EMPLOYMENT TRIBUNALS

Claimant: Mr A Mills

Respondent: Driver and Vehicle Standards Agency

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

On: 23 June 2022

Before: Employment Judge Broughton

Representation
Claimant: Mr Rudd – counsel
Respondent: Mr Serr – counsel

RESERVED JUDGMENT ON A PRELIMINARY ISSUE

The Claimant's claim that he was a disabled person for the purposes of section 6 of the Equality Act 2010 is **not** well founded and his claims of disability discrimination are therefore also not well founded and are dismissed.

RESERVED REASONS

Background

1. At a previous preliminary hearing for case management before Employment Judge Blackwell on 15 June 2021, the case was listed for today's hearing to determine the issue of whether the Claimant suffered from a disability at the relevant time.

2. The Claimant issued a claim on 16 March 2021. Mr Serr confirmed today that the claims include that he was constructively unfairly dismissed because of a breach of the implied duty of mutual trust and confidence, complaints of a failure to make reasonable adjustments and unfavourable treatment (detriments) because of something arising in respect of his disability.

3. The Claimant was employed from 3 September 2018. He resigned and his employment ended on 15 or 16 March 2021.He was employed as a Driving Examiner.

4. The Claimant submitted a second claim on 21 February 2022, in which he complains of victimisation (with the protected act being the first claim).

5. The two claims have been consolidated.

6. As agreed at the outcome of this hearing, the issue of disability is only relevant to the allegations/claims in the first claim .

Disability/ Impairments

7. The Claimant submitted further and better particulars on 12 July 2021 in respect of the first claim (p.42 – 49). Those further particulars confirmed that the Claimant relies on the conditions of hypertension and anxiety as disabilities.

8. It is common between the parties that the Claimant was diagnosed with hypertension in January 2019.

Relevant Period: March 2020 to March 2021

9. I discussed with the parties at the outset what the relevant period is for the purposes of the disability discrimination complaints. Mr Serr confirmed that it was between March 2020 and March 2021 on the basis that first alleged act of discrimination was 9 March 2020 when the Claimant raised a grievance. Mr Serr explained that while he had not actually seen the documents relevant to the formal grievance and was not sure whether the Claimant had actually mentioned in that grievance that he was disabled however, he believes that he had alleged that he was treated differently to his colleagues and had referred to stress and the impact on his health. While Mr Rudd explained that the Respondent does not accept discrimination took place in March 2020, the Respondent accepts that applying what he described as a '*broad-brush'* approach, the relevant period is March 2020 to March 2021.

Evidence

10. I was assisted today by a joint bundle of documents which numbered 195 pages.

11. The Claimant had produced a witness statement. Part of the Claimant's statement dealt with the issue of the Respondent's knowledge. Mr Serr accepted that the final section on the issue of knowledge does not need to be considered during today's hearing.

12. I was concerned by the lack of detail in the Claimant's witness statement, particularly with respect to the alleged effect on his day to day activities of the pleaded impairments. He described symptoms without clarifying the period when they occurred and in some cases the frequency. Mr Serr asked no supplemental questions. I asked a number of questions to assist me in determining the issues. I asked those questions prior to Mr Rudd carrying out his cross examination to ensure that he had an opportunity to address the Claimant's evidence on those points in cross examination. No objection was raised by either counsel to proceeding in this way.

13. The Claimant produced in the bundle GP records for the period September 2018 to June 2021. There was a letter from a counselling service called Insight Healthcare (p.173- 174), an OH report dated 29 January 2021 (including a second slightly amended version), some correspondence relating to admissions into the Emergency Department and extracts from the NHS and British Heart Foundation websites . The

Claimant has not produced a medical report from his GP or other medical professional addressing the issues which I am required to consider in determining whether the Claimant has a disability or disabilities, for the purposes of section 6 EqA.

Late Disclosure

14. After the hearing, the Claimant's representative emailed to the Tribunal on 6 July 2022 further documents and requested that they be taken into account and any judgment deferred until after the parties had the opportunity to make representations. The documents were clinical notes from Insight Healthcare, who had provided the Claimant with counselling. The Respondent wrote on 7 July 2022 objecting to the late disclosure and that it had not had an opportunity to cross examine the Claimant on this new evidence but if the hearing was reconvened to enable it do so, the Respondent expressed concern on the potential impact on the timetable for the final hearing. The documents related to appointments between February and October 2021 and thus the Respondent challenged the Claimant's assertion that he had only just became aware of their existence. The Respondent also made the point that the documents are largely counselling notes from April 2021 onwards and postdate the relevant period in any event. The Claimant's responded to the Respondent's objection, expressing the view that it would be disproportionate to reconvene the hearing and that he was not requesting that. The Claimant stated that if the Tribunal were to decide that the Respondent should be given an opportunity to cross examine the Claimant on the late disclosure, the Claimant would withdraw the application to submit them into evidence.

15. There are entries in the late disclosure which relate to consultations/counselling sessions which took place outside the relevant period and references to the impact of these tribunal proceedings on the Claimant's mental health. It is difficult to see what relevance those records which post-date the relevant period have to the issues to be determined.

16. With respect to the documents which relate to sessions/consultations during the relevant period, the Claimant had been cross examined at some length by the Respondent on the content of the GP records and the extent to which they were consistent with his account of events, his account of the effects of the conditions and the cause of his symptoms. It would not be in accordance with the overriding objective, specifically the need to ensure the parties are on an equal footing, to allow the Claimant to submit further medical evidence at this late stage without giving the Respondent the chance to cross examine him on those documents and make further submissions. In those circumstances, and as neither party want to reconvene the hearing, the application to submit the additional documents is refused.

17. I proceeded to consider the case without reference to those documents.

Findings of fact

18. I made the following findings of fact based on a balance of probabilities. All references to page numbers are to pages in the agreed joint bundle.

19. The findings set out are not intended to be a complete record of all the evidence I heard during the hearing. I took all the evidence into account unless otherwise noted however, I set out the evidence material to the determination of the issues before me.

Start of symptoms : From October 2018

20. The Claimant described starting to suffer certain symptoms but his statement did not address when these first stated. In response to questions I put to him, he gave evidence that he was uncertain when these first began but believed that it was between starting employment in September 2018 and January 2019 when he was diagnosed with hypertension. He ultimately gave evidence that he thought it would have been be in or around **October 2018.**

21. The Claimant complains that he began around that time to suffer with headaches, with heart and chest pains, which became more regular as the symptoms continued and lack of sleep. He described how he thought he was having a heart attack and that he became paranoid because he had not suffered pains in his chest before and he did not know what was wrong with him.

22. He described the headaches as "*daily"* and "*constant*". His evidence is that he was taking about 8 paracetamols a day but the tablets had no effect.

Impact on day to day activities: headaches and other symptoms

23. The Claimant alleges that the "*constant"* headaches affected his daily activities in that his exercise declined, although he was probably still trying to do some but how the headaches were "*morning to night*", debilitated him, and how he would have to " *lie down in a dark room on the bed*" such was the extent of the headaches. However, he describes how although the headaches were "*all the time*" they were not the main concern, the main concern at the time, was the chest pains because there was no explanation for what was causing them. He also complains of not sleeping, having sporadic diarrhoea, it was hard to focus, he had a lack of energy and his health declined

Impact on day to day activities: chest pains

24. In terms of the chest pains, the Claimant described how he could not do the cooking or housework because of the chest pains but how this was mental as well as physical because he was so worried about the cause of the chest pains, the paranoia "*consumed my life*". He went on to clarify that he it was not the physical chest pains but the fear of the cause of the chest pains which stopped the Claimant from undertaking tasks such as a housework. This also impacted on the exercise he took.

25. The Claimant also complained of a lack of sleep; either having no sleep or broken sleep where he was awake; "*50 or more times a night",* which he described as not an exaggeration and that the more he did not sleep, the more worried he became and the more he suffered with chest pains.

September/October 2018: other health conditions

26. The Claimant suffered from other health conditions in 2018.

27. In cross examination the Claimant accepted that in September/ October 2018 he was suffering with a sore throat. The records refer to a diagnosis of Tonsilitis (p.123).

28. In 2018 the Claimant had a second job, working as a part time mobile caretaker (15 hours per week) for Nottinghamshire County Council (Council). He had not mentioned this second job in his evidence in chief. In cross examination he gave evidence, that the role involved opening sites and checking the fire alarms and taking water samples but he disputed that there was any maintenance work involved.

29. On the 21 September 2018 he was issued a fit note for work until 18 October 2018 due to arm and back injury. The Claimant on 17 October 2018 (p.123) was reporting with 5 months of elbow pain arising from a workplace incident in his other job. He was diagnosed with 'tennis elbow' (lateral epicondylitis).

30. The Claimant gave evidence that he later stopped working for the Council however he was rather vague about when this was, he believed it was sometime in 2018.

31. On the 5 November 2018, his GP notes (p.124) record;.

    " ongoing prob with lat epicondyle pain –…
    Was working as caretaker, feels cant do it due to pain R elbow."

    Job with Respondent:

32. The Claimant described how his job with the Respondent required him to *"very alert"* and have good reactions to intervene if he needed to. He describes how any of the symptoms he suffered stopped him doing his job effectively but that together at times it meant it was unsafe for him to carry out his role.

