EMPLOYMENT TRIBUNALS

BETWEEN

Claimant		**Respondent**
Mr A Rehman	**AND**	DHL Services Ltd

JUDGMENT OF THE EMPLOYMENT TRIBUNAL ON AN OPEN PRELIMINARY HEARING

HELD AT Birmingham

ON 22 February 2023 and 8 March 2023

EMPLOYMENT JUDGE Dimbylow

Representation
For the claimant: In person
For the respondent: Miss V Brown, Counsel

JUDGMENT having been sent to the parties on 10 March 2023 and written reasons having been requested in accordance with Rule 62(3) of the Employment Tribunals Rules of Procedure 2013, the following reasons are provided:

REASONS

1.1 The claim. This is a claim by Mr Adnan Rehman (the claimant) against DHL Services Ltd (the respondent). The claimant had been placed with the respondent by an agency. He was not an employee of the respondent, but an agency worker. In the claim forms the claimant brought claims for disability discrimination contrary to the Equality Act 2010 ("EQA"). The claims were and are resisted. There have been several preliminary hearings, both in

private (CPH) and open to the public (OPH). I do not propose to dwell on the history of the claims, which has been protracted, and which is described in the various orders and judgments made in the Employment Tribunal (ET) and in the Employment Appeal Tribunal (EAT). Stated as shortly as possible, the relevant recent history is that there was an OPH to determine whether the claimant was a disabled person at the relevant time ("the disability issue") before Employment Judge Perry on 14 October 2020. The claimant was found by Judge Perry not to be disabled.

1.2 The claimant appealed to the EAT. His appeal before HHJ Auerbach was successful. The case was remitted back to the ET for the disability issue to be determined afresh before a different Judge. The case was listed for a CPH before Regional Employment Judge Findlay, and that took place on 17 August 2022. Various orders were made for the just disposal of the final hearing which is listed to take place over 5 days commencing on 24 July 2023 before a full panel tribunal. Judge Findlay also relisted the disability issue to be heard on 22 February 2023 with a time estimate of 1 day, and it came before me. As it happened, given the volume of documentation I had to consider, the oral evidence and submissions, by close of business on that day I had run out of time to undertake my deliberations and give a reasoned judgment. The parties consented to the case being adjourned and the further date was agreed. The parties also agreed to the resumed hearing being via CVP.

1.3 At the start of the hearing, I canvassed with the parties whether any reasonable adjustments were required, and the claimant signified that there were none. I did say that there would be regular breaks, and these did take place. Also, I agreed a timetable for the first day which included closing oral submissions limited to 30 minutes for each

side. Even so, it was apparent to the parties and me that we were unlikely to conclude in a day. That turned out to be the case. Miss Brown's closing submissions took 25 minutes, and the claimant's 52 minutes. I only mention the timing because in a letter to me dated 23 February 2023 the claimant said: "I was only given a limited chance to present my submissions in full before you in the hearing…." The claimant agreed the time, and he exceeded it.

2.<u>The issue</u>. The issue for me to determine was set out in paragraph 12 of the CPH discussion before Judge Findlay and it is: "…to determine whether the claimant was at the relevant time disabled by the effects of any, or any combination of, the conditions mentioned above." Judge Findlay confirmed at paragraph 9 that:

"The claimant says the disability is:

(a) Keratoconus (an eye condition); and/or

(b) Temporo-mandibular joint dysfunction ("TJD"), which he asserts gave rise to chronic jaw pain; and/or

(c) Mental impairment: stress/anxiety/depression."

Judge Findlay confirmed in her order that the issues to be determined at the final hearing concerned: direct disability discrimination, discrimination arising from disability, and victimisation. She also gave the parties until 8 September 2022 to say whether they thought the list of issues was wrong or incomplete. I have not seen any correspondence to show that either side disputed the list.

3.<u>The law</u>. THE DEFINITION OF DISABILITY

(1) Section 6 of the EqA provides that a person (P) has a disability if—

"(a) P has a physical or mental impairment, and

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

(2) Schedule 1 of the EqA sets out Supplementary Provisions in relation to disability.

(3) Paragraph 2 of Schedule 1 provides the effect of an impairment is long-term if: -

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

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

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

(4) Paragraph 5 of Schedule 1 provides that: -

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

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

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

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

(5) I also read and considered the **Equality Act 2010 Guidance** ("the Guidance") on matters to be taken into account in determining questions relating to the definition of disability.

4. <u>The evidence</u>. I received oral evidence from the claimant. I received no oral evidence from the respondent.

