation, the claimant was reported to be suffering from episodes of central chest pain on exertion. He described suffering from episodes of short-lasting chest pain when he walked more than three to four hundred yards, and he could not climb two flights of stairs at that stage without chest pain. There was some regularity in chest pain of a short duration when he undertook physical activities in his role.

    12.2. The occupational health report noted that the claimant was likely to be covered by the Equality Act and indicated that he was medically fit to undertake his full-time work role but should do so on a pattern of restricted work duties, limited to office type work or light physical work with the condition that he should avoid heavy physical work and that he should not undertake any activity that would require him to walk for more than two to three hundred yards at a time.

13. A second occupational health report was produced on 16 March 2015, after the heart bypass operation. At that time the claimant had satisfactory control of his symptoms as a consequence of surgical intervention and the prescribed medications, which I have previously indicated. The opinion of the occupational health physician was that the claimant was fit to return to work in a rehabilitative role undertaking a temporary position as a Rail Loadout Operator, which was office-based work of a light physical nature; the rehabilitative role being undertaken on a four-week phased return basis with a restriction precluding heavy manual work and an adjustment to duties and activities.

14. The claimant was not at that stage considered to be fit for his full-time role for a period of at least for four weeks but was functionally fit to perform the duties of his temporary restricted role (i.e. without heavy manual work and with the benefit of other restrictions as indicated). The occupational health physician opined that it would be sensible to proceed on the assumption that the Equality Act would be likely to apply, notwithstanding that there was no significant impairment to his ability to undertake his daily activities.

15. A third occupational health report was produced on 8 January 2016. At that stage the claimant reported that he had suffered from episodes of heart palpitations in July and October 2015. He described having a long history of episodes of palpitations which occurred on an occasional basis; the report noted he had been prescribed regular treatment to reduce the frequency and severity of the palpitations. The claimant reported that he no longer suffered with symptoms of angina and that his exercise tolerance was normal. That observation was made in the context of the claimant's office base role in the rail loft, which did not require him to undertake any physically demanding work or activities.

16. The claimant was considered medically fit to continue his Rail Outloader role. The occupational health physician formed the view that the claimant was likely to be regarded as disabled within the meaning of the Equality Act as a consequence of his circumstances.

The claimant's evidence as to the conditions and their effect on day-to-day activities

17. During the claimant's evidence, both in his witness statement and in his evidence before me, he described the consequence of his symptoms and their regularity in this way:

18. He suffers from shortness of breath when climbing stairs: after climbing two flights of stairs, he is sufficiently short of breath that he needs to pause and cannot speak to people for twenty or thirty seconds. Other physical activities, such as gardening, or lifting heavy objects, rapidly lead to him becoming short of breath and he has to sit down to rest.

19. He expanded on that point in his oral evidence, which I accepted, stating that when he uses a wheelbarrow, he is able to take one load before he has to sit down for five minutes to recover his heart rate and his breath. That was not something that he experienced before he developed the IHD and ST.

20. Similarly, he needs to rest if he undertakes any digging or manual labour of any significant onerousness after a short period as his heart will pound and he will become breathless and faint.

21. When asked what he was capable of before he developed the two conditions, he said that he would be able to perform the activities better and for longer periods and would not have to take time to recover after five minutes or so. Again, I accept that evidence as being truthful, accurate and honest.

The Relevant Law

22. Section 6 of the Equality Act 2010 provides as follows:

6 Disability

(1) A person (P) has a disability if—
(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

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

(3)…

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

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

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

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

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

23. The relevant sections of Schedule 1 are as follows:

Long-term effects

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

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

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

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

(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.

Effect of medical treatment

5 (1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if—

(a) measures are being taken to treat or correct it, and

(b) but for that, it would be likely to have that effect.

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

(3) Sub-paragraph (1) does not apply—

(a) in relation to the impairment of a person's sight, to the extent that the impairment is, in the person's case, correctable by spectacles or contact lenses or in such other ways as may be prescribed;

(b) in relation to such other impairments as may be prescribed, in such circumstances as are prescribed.

24. The Equality and Human Rights Commission Guidance ("the Guidance") was issued in accordance with s.6(5) EQA and by virtue of section 12(1) to Schedule 1 a Tribunal must take it into account when determining whether a person is a disabled person.

25. In order to determine whether a claimant has a disability the tribunal should consider four questions (see Goodwin v Patent Office [1999] ICR 302, EAT):-

    25.1. did the claimant have a mental and/or physical impairment? (the 'impairment condition')
    25.2. did the impairment affect the claimant's ability to carry out normal day-to-day activities? (the 'adverse effect condition')
    25.3. was the adverse condition substantial? (the 'substantial condition'), and
    25.4. was the adverse condition long term? (the 'long-term condition').