    January 2019

33. The Claimant on 2 January 2019 (p.126) was seen at the Hospital Emergency Department complaining of diarrhoea and vomiting and a rash. During this visit his Blood pressure was noted to be "*very high".* The Claimant confirmed under cross examination that he was not alleging the symptoms he had attended the hospital with on this occasion related to his blood pressure. The notes also record him referring to work being very stressful.

34. The Claimant was signed as not fit for work from 2 January 2019 to 7 January 2019 with a diagnosis of a *rash/URTI.*

35. There is no record at this time in the GP notes, of problems with headaches or sleeping.

36. His GP records on 2 January 2019 : "*viral but noted to have raised bp.."* and later on 11 March 2019 he is diagnosed with a viral respiratory infection (p.126).

37. There is reference to diarrhoea, but no medical evidence linking this to either of the pleaded impairments. He was suffering a rash and viral infection and by 2 January 2019. The notes record that;

    "*D + v and rash resolving*".

38. The GP records do not report an ongoing issue with diarrhoea. I find on balance, that the diarrhoea was not linked to hypertension or anxiety but the viral infection and was not an ongoing symptom.

39. The GP notes record that by 9 January 2019 (p.125) the Claimant attended for a blood pressure check and now reports the Claimant suffering headaches and dizziness but "*more headaches than anything else".* He was put on a 24 hour blood pressure check machine. The Claimant conceded under cross examination that there was nothing in the GP notes which states that the headaches he reported were caused by high blood pressure and the Claimant accepted during cross examination, that during this period

he also had a viral infection for a few months. When asked what his evidence was about the likely cause of the headaches, he replied that:

" I don't know – not for me to say – I've not said, ' this happened because of that' but just talked about the symptoms in that period – I just said what happened – you are asking me to say medical things I don't know about".

40. However, on **17 January 2019** (p.125) the GP notes record that the Claimant;

"*History 1: discuss blood results*
…
Aware lifestyle related – too much alcohol last year (declined further details) – will cut down
Also put on more weigh – aware needs to lose.
…
2. wants Med3 to cover period 26th Dec til end of Jan
works 2 jobs – full time as DVLA assessor – also part time at night in care - was needing to do manual handling in this job – wasn't able to do this ; same employer has lined up new job for him, but can start end of the mth- cleaning supervisor 3 hrs at night – happy w this arrangement – employer needs med3 to cover period between 26thDec to start date…"

41. The Claimant accepted that the problem with his elbow was on-going in early 2019 but he was vague and could not recall whether or not he took on a different second job or not. The GP notes clearly however indicate that he still had a second job by early 2019 and I find on balance, that he did have another job during this period and he was expecting to change jobs in January 2019.

42. The Claimant accepted in cross examination that during this period, despite the alleged severity of his headaches, chest pains, paranoia and sleep problems and the need to be 'alert' as a driving instructor, he did not take any time off work from his employment with the Respondent.

43. The Claimant was suffering with elbow pain and had requested a fit note from his GP on 17 January 2019, in relation to his second job which involved manual handling. I find on balance, not disputed by the Claimant (who appeared to struggle to recall what the situation was with his second job during this period), that he was expecting to change his second job to a supervisory role which would require him to work nights. He was therefore working during the day for the Respondent and anticipated being well enough to be able to also undertake night shifts in his second job.

44. Although there is reference to headaches and dizziness, there is no indication in the GP records of what the cause of these symptoms were, whether it was blood pressure, stress, viral infection or something other. The Claimant's own evidence, is that he does not know what the cause of the symptoms was.

45. Further, what the Claimant was reporting to the GP during this period, I find is not consistent with the severity or frequency of the symptoms he describes in his evidence in chief.

February 2019

46. The GP notes record that the Claimant was diagnosed with essential hypertension on 20 February 2019 (p.126) following the identification of very high blood pressure (BP)

when he attended the Emergency Department on 1 January 2019 following a '111' call. On the 20 February 2019, he is now prescribed medication for the hypertension , "*Ramipril 2.5mg capsules (one daily)".*

47. Given the identification of high BP in January 2019, the parties are in agreement that the diagnosis of hypertension should be treated as a diagnosis which covers the period from January 2019.

48. The plan on 18 February 2019 was for the Claimant to do his own BP testing at home and fit a monitor (p.126) but this was not appropriate for his driving job so he bought a compact monitor to use at home to record his BP (w/s para 2 and p.126).

49. During this same period in February and in March, the Claimant still had on ongoing sore throat and cough.

50. The GP notes still do not record any opinion expressed by the GP about any possible link between hypertension and any of the symptoms the Claimant described or was reporting. The Claimant accepted that the notes to do not record that he was suffering from any symptoms as a result of hypertension, commenting that ; "*not mentioned in the GP notes but that does not mean it did not happen"*

March 2019

51. That the Claimant however was suffering chest pains from October 2018 is I find consistent with the entry in his GP records on **4 March 2019** (p.126) which refers to the Claimant getting; "*some chest pains since October"* . However, by March 2019 the GP reports the symptoms as follows.

*"**Has been getting some chest pains since October, also some neck pains more recently, comes and goes not related to exercise , play squash and ok there, not yet started meds for BP, stressful time with job 6 weeks training pass or fail at the end**. No SOB, no cough**, no palps…***

Diagnosis MSK chest pains.

Plan: General discussion, simple analgesia"

Tribunal stress

52. There is no mention within the notes of "*constant"* headaches or the other symptoms described by the Claimant.

53. This entry also records *" no palpitations".*

54. When put to him under cross examination, the Claimant did not dispute that the diagnose of "*MSK"* was a reference to *musculoskeletal pain.* The GP therefore I find, did not consider that the chest pains were related to hypertension. The only objectively reasonable interpretation of the notes, is that the GP considered that what the Claimant was describing at the time, was musculoskeletal pain, which is consistent with other entries in the notes of ; "*Tenderness on palpation of the left chest wall and left PSM OF c - spine*". No possible link with hypertension is recorded.

55. The Claimant under cross examination did not himself dispute that the GP notes did not suggest the chest pains were related to high BP, giving evidence that;

" it is not for me to say … I am not a medical procession …I could not accept or deny if professional enters data on it".

56. The Claimant's evidence under cross examination, was not consistent with the evidence in his witness statement which sets out his definitive view of the long term effects since January 2019 of the impact of hypertension and anxiety. There is no mention of diagnosis of MSK in his witness statement or of having a viral infection in early 2019.

57. The GP notes up to March 2019 similarly do not I find, record symptoms consistent with the Claimant's description in his evidence in chief of the effects of the pleaded impairments.

58. On 11 March 2019 (p.126) the GP notes record that the claimant is still doing his job as a driving test instructor as *"they don't like time off".* The Claimant during this same period, according to his evidence in chief is having constant headaches, not sleeping, suffering diarrhoea, heart palpitations and chest pains and yet does not require time off work. That he did not require time off work is not consistent with his evidence about the effect on his normal day to day activities. His GP also records that in March 2019 to he was still playing squash *"and ok there*".

59. There are also entries on 11 and 25 March 2019 which refer to a sore throat and cough but that his chest is clear with a diagnosis *of " infection related".* `

May- July 2019

60. There is significantly less activity in terms of attendance with his GP during the months of May to July 2019.

61. As at end of March 2019 (p,127) he is noted as having a persistent cough.

62. There is a notable entry on **23 May 2019** when the Claimant reports itchy, gritty eyes and.

"sometimes vision slightly blurry at a distance , no eye pain, never had eyes tested…

…difficult to see fundi ? beginning of cataract.
Normal eye movements, no inflammation of conjunctive"

63. There is no indication whatsoever in the notes that the blurry vision the Claimant reports he sometimes has, is related to hypertension and/or anxiety. The Claimant has not produced any other medical evidence which deals with the issue with his eyesight. The Claimant alleges in his statement that having had hypertension over a long period of time, this may now have affected his vision. There is nothing in the medical evidence provided which sets out what his symptoms are, what the cause is likely to be and at what stage if any, the hypertension may have had an impact on his vision.

2 August 2019

64. The Claimant attended his GP on 2 August 2019 following a road traffic accident that day, reporting radiating pain in left knee and lower back. He was diagnosed with soft tissue injury and prescribed medication (naproxen and omeprazole) .

65. The Claimant accepted under cross examination that this incident caused him ongoing musculoskeletal pain. Something he neglected to mention in his evidence in chief.

August 2019

66. There is an entry in his GP records on 15 August 2019 that the Claimant was not fit for work from 15 to 28 August 2019 due to lower back injury and knee pain and on 28 August 2019 the Claimant was diagnosed as not fit for work from 28 August to 10 September 2019 with again a diagnosis of lower back injury and knee pain.

67. The Claimant complains that one of the effects he suffered because of the hypertension/ anxiety was not being able to exercise. He declines however to address in his evidence in chief, the knee and back pain he suffered from 2 August 2019 because of the road traffic accident and the degree to which this impacted on the exercise he could take and his ability to play squash.