I also received documents from the parties, which I marked as exhibits in the following way:

C1 Letter from the claimant (4 pages -undated)
C2 Claimant's skeleton argument
R1 Agreed bundle of documents (329 pages – although this was added to later)
R2 respondent's skeleton argument
R3 an email chain from the respondent (3 January to 14 February 2023)

The parties also asked me to consider the following cases:

Goodwin v Patent Office [1999] ICR 302
J v DLA Piper [2010] ICR 1052
Leonard v Southern Derbyshire Chamber of Commerce [2001] IRLR 19
Elliott v Dorset County Council UKEAT/0197/20/LA(V)
James v Chief Constable of Norfolk [referred to by the claimant but no copy produced or found by Miss Brown]
Ginn v Tesco Stores Limited [2005] UKEAT 0197_05_2608
Patel v Oldham Metropolitan Borough Council and Another [2010] ICR 603
Cruickshank v VAW Motorcast Ltd [2001] UKEAT 645_00_2510
SCA packaging Ltd v Boyle [2009] UKHL 37
Rehman v DHL Services Limited [2022] EAT 90

5. My findings of fact. I make my findings of fact on the basis of the material before me taking into account contemporaneous documents where they exist and the conduct of the claimant at the time. I have resolved such conflicts of evidence as arose on the balance of probabilities. I have taken into account my assessment of the credibility of the claimant and the consistency of his

evidence with the surrounding facts. Having made my findings of primary fact, I have considered what inferences I should draw from them for the purpose of making further findings of fact.

6. In the preamble to the Guidance it includes this: “In the vast majority of cases there is unlikely to be any doubt whether or not a person has or has had a disability, but this guidance should prove helpful in cases where the matter is not entirely clear.” In the case before me, it is not entirely clear and therefore I have considered the contents of the Guidance carefully.

7. The claimant was born in 1992 and is now 30 years of age. The claimant’s evidence in chief to me in this hearing was in his 2 impact statements (the first on pages 28 and 29 (thought to be from March 2020) of the bundle, and the second running from page 32 to 144 (thought to be from August 2020), wherein he described suffering from both physical and mental impairments. The claimant relied upon the contents of a number of medical notes and reports contained in the bundle.

8. In his impact statements the claimant sets out his substantial adverse effects on normal day-to-day activity. In the first statement the claimant asserted that he cannot ride a bike, is unable to go swimming and cannot play football properly. I find that the first two items are normal day-to-day activities but the third is not. He goes on to state he struggles to eat food, struggles to socialise and to keep a job. Eating and socialising are normal day-to-day activities. Working is a normal day-to-day activity. In his second impact statement the claimant expands the points raised in the first statement. Even wearing his contact lens in his left eye, he finds it difficult to iron and make tea. These are normal day-to-day activities. Walking at night is difficult because of his eye condition. The claimant

describes the vision in his right eye as being blurred and he has difficulty reading very small print. The claimant describes not being able to drive since Covid 19 happened, and since the statement is not dated, I take it that it was written after the onset of Covid 19 in March 2020, this being after the relevant time.

9. In relation to his chronic jaw pain the claimant finds it difficult to sleep without medication. Because of his inability to chew properly he no longer goes to restaurants as he felt he was being laughed at.

10. The claimant states that he loses control easily because no one understands him. There is no doubt that the claimant has anger management issues. I have seen the claimant's GP notes from May 2018 until November 2019 (152-161). The claimant registered with his then GP practice on 29 May 2018. He had to change from his previous surgery because of the fact he behaved in a way which conflicted with its zero-tolerance policy. Very early on at his new practice in May 2018 it is noted that when the claimant asked for and was refused a form MED 3 he left upset and rude, and a note was added: "consider zero tolerance-intimidating behaviour". The claimant does not like it when he does not get his own way. Fortunately for the claimant the new practice did not go down the route of removing him from the practice in view of his outburst. In 2018 there are numerous entries in the notes confirming that the claimant did not attend for an appointment: 21 September, 19 October, 25 October, and 15 November. This conduct continued into 2019 when he failed to attend on 15 January, and 18 January. It was also noted that he failed to attend a hospital appointment on 7 February 2019.