Impairment

26. The meaning of impairment is dealt with at A3 of the Guidance which provides: "*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."*

27. Thus 'Impairment' in s.6 EQA 2010 bears 'its ordinary and natural meaning… It is left to the good sense of the tribunal to make a decision in each case on whether the evidence available establishes that the applicant has a physical or mental impairment with the stated effects' (McNicol v Balfour Beatty Rail Maintenance Ltd [2002] ICR 1498, CA) The term is meant to have a broad application.

28. In Rugamer v Sony Music Entertainment UK Ltd [2002] ICR 381, EAT, the Employment Appeal Tribunal suggested the following definition of physical or mental impairment under the DDA: 'some damage, defect, disorder or disease compared with a person having a full set of physical and mental equipment in normal condition'.

29. Appendix 1 to the EHRC Employment Code states that 'There is no need for a person to establish a medically diagnosed cause for their impairment. What is important to consider is the effect of the impairment, not the cause' — para 7. This endorses the decision in Ministry of Defence v Hay [2008] ICR 1247, EAT, where the EAT held that an 'impairment' under S.1(1) DDA could be an illness or the result of an illness, and that it was not necessary to determine its precise medical cause.

30. It will not always be essential for a tribunal to identify a specific 'impairment' if the existence of one can be established from the evidence of an adverse effect on the claimant's abilities (see J v DLA Piper UK LLP [2010] ICR 1052, EAT. Similarly, it is not always necessary to identify an underlying disease or trauma where a claimant's symptoms clearly indicate that he or she is suffering a physical impairment (see College of Ripon and York St John v Hobbs [2002] IRLR 185, EAT.)

Substantial adverse effect

31. The meaning of 'substantial adverse effect' is considered at section 212(2) EQA 2010 and paragraph B1 of the Guidance which provides "a substantial effect is one that is more than a minor or trivial effect".

32. The Tribunal's focus, when considering adverse effects upon day-to-day activities, must necessarily be upon that which claimant maintains he cannot do as a result of his physical or mental impairment" (see Aderimi v London and South Eastern Railway Ltd UKEAT/0316/12, [2013] ICR 591).

33. In that context, the appendix to Schedule 1 of the Equality Act 2010 includes examples of factors which it would be reasonable to regard as having a substantial adverse effect on normal day-to-day activities. These include "a total inability to walk, or inability to walk only a short distance without difficulty; for example because of physical restrictions, pain or fatigue, and persistent distractibility or difficulty concentrating."

34. Conversely the guidance indicates that the following factors would not reasonably be regarded as having such an effect: "experiencing some tiredness or minor discomfort as a result of walking unaided from a distance of about 1.5 kilometres or 1 mile; inability to concentrate on a task requiring application of several hours."

35. Day-to-day activities include normal day-to-day activities and professional work activities, even if there is no substantial adverse effect on activities outside work or the particular job (see Igweike v TSB Bank Plc [2020] IRLR 267). In conducting that assessment, the tribunal should disregard the effects of treatment (see Guidance at sections B12 to B-17).

36. The Guidance addresses recurring or fluctuating effects at C5. Examples of how to address episodes of such conditions as depression, or conditions which result in fluctuating symptoms are given at paragraphs C6, C7 and C 11; they provide:

C6. If the substantial adverse effects are likely to recur, they are to be treated as if they were continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long term.

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

C11. If medical or other treatment is likely to permanently cure condition and therefore remove impairment so the recurrence of its effects would then be unlikely even if there were no further treatment, this should be taken into consideration when looking at the likelihood of recurrence of those are facts. However, if the treatment simply delays or prevents a recurrence, and a recurrence would be likely if the treatment stops, as is the case with most

medication, then the treatment is to be ignored and the effect is to be regarded as likely to recur.

37. In all four contexts the Guidance stipulates that an event is likely to happen if it 'could well happen' (see para C3). This definition of the word 'likely' reflects the House of Lords' decision in Boyle v SCA Packaging Ltd (Equality and Human Rights Commission intervening) 2009 ICR 1056, HL.

Discussions and Conclusions

38. I address the questions set out in Goodwin.

Did the claimant have a mental or physical impairment?

39. There is no dispute in this case that the claimant had physical impairments, namely the two conditions relied upon: ischaemic heart disease and super ventricular tachycardia.

Did the impairment affect the claimant's ability to carry out normal day-to-day activities?

40. There is some dispute as to the precise nature of the impairment caused the condition. I observe that the claimant was first diagnosed in approximately 2000 with IHD and with SVT in 2014. Since those dates he has been prescribed a medication to manage those conditions which he takes daily.

41. There is evidence before me demonstrating the nature of the conditions and their effects in terms of palpitations and otherwise. I turn to address the respondent's arguments in relation to these matters.

42. I deal firstly with the medical evidence in the form of the occupational health reports. I observe that all of the reports recognise that the claimant's condition amounted to a disability within the Equality Act. Mr Humphreys says that there is nothing within the reports that would support the conclusions that are reached on that issue, given the findings that are made as to the impact and the claimant's ability to perform the rehabilitative role.