68. The Claimant accepted under cross examination that from March to August 2019, (p.127) he took no sick leave from his job with the Respondent apart from a few days in 2019. Again that is not consistent I find, which his description of the symptoms he suffered of constant headaches, palpitations and inability to sleep. His job required him to be 'alert' and in charge of a vehicle on the road for hours at a time.

September 2019

69. The Claimant was absent from work from the Respondent on 5 September 2019 due to lower back and knee pain due to the road traffic accident and by 10 September the GP notes record that due to back/knee injury he had not worked for 6 weeks or so.

70. The Claimant's GP records refer to the Claimant on 10 September 2019 (p. 128) alongside 'HT' (which it is not disputed refers to hypertension), not taking the prescribed medication because of side effects. The notes do not record the what the alleged side effects are. The print out from the GP of the medication prescribed (p.139) shows a prescription of 28 capsules (one to be taken daily) on 20 February 2019 but no further prescription until a year later on 25 February 2020 which is consistent with the body of the GP notes with the entry on 25 February 2020 (p.131) stating :"*put pt straight on bp meds"* after a recording of high BP.

71. I find therefore that for almost 12 months from about March 2019, the Claimant had not taken the medication prescribed to help reduce his blood pressure, and only started it again in February 2020.

72. A fit note was issued and the Claimant was deemed not fit for work from 10 to 23 September and then from 24 September to 7 October 2019 2019 with a diagnosis of knee/back injury which was under review .

73. On 25 September 2019 there is (p.128) reference to ongoing back pain with sciatic radiation and the Claimant feeling stressed due to an Occupational Health (OH) review which included the comment that he would be better with a session of two of physiotherapy, with the GP recording that there is no guarantee that this would be curative. On 26 September 2019 the Claimant is reporting as feeling; "*slightly anxious or depressed*". The Claimant in answer to my question, gave evidence that he could not recall an actual diagnosis being given of depression. No diagnosis is recorded in the GP notes or any other medical evidence provided by the Claimant and I find no such diagnosis was made.

26 September 2019

74. There is an entry in the GP records (p.128) which states that his BP fluctuates and lists his hobbies as squash and badminton. There is reference to some mobility issues with the Claimant reporting having slight problems in walking about and;

"*slight ache on EOR due to stiffness*
MP 10 % reduced …
Advised gradual return to fitness, squats lunges, dynamic balance, stairs, hip..
…
Advised on heat therapy
Pt anxious therefore booked with B5 to do some gym excs to enable return to fitness
…
Lack of activity causing stiffness
RTA reduced confidence in activity…"

Tribunal stress

75. The Claimant in cross examination gave evidence that at this time his sleep was affected by the pain and discomfort from the road traffic accident but also the anxiety arising from the alleged bullying at work. He accepted that during this period with respect to the pain from the injuries he sustained in the road traffic accident; " *100% it would affect sleep, if had painful joints definitely*" and that the HP "*may be a factor*" also.

76. There is no reference in the GP notes however to hypertension or anxiety impacting on his sleep but the records report "*sleeping affected*" following a reference to the knee injury and the pain across his back.

77. There is reference to the Claimant having "*moderate problems*" with his " *usual activities*" such as work, study, housework, family or leisure activities. (p. 128) however, this is not identified as relating to hypertension of anxiety and I find, that considering the context in which these affects are recorded, these effects relate to the impact of the knee and back. The GP goes on to recommend a return to exercise and that it is the RTA which has "*reduced confidence in activity*". There is a recommendation for MSK pathway referral and physiotherapy. There is no discussion at this stage about medication or counselling for anxiety. I find the effects on his normal activities as described, were not related to either of the pleaded impairments at this stage.

78. There is also no reference to diarrhoea but rather *"constipation*" caused by the naproxen (prescribed for the knee and back pain).

79. By the 26 September 2019, the Claimant is reporting that he is *"slightly anxious or depressed"* He is not reporting problems with headaches, or difficulty sleeping due to anxiety or any other effects I find, of anything other than the back and knee pain.

October 20219

80. On the 2 October 2019 (p.129) the GP records, refer to there being; "*No reported problems or complications encountered"* and that the *" Patient feels well…"*

81. The Claimant attended the nurse for a BP check(p.130) on 16 October 2019 and there is no record of any reported impact on his activities caused by either pleaded

impairments, during this consultation. Albeit it is not disputed that it would have been a short appointment.

3 January 2020

82. The Claimant attended his GP on 3 January 2020 (p.130) because of a cough. The Doctor checks and comments that his lungs are clear.

83. There is still no record of the Claimant reporting headaches, sleeping difficulties or other effects of the pleaded impairments at this stage.

25 February 2020

84. The Claimant was prescribed Ramipril again in February 2020 (p.131)to try and bring his BP down due to a high BP recording however, there is no record of the Claimant reporting any problems at all in terms of any impact on his day to day activities. There is no reference to issues with his sleep, headaches, diarrhoea, concentration or indeed any of the alleged adverse effects of the pleaded impairments.

March 2020

85. The Claimant's evidence is that in March 2020 he was allocated another line manager but the stress at work continued and his health declined, and he clarified that by this he meant his palpitations and chest pains were becoming stronger and he was sleeping less and that this resulted in uncontrolled episodes with ambulances called to him and an admission into hospital. He gave evidence that the ambulance had been called, not directly by hm but after calling "111", 3 times over a period of 3 ½ years but he could not recall the dates. When I asked whether on each occasion it was due to chest pains, he referred to it being "*3 different issues".*

86. The Claimant describes that in terms of the effect on his normal day to day activities, it was the "*same thing*", he had no interest in doing things , his exercise was reduced, he was not socialising, eating too much or not properly .

87. The Claimant gave evidence that he was probably still trying to do some exercise but could not do what he had done before, it was probably "*little to none*". He stopped playing squash which had been a passion of his. He described how his mental health was profoundly affected . He also describes his headaches in response to a question I asked, in March 2020 as still *"persistent and consistent".* That he had them most of the day and it was "*tiring me out".* He could not recall if he was still taking any paracetamol for the headaches or not because they had had no effect. He described how he did know how he continued working because he was "*bombed out*". That there was very little going on at home, it was all at work, that he was under so much pressure from his Acting Manager that it consumed his life. I find that his description of how he was feeling is not supported by the medical evidence he has provided.

11 March 2020

88. The Claimant attended his GP again on 11 March 2020 (p131) and his BP was still raised. There still however, is no reference to any side effects/symptoms of the BP, no reference to headaches or inability to sleep. Indeed I note that what is recorded is.

*"**No reported problems or complications encountered***

***Patient feels well** …"*

24 March 2020

89. The Claimant has a telephone consultation on 24 March with his GP (p.131). It notes that his BP is still high but that the claimant; ***" sounds very well on the phone".***

90. The Claimant under cross examination, denied being asked about how he was feeling during this call. He had not addressed this in his evidence in chief. I also do not find it credible that given his alleged issues with his memory and the vagueness around his recollection of some events, (including whether he had started a different role with Nottinghamshire City Council), it is plausible that he could recall this particular call with his GP from March 2020. In any event, he does not allege that he raised any concerns during this call either, about headaches, disturbed sleep or otherwise effects from the hypertension or anxiety. There is an issue recorded about his urine but "*no chest symptoms*". I find on balance, that he did present to that GP as sounding well on the phone, whether he was specifically asked the question or not.

Covid – shutdown- end March 2020

91. The Claimant did not dispute under cross examination that at the end of March 2020 the Respondent shut down its business fo*r* 4 months and the drivers were sent home during the Covid pandemic and therefore he was not required to work.

April 2020.

92. On the 8 April 2020 (p.131) the GP notes record that the Claimant's BP was still raised but had gone down slightly and the Claimant thinks because he was off work, the reason could be the stress at work.

93. The GP records also refers to the Claimant having bought a treadmill and that he had started using it . The Claimant accepted under cross examination that a contributory factor to his high blood pressure could have been his lifestyle including issues with his weight and his alcohol consumption and in fact the GP records refer to him losing weight and his BP having come down at this time.

94. On 18 April 2020 an ambulance was called to the Claimant and there is an Ambulance care summary (p.150). The call out was related to abdominal pain. The Claimant's case is that he believes the pain was due to his heightened anxiety about his health and this anxiety caused him to seek emergency advice. The Claimant in answer to my question, gave evidence that he believed this was the first occasion an ambulance was called out to him. The record of this incident refers to chronic abdominal pain and diarrhoea. It refers to blood pressure as 196/125 which the Claimant alleges (which not supported by medical evidence but was not disputed in cross examination or submissions), that anything over 200 would probably indicates a stroke and therefore the BP reading was very high and chronic.

95. He gave evidence that there were other episodes when he had chronic chest pains but he did not seek assistance on those other occasions, when his heart was "*beating through his chest"* but because of the Covid pandemic and he did not want to "*clog up the phones".*

96. The Claimant in his evidence referred to abdominal pain being a side effect of the medication he was taking however, there is no medical evidence to support that and later in his oral evidence, he alleged that the anxiety was also a possible explanation for the abdominal pain.

97. The Call Incident Report (p.151) refers to occasional diarrhoea and cramping /bloating and gives a diagnosis of *: Imp – abdo pain? Viral GE - ? cause."* There is no reference to the symptoms likely to be caused by medication, hypertension or anxiety. There is by this stage no referral for counselling or advise about medication for anxiety/stress.

May / July 2020

98. There are a number of entries of attendances with the Claimant's GP throughout May 2020 and no reported affects/symptoms. The Claimant alleged in cross examination that headaches are part and parcel of BP and just because the GP did not record headaches does not mean that he was not having them and that he had got so use to them they became *"insignificant*" hence he did not mention them to the GP. Paracetamol did not help and he was taking no medication to help with them . However, not only do the GP notes not report the pleaded symptoms/effects, the entry for 19 May 2020 (p. 132) actually states.

"No reported problems or complications encountered

Patient feels well …"

99. The Claimant in his evidence states that the dosage of Ramipril was increased to 10ml in May 2020 but this had little effect so he was also prescribed Amlodipine. He expresses an opinion that without the Amlodipine the symptoms of his hypertension would be far more severe as he was told that he was a *stroke waiting to happen*. There is no medical evidence to support this and nothing in the GP notes record any such advice or opinion. There is no medical evidence on the reason for the medication, the effects of it or what the likely effects would have been without it. Further, what is clear is that he was still being advised that what would also assist was changes to his lifestyle, such as diet, exercise and reduced consumption of alcohol.

100. The Claimant's further oral evidence was that the purpose of the Amlodipine was to draw sodium in the body so that he would use the lavatory more, to assist the Ramipril.

101. The medical records suggest and the Claimant does not dispute, that he was not prescribed Amlodipine until **July 2020** (p.139).

Ramipril

102. The Claimant was prescribed Ramipril at 2.5 mg in February 2019, the prescription was increased to 5mg on 24 March 2020 and then reduced to 2.5 mg on 21 April 2020. It increased to 10mg on 12 May 2020 and that dosage continued to be prescribed until 12 May 2021. The Claimant's oral evidence is that the Ramipril on its own had little effect without the Amlodipine (which was introduced in July 2020) but that he believes the medication is still not effective now. In answer to questions I put to him, the Claimant gave evidence that his symptoms were not helped by the medication. He described how the diarrhoea was still sporadic "*not often"*, the headaches remained daily, the chest pains were not everyday but "*often*" and the heart palpitations progressed mainly at night to "*all the time*" and how his heart could be seen beating in

his chest.

103. The Claimant gave oral evidence that chest pain and palpitations are a common side effect of the medication for high BP however, there is no medical evidence which deals with the impact or side effects of the medication and further, he had complained of suffering chest pain before taking the medication. The reference to chest pain in the GP notes records a diagnosis of MSK.

104. I do not find on the evidence, that the chest pains and palpitations were a side effect of the medication prescribed for high BP.

27 May 2020

105. The Claimant gave evidence that under cross examination that he was not sure whether he had been asked to return to work by the Respondent by 27 May 2020 however, the GP notes record the Claimant informing his GP that on that date that he had been asked to return to work and he was warned about a return with raised BP. I find therefore that he had by this date been asked to return and his concern was about the risk of Covid. The notes entry appears to record his GP advising that to Claimant that he was not at increased risk with high BP.

April/May 2020 to September 2020

106. In answer to a question I put to the Claimant, he gave oral evidence that there was no change in his symptoms from April/May 2020 through to September 2020, that the symptoms remained the same and he has the same symptoms as at the date of this hearing. However, there is no record in the GP notes of the effects on his day to day activities he describes. There is no reference to the Claimant reporting that he is suffering from headaches, disturbed sleep, palpitations, diarrhoea, loss of concentration, impact on memory, motivation to exercise or engage in social situations etc

107. The Claimant accepted that it was around June/ July 2020 that he returned to work. There is reference to the Claimant on 6 July 2020 having a lots of stress at work and going through a grievance which was likely to be a contributory factor, but no reference to the impact on his normal daily activities or otherwise any potential symptoms, other than raised BP.

October 2020.

108. There is no attendance after 6 July 2020 until 12 October 2020 (p.133). The next notable entry in the GP records is on 31 October 2020 when the Claimant reported that he contacted '111' because of chest pains for 3 days and palpitations.

109. There is another Ambulance Care Summary document dated **31 October 2020** (p.153). The complaint is recorded as chest pain radiating to his back with a BP reading of 185/102. The Claimant gave evidence that his BP was still chronic and uncontrolled even though he was taking medication.

110. There is a letter from the Hospital dated 31 October 2020 (p.155) which refers to his attendance at the Emergency Department and refers to his chief complaint being chest pains but that in terms of diagnosis; *"No abnormality detected".* He was given verbal advice and discharged home. There is no issue raised in the medical evidence

about a possible link between the chest pains and his hypertension to which the Claimant gave evidence that; "*I have never said it was- it can be- but I have stress and anxiety at the same time"* and *"heart rate and palpitations are a classic sign of stress and anxiety".* The Claimant then went on to comment that his GP reported a 120 heart rate (p.133) and suggested this may be a side effect of the medication .

111. The Claimant however was not able to identify anything within the medical evidence to suggest that any medical practitioner considered that the reason for the chest pains was stress and anxiety. When this lack of supporting medical evidence was put to the Claimant under cross examination, his response was that it was not his job to tell the doctor what to do. However, later on 3 November after follow up investigations (p.134) following the Claimant attending the Emergency Department on 31 October 2020, the diagnosis is reported as ; " *MSK chest pain2 Viral URTI".*

112. It also reports that the Claimant had stopped taking Amlodipine and Ramipril 2 months before. The Claimant gave evidence that he stopped taking the medication because he felt it was contributing to his heart palpitations but under cross examination, he gave evidence that he did not actually know if the palpitations were due to the medication or BP.

113. The Claimant was still however working for the Respondent during this period and conceded no adjustments were made because *; "I did not* acknowledge *I had a problem."*

114. On the 30 November 2020, the GP entries record work related stress and records the level of alcohol the Claimant was drinking. The notes record the Claimant as understanding that the raised BP may be related to his drinking. He was signed off sick from 30 November to 10 January 2021 with a diagnosis of work related stress and hypertension being secondary.

115. There is a reference to the Claimant feeling "*panic*" on 3 November 2020, and reference to panic attacks on 25 January 2021.

116. The Claimant was absent from work on sick leave from 30 November 2020 and did not return to work for the Respondent .

25 January 2021

117. By 25 January 2021 the GP notes record that that the Claimant was reporting work related stress for over a year, "*feels tense and episodes of strong palpitations making the patient worry even more".* It also refers to the Claimant having a cough since Christmas, of being unsure if this was coronavirus and (p.136).

*"…**since then impaired eyesight** – noticed to be a lot more-blurry, headaches, lightheadedness, back and neck pain (paracetamol hasn't helped)."*

118. The diagnoses records hypertension, work related stress and panic attacks, and long term symptoms of a cough (possibly Covid).

119. The treatment recommended is to restart BP medication and the GP records that the palpitations are.

"..*more likely due to panic attacks rather than medication side effects*."

120. CBT therapy is recommended for stress and panic attacks.

121. There is also an entry recording "*sleep poor*" on 25 January 2021.

OH report 29 January 2021

122. The Occupational Health (OH) report of 29 January 2021 (p.165) refers to the Claimant being unfit for work due to impaired psychological health and perceived work related stressors. It reports that the Claimant continues to suffer from symptoms of stress and anxiety. It refers to him taking medication for raised blood pressure and reporting no side effects. It reports that his symptoms appear to be reactionary due to the stress and strain he perceives he has been under at work and that the disability legislation is unlikely to apply as the HP has not been ongoing for 12 months and he is unlikely to have any long term or substantial impairments of his daily activities. There is a second version of the report again dated 29 January 2021 (p.168) provided by same OH Advisor, the only difference is the paragraph on the disability legislation now states.

" The *disability legislation may apply (Mr Mills confirmed that his hypertension has been ongoing for twelve months or more).*"

February 2021

123. On the 16 February 2021, the GP records record a further consultation where the Claimant reports.

"Headaches – frontal resolve with paracetamol – wonders if related to BP meds – ***unlikely" (****p.136)*

Tribunal stress

124. The diagnosis is work related stress and hypertension. The Claimant disputes that his headaches were resolved with paracetamol.

125. On the 23 February 2021 (p.137) another entry reads that the claimant.

"*still anxious and depresses, still having headaches.*
Paracetamol doesn't help with headaches…
Not sleeping, counselling not working would like medication
Used to run on treadmill, but not feeling motivated, but considering going back on it".

126. The Claimant in cross examination accepted that he had not started medication but starting counselling and attended 2 rounds of counselling.

127. There is a report from Insight Healthcare (p.156) who provided the Claimant with counselling, following a referral by his GP, dated 22 February 2021. The report refers to Depression and Generalised Anxiety Disorder but it is expressed not to be a formal diagnosis but with psychometric measure of its severity.

128. The Claimant's evidence is that he began counselling in February 2021 fortnightly by telephone (due to the Covid restrictions), for 3 to 6 months. He was not prescribed nor wanted to take anti- depressant medication although he recalled his GP mentioning medication on a couple of occasions.