43. However, it is clear from the OH report produced in March 2015 (at p171) that the occupational health report was expressing its opinion on the claimant's abilities which benefited from the effect of medical treatment, including the medication. Secondly, (at 173), the occupational health practitioner observes that there is a long history of episodes of palpitations which occur on an occasional basis, and again notes the prescription of regular drug treatment to reduce the frequency and severity of those episodes. Certainly, therefore, it was the conclusion of the occupational health team that at least some of the medications were taken to treat the conditions.

44. The respondent also relies upon the assessments contained in the undated Health Register Report (at pages 338 and onwards) which classified the claimant as fit to undertake each of the activities listed in the report. Mr Humphreys very reasonably accepted that the assessment must have been in relation to claimant's role at that time, which was the rehabilitative role as a Rail Loadout Operator, but stressed that the report consistently classified the

claimant as being fit, and argued that the report was the only third party evidence in relation to the substantial adverse effect of the condition.

45. However, the evidence had limited power, in my judgement, as there was no evidence before me as to the medical qualifications or understanding of the individual who prepared the report or their awareness of the claimant's underlying health issues or the treatment that he received in respect of it. Its scope is necessary limited to consideration of whether the claimant was capable of performing certain roles or functions within the respondent's workplace, which were office based and did not involve any element of heavy labour or arduous activity. The test I have to apply is necessarily a wider one, the impact of the condition upon day-to-day activities outside the workplace.

46. Lastly, Mr Humphreys suggested that the assertions that the claimant made in respect of his conditions were not supported or corroborated by the Health Register Report, which classified them as 'minor,' albeit, again, Mr Humphreys very fairly accepted that that it was impossible to know the nature of the categorisations between 'significant' and 'minor,' as there was no evidence in the report identifying it. Given the relative low hurdle that the claimant has to clear to establish that the conditions had a 'substantial' adverse impact, being one which is more than trivial, their categorisation as 'minor' would not of itself preclude me reaching the conclusion on the basis that the available evidence that the effect was more than minor.

47. In any event, I accept the claimant's evidence as to the manner in which he self-managed his condition without recourse to his GP or medical treatment as detailed below. Further, I take into account that the absence of references in the medical records, particularly in the relevant period, has to be viewed in the context of the impact the pandemic had upon access to medical treatment. The claimant said that he did not go to his doctor every time that he had a heart palpitation, but largely sought to self-manage it by lying down, raising his feet, and the taking steps detailed in his impact statement to ameliorate the effects of an attack or the shortness of breath and faintness caused by exertion. Again, I accept that evidence as being plausible, and I found the claimant to be an honest, straightforward and credible witness. That, it seems to me, explains the absence of such references in the medical reports and records and therefore I do not draw the conclusion from those absences that the claimant's evidence as to the regularity or effect of his palpitations should be rejected. I find it credible and have accepted it.

48. The description the claimant gives is one of difficulties in undertaking what may be described as relatively low-level physical activities which would from part of day-to-day activities, namely gardening and climbing stairs. Furthermore, that he is very limited in the time that he can undertake the activities for before he becomes so short of breath that has to stop and take remedial steps. Similarly, his ability to walk even 200 or 300 metres or to climb stairs is very limited. I note that the Guidance suggests that being unable to walk less than a mile would fall within the definition. Being unable to work more than 300 metres must also.

49. For all those reasons I find that there was an impairment in the claimant's ability to carry out normal day-to-day activities.

Was the adverse condition was a long-term one?

50. In this context, the impact of medication is significant. The claimant has had one condition for about six years, another for a significantly longer period. Since the diagnosis of each of those conditions the claimant has been prescribed daily medication and he required a double heart bypass in 2016. Whilst some of the symptoms may be connected to the hypertension, this is an organic situation in which each of the conditions (both those relied upon as disabilities and those that are not) has some part to play. I cannot say on the basis of the medical evidence that it is appropriate or reasonable to conclude on balance that it is the hypertension that is the cause of the effect on the claimant's day to day activities, rather than the IHD or ST, and certainly the medical evidence references the latter two as much as it references hypertension. Where I have been taken to entries relating to hypertension, they are in the context of an annual health review, which is of course a sensible step for someone with an underlying heart condition, such as the claimant. That does not demonstrate that hypertension caused the claimant's symptoms and IHD and/or ST did not.

51. Applying the guidance, I am satisfied that the effects of the conditions were long-term as, taking into account the nature and regularity of the symptoms whilst managed by medication (an effect which I must of course disregard when assessing what the symptoms would be and the period over which they would last), I conclude that they have lasted for more 12 months and/or are likely to recur.

52. For those reasons I conclude that in the period from 3 August – 16 October 2020, the claimant was a disabled person for the purposes of the Act.

Employment Judge Midgley
Date: 11 April 2022

Reasons sent to parties: 11 April 2022

FOR THE TRIBUNAL OFFICE

Note - Reasons for the judgment having been given orally at the hearing, written reasons will not be provided unless a request was made by either party at the hearing or a written request is presented by either party within 14 days of the sending of this written record of the decision.

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