129. The GP records report on 23 February 2021 (p,137) that he was still having problems at work and anxious and depressed and still having headaches and that paracetamol does not help. It also reports that.

"N*ot sleeping. If counselling not working would like medication*

Used to run on treadmill but not feeling motivated but considering going back on it"

130. The Claimant conceded in cross examination that there was no diagnoses in the medical records of clinical depression, the diagnosis is work related stress.

23 February 2021

131. On the 23 February 2021 shortly before his decision to resign (p. 137), the GP reports that the Claimant had started counselling the day before and that he was not interested at that point in taking medication for his mood and that the Claimant felt that he should make a decision about his job and that;

"….*he feels like that would be a massive weight off his shoulders".*

132. The Claimant's evidence is that the counselling was fortnightly for about 3 to 6 month. There is no evidence from the GP or Insight Healthcare about how many sessions the Claimant had, whether further counselling was recommended or what had been achieved through the counselling process and what the impact on his day to day activities may have been, without the counselling. The Claimant does not allege that further counselling was recommended at the end of the 3 or 6 month period (he could not be more specific about how long the sessions were intended to last) or that he asked for it, however this would have fallen outside the relevant period.

Long terms effects

133. The Claimant also in his evidence in chief states that because he has had hypertension over a long period of time, this may now have affected his vision, that he recently had an eye test and was told he has a form of astigmatism. He could not recall when he started suffering blurred vision but the eye test was early in 2022, he was not more specific on dates. The GP records (p.127) refer to " *slightly blurry left eye*" and refers to " *beginning of cataract* on 23 May 2019.

134. The Claimant has not produced the results from his eye test and I was not taken to any reference in the GP notes where it records the possibility of blurred vision being caused by the hypertension in the Claimant's case.

135. The Claimant in answer to my questions, clarified that his evidence is that the blurred vision happened "*occasionally"* about once per week and the impact on him is that he has to leave the room if he is watching TV and wait 30 minutes for his vision to reset. He has spectacles for long distance and does not require them to watch television, however he does not watch a lot of television but reading for a '*long period'* can also bring it one; he did not elaborate on what he meant by a '*long period'.*

136. The Claimant complains that he finds it difficult to engage with any form of exercise and is no longer playing squash or any form of sport but he has a treadmill at home and was running 5k in just under 30 minutes but because of daily headaches and chest pains, he cannot use it and has gained 2 stone in weight over the past 18 months.

He complains that part of the reason he has stopped playing squash is that he does not want to talk to people at the gym because he feel uncomfortable.

137. The Claimant also complains that he had become very disconnected from friends and family and no longer attend any social events and is suffering with low mood such that he rarely goes out of the house.

138. The Claimant complains that his memory and concentration have also been impacted and that he sometimes has to pull over because he cannot recall the direction that he is supposed to travel in.

139. He refers to the side effects of the medication, including going to the toilet more frequently. He described this as tiring, like having a urinary infection. He also describes nausea and headaches and the long terms effects of uncontrolled hypertension which include the high risk of stroke and heart attacks . His evidence is that he no longer drives for long periods of time due to the need to use the toilet more often.

140. In terms of the long terms effects, I tried to establish with the Claimant when those started because this was not dealt with in his evidence in chief. . He referred to the impact on his memory and concentration which he complains about being "*later on",* about " *last year*", which would be 2021, he could not say more precisely when. The incident when he needed to pull over while driving because he could not recall where he was going, he thought may have been perhaps in the "*middle of 2021"* but then said that he could not recall when it was.

141. The document in the bundle from the NHS website, refers to high blood pressure or hypertension as a condition which;

> *"…rarely has noticeable symptoms but if untreated , it increases your risk of serious problems such as heart attack and strokes.*
>
> *About a third of adults in the UK have high blood pressure, although many will not realise it." (p.189)*

142. The pages from the British Heart Foundation (p.1893) advise that many people with high blood pressure feel fine so it is important to get blood pressure checked regularly but goes on to state that high blood pressure.

> ..." *rarely has noticeable symptoms. The following can be symptoms of high blood pressure.*
>
> *Blurred vision*
> *…*
> *Chest pain*
> *Dizziness*
> *Headaches…*

Submissions

143. I set out below the submissions of the parties which I have considered in full;

Respondent's submissions

144. The Respondent submitted a written skeleton argument which I have

considered and made further oral submissions.

145. The Respondent submits that the burden of establishing the disability rests with the Claimant.

146. It is submitted that to deduced effects are not relied on and in any event it would usually require expert evidence to decide on what the effects of the conditions would be without medication.

Hypertension

147. It is accepted that the Claimant suffers from hypertension and had high BP from 2019, this is established from the medical records and it is submitted, on the evidence probably manifested from January 2019 when it was picked up in routine tests. It is submitted that the blood pressure rate fluctuated as can be seen from the GP entries.

148. The Claimant was treated with two medications but the key issue is whether it caused long term substantial adverse effects .Counsel refers to a short period of the Claimant taking Ramipril in 2019 and then again in 2020.

149. It is submitted that hypertension is an asymptomatic condition with reference to the NHS guidance documents.

150. While the Claimant alleges he had symptoms and they *may* have been an effect of the hypertension, while it is possible, it would require medical evidence to confirm the link. It is submitted that the Claimant is an individual with lots of medical problems (eg urinary tract infections over that period, injuries from a road traffic accident which caused problems with his chest and viral infections), thus there needs to be clear evidence of what the cause of the effects were.

151. It is submitted that there is however cogent medical evidence that shows there is in fact no link and counsel refers to the following entries specifically;

- *24 March 2929 where the entry states; " no symptoms due to high blood pressure" (p.131) and*
- *16 February 2021 (p.136) where it states "headaches frontal resolve with paracetamol wonders if related to BP meds, unlikely*

152. Counsel submits that there is evidence in the GP records that the high blood pressure and hypertension **was** linked to the Claimants' lifestyles and while it is not important what caused the hypertension, it is relevant to consider in terms of likely effects of it and that the symptoms/effects can be controlled with sensible measures. Counsel refers to the Guidance document on matters which should be take into account when determining disability (see below) .

153. The Claimant stopped taking the medication for hypertension and the entries record that during those periods there were no side effects of not doing so and his evidence is that the symptoms remained the same.

154. Counsel refers to the OH report and the opinion that the disability legislation is unlikely to apply with the second version stating that it may, however counsel submits that the issue is not how long the Claimant has had hypertension but what the effects

of it are on his normal day to day activities and how long those lasted and the OH Advisor does not engage with that. It was in January 2021 that the Claimant was off sick with work related stress.

Anxiety/stress

155. It is submitted that the references to stress and anxiety in the GP records 'come late in the day', and largely after the Claimant went off work sick in November 2020.

156. There is no clinical diagnosis of depression and the Claimant took no medication for it.

157. Counsel submits that until November 2020 it is not clear from the medical evidence what effects the stress at work is having and indeed whether the stress is an important factor in his health at all.

158. Counsel refers to: ***J v DLA Piper UK LLP 2010 ICR 1052, EAT*** and submits that there is a distinction to be drawn between suffering "*clinical depression*" rather than simply a reaction to adverse life events and the latter applies, he submits in this case.

159. Even if wrong about the effects of stress, counsel argues that the effects did not last 12 months because they only started from **November 2020** and there is no evidence of likelihood of lasting 12 months from that date; there is no expert evidence, the Claimant did not require medication and it was reactive to what was happening at work.

160. Counsel also referred to **Mr E Parnaby v Leicester City Council UKEAT/0025/19/BA** and invited me to distinguish that case on the grounds that in this case, the Claimant was not dismissed because of his disability, he resigned.

161. Counsel also submits there is no evidence that the Claimant stopped exercising because of stress, he was drinking too much and he was warned about his lifestyle.

Claimants submissions

162. Counsel for the Claimant clarified that the included a claims do not include a complaint that the dismissal was an act of disability discrimination. Counsel referred to paragraph 21 of the further and better particulars of the claim (p.46) where it sets out the claim of constructive unfair dismissal based on a breach of the implied duty of mutual trust and confidence.

163. Counsel submits that there is a problem with the Respondent's submissions in that I am being invited to separate out the two conditions of hypertension and stress/ anxiety, when what I am invited to do by the Claimant is combine the two conditions and focus on the combined effects; headaches, heart palpitations, chest pains that lead to the effects and whether together they meet the definition of substantial.

164. Counsel referred to the Claimants' evidence about his lack of motivation, not playing squash, not exercising, not going to the pub, or engaging in social situations and the Effect on relationships and together they are substantial and that the high blood pressure '*can*' cause itself cause stress and anxiety.

165. Counsel refers to the hypertension diagnosis in January 2019 and by March 2019 the symptoms are "*already manifesting themselves* ".

166. **I** asked by what date he submits the effects had lasted or were likely to last 12 months, counsel submitted that it was February 2020, based on the fact that hypertension and stress were recorded in the records back in January and March 2019. Counsel submits that the effects had lasted for 12 months by that stage but in any event by March 2021, it was clear that the effects were likely to last more than 12 months.

167. As for the OH report, counsel submits that the explanation for the two versions is that it was probably amended after the Claimant had asked for a copy of the report.

168. Counsel also submits that I must consider the effects of the conditions without the medication and counselling but did not expand on this and make submissions about it was being alleged the effects would be but for the treatment.

169. Counsel concedes that there is no diagnosis of depression but when considering the stress/ anxiety I am invited to take into account the high reading from the assessment about his mood (23/27).

170. As for the ***Parnaby*** case, counsel submits that the claimant's resigned in circumstances where it was constructive unfair dismissal but in any event his symptoms have continued from that date (ie termination was not curative in any event).

The Law

Disability

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

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

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

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

Section 6. Disability

a. A person (P) has a disability if—

i. P has a physical or mental impairment, and

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

…

Schedule 1 sets out supplementary provisions including:

Part 1: Determination of disability

Impairment

Long-term effects

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

iii. it has lasted for at least 12 months,

iv. it is likely to last for at least 12 months, or

v. it is likely to last for the rest of the life of the person affected.

b. 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.

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

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

e.

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—

i. measures are being taken to treat or correct it, and

*ii. but for that, it would be **likely** to have that effect.*

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

PART 2 GUIDANCE

Preliminary

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

Examples

11 The guidance may give examples of—

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

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

Adjudicating bodies

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

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

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

A3. The definition requires that the effects which a person may experience must arise from a physical or mental impairment. The term mental or physical impairment should be given its ordinary meaning. It is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness.

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

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

2.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…

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

Section B Meaning of 'substantial adverse effect'

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

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

Cumulative effects of an impairment B4.

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

B6. A person may have more than one impairment, any one of which alone would not have a substantial effect. In such a case, account should be taken of whether the impairments together have a substantial effect overall on the person's ability to carry out normal day-to-day activities.

Effects of behaviour B7.

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

Effects of treatment B12.

The Act provides that, where an impairment is subject to treatment or correction, the impairment is to be treated as having a substantial adverse effect if, but for the treatment or correction, the impairment is likely to have that effect. In this context, 'likely' should be interpreted as meaning 'could well happen'.

B13. This provision applies even if the measures result in the effects being completely under control or not at all apparent. Where treatment is continuing it may be having the effect of masking or ameliorating a disability so that it does not have a substantial adverse effect…

Section C: Long-term

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

Meaning of 'likely' C3.

The meaning of 'likely' is relevant when determining: • whether an impairment has a long-term effect (Sch1, Para 2(1), see also paragraph C1); whether an impairment has a recurring effect (Sch1, Para 2(2), see also paragraphs C5 to C11); whether adverse effects of a progressive condition will become substantial (Sch1, Para 8, see also paragraphs B18 to B23); or how an impairment should be treated for the purposes of the Act when the effects of that impairment are controlled or corrected by treatment or behaviour (Sch1, Para 5(1), see also paragraphs B7 to B17).

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

Recurring or fluctuating effects C5.

The Act states that, if an impairment has had a substantial adverse effect on a person's ability to carry out normal day-to-day activities but that effect ceases, the substantial effect is treated as continuing ***if it is likely to recur****.*

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

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

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

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

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

The following examples appear relevant to this case; *Difficulty entering or staying in environments that the person perceives as strange or frightening; Persistent general low motivation or loss of interest in everyday activities; Persistently wanting to avoid people or significant difficulty taking part in normal social interaction or forming social relationships, for example because of a mental health condition or disorder.*

Case Authorities

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

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

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

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

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

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

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

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

179. In **J v DLA Piper (2010 ICR 1052) the Employment Appeal Tribunal ,** presided over by Underhill P, gave important guidance as to the approach to the determination of disability which Employment Tribunals should adopt at paragraphs 39 and 40 of their judgment and I have considered that guidance.

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

181. The impairments do not need to be related or interact with each other for their combined effect to be considered — ***Ginn v Tesco Stores Ltd EAT 0197/05*.**

182. Where a claimant is seeking to rely on a number of potential conditions and it is unclear which conditions might have led to his or her various symptoms, it is important that the tribunal makes clear findings as to the nature of the disability and which symptoms were attributable to it: ***Morgan Stanley International v Posavec EAT 0209/13***

183. **Mr E Parnaby v Leciester City Council UKEAT/0025/19/BA** The EAT determined that, as set out in the headnote **; "***..The ET had needed to consider the question of likelihood – whether it could well happen that the effect would last at least 12 months or recur – at the time at which the relevant decisions were being taken, which was prior to the implementation of the decision to dismiss".*

Conclusions

184. Having regard to my findings of fact, and applying the appropriate law, and taking into *account* the parties' submissions, I have reached the following conclusions:

185. The first matter we have to decide is whether the Claimant has established that he was *suffering* from the pleaded impairments at the relevant time:

(1) <u>The impairment/condition</u>

Hypertension

186. I am mindful of the guidance on **Goodwin** repeated in the **DLA Piper** case, that in in *cases* where there may be a dispute about the existence of an impairment it will make sense, to start by making findings about whether the Claimant's ability to carry out normal day-to-day activities is adversely affected (on a long-term basis), and to consider the question of impairment in the light of those findings.

187. However, it is not disputed that the Claimant had the impairment of hypertension and that it was diagnosed in January 2019. Counsel for the Claimant in his submissions did not seek to argue that I should find that the Claimant had this impairment at a time prior to January 2019.

188. The GP notes support the Claimant's case, not disputed by the Respondent that he continued to have this impairment from 2 January 2019 throughout the relevant period. He was still being prescribed Ramipril until 12 May 2021, albeit there was some fluctuation in his blood pressure levels.

Stress/ anxiety

189. It is conceded in submissions by the Claimant that there was no formal diagnosis of clinical depression during the relevant period, and I am not invited to make a finding that contrary to the medical evidence, the Claimant suffered from clinical depression. The condition is identified within the further and better particulars of the claim, as anxiety and in submissions counsel referred to the condition only as stress/ anxiety.

190. Counsel for the Respondent focusses on the effects and cause of the symptoms which he submits are due to adverse life events, as supporting a finding that the Claimant did not have what could be described as an 'impairment'.

191. Because of the absence of any formal diagnoses, I consider that it is appropriate to return to the question of whether the symptoms he suffered from stress/anxiety are such that they support a finding that he was suffering from a condition amounting *to* an impairment; **Section C of the Guidance**.

192. While the effects on the Claimant of one condition may not have been during the relevant period, sufficiently substantial to constitute a disability, the cumulative effects of his problems may have had an adverse and substantial impact on his ability to carry out day-to-day activities. The *impairments* do not need to be related or interact with each other for their combined effect to be considered: ***Ginn v Tesco Stores Ltd EAT 0197/05*.**

193. A potential difficulty with cases involving more than one impairment is however, that it may be *unclear* which symptoms are attributable to which impairment and in this case the medical evidence confirms that the Claimant suffered from a number of conditions during the period from 2018 onwards to the end of the relevant period (tennis elbow, viral infections, etc) and symptoms (headaches, palpitations etc) which might or might not have been part of or attributable to the two conditions he has pleaded in his claim.

194. The lack of detail from the Claimant in his evidence and the absence of a medical report makes the task of assessing which impacts arise from which conditions difficult. However, it is nonetheless incumbent on me to identify the nature of the disability as far as I am able to do so, and make findings as to which symptoms were

attributable to the conditions that the Claimant is relying upon.

(2) Adverse effects of the condition/s

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

196. I reminded myself of paragraph A7 of the Guidance including that the effects of a mainly physical nature may stem from an underlying mental impairment, and vice versa and A8 which provides that it is not necessary to consider how an impairment is caused .What it is *important* to consider is the effect of an impairment not its cause – provided that it is not an excluded condition.

Hypertension : impairments

Headaches

197. Taking into consideration account the NHS guidance that has been *supplied* which neither party seeks to argue against and in the absence of any medical report, I conclude that hypertension generally speaking, rarely has noticeable symptoms.

198. Counsel for the Claimant submits that I must consider the effects of the conditions without the medication and indeed the counselling. Before *considering* the impact of the medication, the first step is to determine what the effects of the hypertension were from January 2019.

199. The Claimant describes headaches and although in his evidence in chief he refers to the *headaches* being because of hypertension, there is no reference in the GP notes to his doctor expressing an opinion that there is or is likely to be, any link between the headaches and hypertension. As set out in my findings, the Claimant is advised that it is "*unlikely*" that there is any link (p. 136)

200. The Claimant does not allege that he had been told that the hypertension was the cause or likely cause of the *headaches*. His evidence is that he did not know and it was not for him to say. However, the burden of proof rests with the Claimant and if his own case is that he does not know whether there is a link or not and he has not produced any medical evidence to even suggest a link, in light of the contradicting evidence, the only possible conclusion is that he has failed to satisfy the burden of proof. He has not established on the balance of probabilities that the headaches he alleges he suffered were related to the impairment hypertension.

201. Aside from the issue of whether it is the pleaded impairment of hypertension which caused the headaches, the Claimant's description of his headaches/ the effects, is I conclude, not credible. The Claimant's evidence about the frequency and severity of the headaches is not consistent with the medical evidence as set out in my findings. His description of those effects is not plausible and I conclude is exaggerated.

202. The Claimants' description was of headaches which were *" constant"* from "*morning to night"* such that he had to; *" lie down in a dark room on the bed"*. He also described how paracetamol did not help and therefore there is no issue about considering how serious those headaches may have been but for this medication. Further, despite numerous attendances with his GP from January 2019 to March 2021,

there is scant reference to a problem with headaches and nothing on the scale he describes.

203. There is a reference to headaches and dizziness on 9 January 2019 but no description of the impact as he describes it or the frequency of them. There is also reference over a year later on 16 February 2021 to headaches but again nothing in terms of the extent or severity he describes.

204. The Claimant alleges the headaches were not significant because he had them so often and that he puts forward as the explanation for not mentioning them to his GP. That is simply not credible. He reports a cough for example but over a number of years neglects to mention headaches so intense and frequent that he has to lie in a dark room.. He does not ask his GP for any stronger pain killers and although he describes how 'alert' he needs to be to function in his job, he continued to work while allegedly suffering daily, debilitating headaches

205. Further, as set out in my findings there are entries where the Claimant is reported as feeling well on 11 March 2020 and on 19 May 2020 (p. 131).

206. I do not find credible nor plausible that someone suffering with such constant and debilitating headaches could continue to carry out a job which requires them to be alert while being unable to ameliorate the headaches with pain killers, and although he mentions to his doctor having quite a sore throat (p.134) he does not consider the headaches sufficiently significant to mention.

207. I find on *balance* that the Claimant had on occasion, suffered some headaches because the notes report him 9 January 2019 and over 12 months later on 16 February 2021 referring to having headaches, however, I do not find that he had those uninterrupted over a period of 12 months and further, do not accept that the limitation caused by the headaches were substantial. I conclude that he had occasional headaches and that it is normal for people to have occasional headaches. I do not find that the headaches had the impact he describes, which would explain why he never asked for stronger painkillers from his GP.

208. I heard no evidence about the likelihood of the headaches recurring after 19 January 2019 or 16 February 2021, on the occasions when he reported having them . On 9 January 2019 the Claimant was suffering with a viral infection, which I conclude is most likely to have been the cause of the headaches he was reporting on that occasion. The GP also cautions the Claimant about his lifestyle, his alcohol consumption and weight, which may also have been a cause or contributory factor.

209. I conclude that the Claimant has failed to establish that the headaches were an effect of the hypertension. I am also not *persuaded* that the headaches were such that they had a substantial effect on normal day to day activities. I do not find the Claimant's description of their severity or frequency to be reliable. (I am mindful that if not substantial separately however, I need to consider the combined effect).

Insomnia

210. The Claimant's description of the problems he had sleeping would amount to a substantial adverse on his normal day to day activities (i.e. sleeping) and be likely to have caused significant fatigue during the day. However, I do not find his description of the impact on his sleep from October or even from January 2019 to November 2020 to be credible. There are scant references to this problem in the GP notes and further.

I take into consideration that he continues to be able to carry out his job (subject to short periods of absence and time away from work during the Covid shutdown), until November 2020.

211. From October 2018 the Claimant was in pain from an elbow injury and on balance, my findings are that if his sleep was effected during this period, it was more likely than not due to the pain from his elbow. He was signed off work in December 2019 but this was due to his elbow injury and related not to his employment with the Respondent but to the second job which according to the GP records, required manual work.

212. I conclude that the Claimant has failed to establish that insomnia was an effect of the hypertension.

Chest pains /palpitations

213. The Claimant complains of chest pains and palpitations from October 2018 . There is medical evidence of reports of these chest pain and palpitations (p.126) however, there is no medical evidence that links the chest pains and palpitations to the hypertension. As set out in my findings, the only diagnosis is that the chest pains are due to MSK and the is treatment prescribed is simple analgesia. The Claimant suffered a road traffic accident which caused ongoing musculoskeletal pain. The Claimant took no time off work form the Respondent from March to August 2019. The Claimant maintains that the chest pain and palpitations may be due to anxiety about the hypertension and I address this below.

214. An ambulance was called out to the claimant on 16 October 2019 and 18 April 2020 when the claimant was attended by the Ambulance Service because he was experiencing abdominal and back pain but there is no indication in the medical evidence that the pain was caused by high blood pressure. The Claimant attended hospital on 31 October 2020 complaining again of chest pain but an ECG was conducted with no abnormality detected.

215. The Claimant's oral evidence is that at the time he thought the pains and palpitations *may* have been caused by medication for the blood pressure however, there is medical evidence to support this and complains of chest pains and heart palpitations before he started taking the medication.

216. I am not persuaded on the evidence that the chest pains or palpitations, were an effect of the hypertension and the Claimant himself in answer to questions in oral evidence shifted his position to allege that they are a "*classic sign of anxiety"* rather than caused directly by the hypertension or medication. His evidence was not consistent on which impairment he was alleging caused those effects and I find on balance on the medical evidence, that any chest pain was caused by MSK and that the palpitations were possibly a result of panic, a side effect of the MSK chest pain.

Diarrhoea

217. The Claimant complains of diarrhoea, however there is no medical evidence to link this to the blood pressure.

218. The entry for diarrhoea and vomiting in January 2019 was at time when the Claimant also had a rash and he does not seek to argue that those symptoms related to high blood pressure.

219. The Claimant complains that he suffers with diarrhoea as a result of the medication however, there is no reference in the medical notes to suggest that the Claimant is suffering from *diarrhoea* as a result of the medication. While taking the medication, he did not have a significant amount of time off work as a driving test examiner, until there was an escalation in his anxiety/ stress later in November 2020 and by that stage, the Claimant had for many months been taking the same medication.

220. In conclusion, I do not find his evidence plausible that he was suffering from such adverse side effects from the medication and this is not reflected in the medical evidence and did not prevent him from carrying out his driving duties. Further, I conclude what is more likely is that the occasional incidents of diarrhoea were caused by other unrelated conditions such a viral infections.

Lack of exercise/ impact on sports/hobbies

221. The Claimant alleges that he did not engage in exercise and sports because of daily *headaches* and chest pains. As I have concluded, the Claimant has not established that the chest pains and headaches were linked to the hypertension.

222. There is in the GP notes a reference in September 2019 to the Claimant not *undertaking* activities but this impact on his activities, is recorded as due to reduced confidence, not due to heart palpitations and chest pain but the injuries arising from the road traffic accident as set out in my findings.

223. Throughout the GP reports there is also reference to the Claimants' lifestyle and the GP encouraging the Claimant to exercise, reduce his weight and drink less alcohol.

224. There is no evidence that the hypertension caused the chest pains or palpitations, or that he was unable because of the hypertension, to continue to exercise.

225. In conclusion, I am not persuaded that any reduction in his sporting activities and exercise is a side effect of the medication or hypertension.

Blurred vision

226. I am not persuaded that the Claimant's report of blurred vision is linked to the impairment of hypertension.

227. The Claimant in his evidence in chief states that the hypertension "may" have caused blurred vision but there is no advice from an Optometrist or Ophthalmologist or even his optician to suggest that there was any connection. The Claimant's description of the impact on his vision is also in any event, I find not substantial, he describes it occurring when he watched TV and will need half an hour to reset his vision or if he reads for a long time but does not describe how long that it and those affects may of course be due to natural aging.

228. I am not persuaded on the evidence that the Claimant has established, that there was a link between the hypertension and the blurred vision.

Concentration/memory

229. There is no evidence in the medical records to suggest that he suffered from the alleged effects on his concentration and memory as he describes or that such

effects are linked to the impairment of hypertension or the medication he takes for it.

230. I am not persuaded on the evidence and my findings of fact as set out, that the Claimant has established that there was a link between the hypertension and any such alleged effects.

Social life/ effect on relationships

231. The Claimant refers to rarely going to the pub and the impact on the relationship with his partner, although he did not expand on what that impact on his relationship is and therefore it is not possible to assess the severity of it.

232. The Claimant does not in his evidence, explain however why he alleges the effect on those activities are caused by the impairment of hypertension rather than the stress and anxiety he was feeling and there is no support for them being an effect of the hypertension in the medical evidence, as set out in my findings.

233. I am not persuaded on, that the Claimant has established, that there was a link between the hypertension and these alleged effects on those activities.

Medication

234. With respect to effects of the medication and the extent to which this may have masked the extent of the adverse effects, the Claimant's evidence is that he does not *take medication for the headaches*, and paracetamol makes no difference.

235. In terms of the hypertension, the Claimant's evidence is that the Claimant gave evidence in response to my questions, that the symptoms/adverse effects were not helped by the medication in his opinion. He gave evidence that while he complains of chest pain before taking the medication his evidence is that after he was diagnosed with high blood pressure and started the medication, the chest pains did not go, the symptoms continued as before.

236. The Claimant refers in his evidence to the long terms effects with uncontrolled HP including high risk of stroke and heart attack. There is no medical evidence however specific to the Claimant about the likely effects for him of the hypertension impairment if he did not take the medication or what the likelihood would be of a stroke or heart attack.

237. Further, I also take into account that the 'likelihood' of such long term effects would also have to take into account the effect/impact of his own behaviour and what he could reasonably be expected to do to modify his behaviour including the reasonable restrictions he should place on his lifestyle, including reducing his consumption of alcohol and controlling his diet, as he was being fairly regularly advised to do. On the 30 November 2020 his GP is recorded as referring to him drinking over 60 units of alcohol per week and 5 years of regular weekend binges and that the blood pressure readings were raised about the same time and the Claimant understanding that raised blood pressure may be related and that he is confident he can stop drinking.

238. I accept the Claimant's evidence which was not disputed, that anxiety can increase blood pressure and thus controlling anxiety can in turn help control hypertension. I have therefore considered to what extent the counselling should be considered when determining whether the impairment of hypertension was likely to have caused a stroke or heart attack as the Claimant but for this treatment. However,

the Claimant did not address this specifically in his evidence nor did he produce any medical opinion to assist me in that exercise. The Claimant has not therefore established that without the counselling, the hypertension is likely to have had a substantial adverse effect on his normal day to day activities.

239. In conclusion, there are no adverse effects on the Claimants' normal day to day activities which *he* has established on the balance of probabilities, were caused by the pleaded impairment of hypertension or that the impairment is likely to have a substantial effect on his day to day activities or result in a stroke or heart attack, but for the medication and/or counselling.

Anxiety

240. The Claimant in his oral evidence focused on the anxiety induced by the heart palpitations and the impact this had on his confidence to undertake exercise however, I am not satisfied that the anxiety and stress he felt was the cause of the chest pains and palpitations. The chest pains are more likely I find, to have been caused by MSK, but accept his evidence that the pains in turn caused him some anxiety.

241. The Claimant's evidence is that his health declined from March 2020 when he was allocated another line manager at work, and the medical records do refer to the C*laimant* feeling very stressed in the context of work from January 2019 (p.125) and then on 4 March 2019 (p.126) again in the context of work. He reports feeling slightly anxious or depressed in in September 2019. There is no referral for counselling or discussion about medication and there is no report of any symptoms as a result of the stress in the GP records at this time. He reports feeling well on 11 March 2020.

242. The level of stress then I find, escalates to "*anxiety, fear and panic*" on 3 November 2020 (p. 134). This then ties in with when the Claimant going off work sick from 30 November 2020.

243. The only symptoms referred to in the OH on 29 January 2021 report are high blood pressure , insomnia and headaches. High blood pressure is however not of itself an effect on normal day to day activities. There is no reference in the medical evidence to further panic attacks after the 25 January 2021 and I heard no evidence (or submissions) about the likelihood of the reoccurrence of panic attacks.

244. The headaches the Claimant alleges he began to suffer from October 2018 he asserts could be caused by hypertension or the anxiety. For the reasons I have set out in my findings and conclusions, I am not persuaded that the Claimant suffered the headaches as severe or frequently as he alleges. The stress and anxiety is not reported until many months after the Claimant alleges he started experiencing the alleged debilitating headaches.

245. I take into consideration however, that the OH report does refer to headaches. This does tie in with an entry in the GP records on 16 February 2021 reporting headaches and the further entry on 23 February 2021 which reports that he is still having headaches and paracetamol does not help.

246. I am *persuaded* on the basis of the OH report and GP records, that by January 2021 the Claimant was suffering with headaches and as this was at a time when he was now reporting fairly regularly with stress and reporting feeling tense, that the headaches on a balance of probabilities, were caused by the stress/anxiety. I am not

persuaded that the headaches even during this period, were as severe or frequent as the Claimant alleges. His account of their impact is not supported by the medical records or OH report. I do accept on balance that he was having fairly regular headaches during this period which were not alleviated by medication. Given how unreliable however I find the Claimant's evidence as to the extent of the impact of the symptoms, it is difficult or make a finding as to the severity or frequency.

247. The OH report also refers to the Claimant suffering from insomnia.

248. The Claimant was signed off work from November 2020. The Claimant refers to prior to this, after his return in June/July 2020 following the Covid shutdown period (March to June 2020), returning home and feeling *'shot'* and just because he could do his job, the Claimant argues that this does not mean that the effects did not make it more difficult. In March 2020 he was reported as sounding well on the phone by his doctor and in April 2020 he had bought a treadmill and had been using it for the last week. At the end of May he reports concerns about returning to work and stress at work in July 2020, but there is no report in the GP notes of insomnia or headaches or other symptoms that were causing him difficulties, until the chest pains and palpitations on 31 October 2020 (as set out in the findings) and then anxiety , fear, and panic on 3 November 2020. The Claimant was then signed off work with work related stress from 30 November 2020.

249. As set out in my findings from November 2020 he is then reporting a collection of symptoms; panic attacks, headaches, lack of motivation, poor sleep and is in due course referred for counselling.

250. The effects the Claimant describes in his evidence about lack of motivation, sleep, headaches, panic attacks, lack of interest in social engagements, is supported by the OH report and GP records from November 2020 and he is then signed as unfit to return to work.

251. It is not possible to reach a finding on how substantial each of those effects were separately given that I have found the Claimant's description of the impact of the effects to be unreliable and the lack of supporting medical evidence however, taking into account the OH report, the Claimant's evidence about the symptoms worsening over time and the entries in the GP records and the GP signing the Claimant as unfit to work, I am persuaded that from the end of October 2020 the combined effects at least of those symptoms were, on a balance of probabilities, more than trivial. I conclude that the Claimant was experiencing persistent general low motivation or loss of interest in everyday activities including attending social events and carrying out exercise**;** at times a loss of concentration, wanting to avoid people or difficulty taking part in normal social interaction and difficulty sleeping.

252. I conclude that the substantial adverse effects started from the end of October 2020 when he first reported (p. 133) chest pains for 3 days and palpitations following which on 3 November 2020 he was recorded as experiencing anxiety, fear and panic.

253. Returning the issue of impairment, I conclude that the effects he was experiencing, collectively were caused by stress/anxiety and that the Claimant suffered from a stress-related illness**.**

(3) Long term

254. The next issue to determine is whether at any point from **October 2020** until

the end of the relevant period in **March 2021**, the impairment of a stress related condition was likely to last for 12 months.

255. I take into consideration that the GP notes record in one of the last entries, on 23 February 2021, before the Claimant resigned, that the Claimant was feeling that he should make a decision about his job and hoe he feels that this would be a "*massive eight off his shoulders*"(p.137) .

256. This is not a situation like the Parnaby case, where I am considering the effect of a further act of alleged discrimination (i.e. a dismissal), *but* the effect of a decision the Claimant is himself planning to take and what he considers at this stage, the beneficial effect of that may be. The Claimant clearly is of the opinion, that to make a decision about his employment would alleviate his anxiety. The Guidance (B7) 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.* I consider it equally relevant to take account of the action the Claimant himself considers he could take to prevent or reduce the effects of the stress/anxiety he is suffering by making a decision. The Claimant does make the decision ultimately of course to resign.

257. I also take into account that the Claimant had by February 2021 been signed off work and started counselling on 22 February 2021 (according to the GP notes of the 23 February 2021: p.137). The Claimant's evidence, not disputed, was that the counselling was due to last for 3 to 6 months. It was expected therefore that the Claimant would require counselling up to end of May or August 2021.

258. There is no medical evidence/report from the Claimant dealing with the likelihood as at October 2020 to March 2021, of the adverse effects on his normal day to day activities continuing such that they would last for 12 months (ie continue to October 2021). Whether or not the adverse effects did in fact continue, is not relevant

259. The Claimant did not address this issue of likelihood of the adverse effects being long term in his evidence, he only gave evidence that they had in fact continued

260. There is no opinion from his GP and no report from Insight Healthcare or OH, about how long the adverse effects were likely to last.

261. The evidence I have before is the Claimants' evidence that the counselling arranged for him was to last between 3 and 6 months and there was no suggestion from the Claimant that it was anticipated (before the end of the relevant period) that he would require further sessions. There is no evidence before me, whether from the Claimant or in medical evidence about the likelihood of reoccurrence and this was not addressed in submissions.

262. Taking all these factors into account, the Claimant has not established on a balance of probabilities, that at any time during the **relevant period** it was likely that the adverse effects of the impairment, namely the stress- related illness, was likely to last for 12 months.

263. I stress that I am not determining what happened after the end of the Claimant's employment. His symptoms may have become worse and he may therefore have continued to suffer the effects of the stress related illness long term however, what I am limited to considering is what happened and what was seen as likely to happen, during the **relevant period** only.

264. It is invariably difficult without a medical report which addresses the relevant issues and sufficiently detailed (and reliable) evidence from the Claimant, for a tribunal to determine issues around mental health, especially where there is no formal diagnosis of a medical condition (such as clinical depression). What I have had to determine is whether the Claimant has met the required burden of proof based on the evidence which has been produced. The Claimant exaggerated I conclude the symptoms and effects he was suffering from which rendered his evidence in material respects, unreliable. The burden of proving that he met the definition under section 6 of the Equality Act 2010, rests with the Claimant and he has not satisfied that burden.

265. The Claimant did not have a disability for the purposes of section 6 of the Equality Act 2010 at any stage during the relevant period. This means that the claims of disability discrimination, cannot success and are struck out accordingly.

Orders

266. Separate orders *are* made for case management.

Employment Judge Broughton

11 August 2022

Date sent to the parties

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