11. When we get closer to the relevant time the notes refer to another failed appointment on 4 April 2019 and a failure

with an eye specialist on 23 April 2019. The notes confirm the claimant being prescribed zopiclone on 5 April 2019. He was issued with a fit note confirming he was unable to work on 8 April 2019. This appears to cover the period from 25 March 2019 to 5 April 2019. Reference is made on 8 May 2019 that the claimant "suffers from chronic pain in his jaw following an injury in 2014 and operated subsequently…..he suffers from insomnia and because of mental health issues he has been referred to Birmingham healthy minds." The notes confirm that on 16 May 2019 the GP practice referred the claimant to hospital to see a consultant ophthalmologist. The claimant saw his GP on 17 May and matters troubling the claimant at work were recorded in the notes. On 28 May 2019 the claimant was prescribed amitriptyline for 28 days. The claimant failed to attend an appointment on 30 May 2019. On 5 June 2019 the claimant was diagnosed with anxiety and recorded as not fit for work from 1 May 2019 to 6 June 2019. At an appointment on 17 June 2019 there was a diagnosis of anxiety and a new MED 3 issued confirming the claimant was not fit for work from 6 June 2019 to 20 June 2019. A further failed appointment is noted on 25 July 2019. On 29 July 2019 the claimant is at the surgery again, asking for a letter to confirm that he has mental health issues. The note goes on to say that there was nothing in the record, "so maybe in the paper records as patient is insisting that he had mental health issues, only one letter in the records that he has not attended the appointment, he had issues with previous surgery and was deregistered on zero tolerance. Requested…to pull out paper record." The claimant was asked to contact the practice the following day to find out the outcome. Unfortunately, there is nothing on the GP records until 27 August 2019. On that day, the claimant failed to attend a hospital appointment, and the same occurred on 18 October 2019.

12. Plainly the GP records are incomplete as we only have a relatively short period of time. The mental health issue is described elsewhere. At page 118 is a report from Dr Kavita Misra dated 2 May 2020, following an interview with the claimant on 28 April 2020. Dr Misra is a chartered clinical psychologist who specialises in personal injury, trauma and related disorders, chronic pain and effects of stress and abuse in both adults and children. The claimant was referred to Dr Misra by his solicitors whom he instructed following a road traffic accident on 15 September 2018. In a short summary, Dr Misra said this: “Taking into account claimant self-report, accident and non—accident factors, my opinion is that following the index event he had an exacerbation of a pre-existing low mood and anxiety disorder.” Dr Misra dealt with causation and said this: “There was relevant pre-accident history which impacted on his accident-related problems in terms of his predisposition or vulnerability to mood disturbance and anxiety and his pre-existing mood disturbance and anxiety.” Furthermore, she stated this: “The claimant’s pre-accident symptoms were exacerbated by the accident for a period of 1 year 7 months.” More specifically, she went on to say: “Taking into account self-report, accident and non-accident factors, my opinion is that following the index event he had an exacerbation of a pre-existing low mood and anxiety disorder.” The expert plainly acknowledges that she relied upon the claimant’s own account of his problems but still came to her opinion based upon it.

13. It is worth reciting some of Dr Misra’s observations:

“Mood Disturbance: He is clinically depressed. Mood variability should continue to improve over the next 6 months.

Travel Anxiety: This will continue to improve with practice and advice given. It would be accelerated by brief CBT

therapy focusing on gradual re-exposure and repeated, regular practice.

General Anxiety: This will continue to improve especially with use of general anxiety management techniques and positive thinking.

His feelings of pessimism, reinforced by low level of behavioural and social activity are, in all probability, maintaining his low mood and low self-confidence. He could be encouraged to increase his level of activity. Brief CBT therapy...…..would accelerate this process.

Social Relationships Impairment: This should start to improve with increased social activity over the next 6 months.

Chronic Pain: In all probability, there is an interaction between his ongoing pain tolerance, level of behavioural activity and mood variability. He needs to gradually and incrementally increase his behavioural and social activity levels, recognise the significant efforts he has already made and continues to make and also understand more about pain coping strategies.

Cognitive Impairment: This continues. I would recommend a neuropsychological assessment to identify any residual cognitive deficit. However, in my opinion this is most likely to be due to his low mood and anxiety.

Accident-related psychological symptoms of travel anxiety should resolve within 3-6 months of starting psychological therapy. These residual symptoms are, in my opinion, attributable to the index accident. His low mood and anxiety are not attributable to the index accident."

14. I do not wish to recite anything further from the numerous reports at this stage. What is plain is that as a fact the claimant had numerous matters troubling him at the relevant time. He was involved in 2 accidents, the trip and the RTA which resulted in litigation which was ongoing at the relevant time, and which bring their own pressures. He had surgery on his jaw in the year before. There were personal family matters causing worry to him.

15. The submissions. I heard from Miss Brown first. She spoke to her written submissions and there is no need for me to recite everything she said here. I note some of her supplementary submissions. There was nothing in the EAT decision which was binding on me, and I had a free hand to determine the issue unfettered by any findings of fact from the EAT. Miss Brown raised the issue of credibility of the claimant. She submitted that I should find that he was prone to exaggeration, avoided questions in cross examination, either subconsciously or consciously he was motivated by furthering his own cause, which caused conflict in his evidence, and furthermore he was simply implausible. Miss Brown then directed her attention to the three impairments and asked me to note various factors which pointed away from me concluding that the claimant was disabled whether looking at the conditions individually or collectively. I take the opportunity of thanking Miss Brown for her commendably professional approach to the hearing and the help she gave in providing me with links to the case law and other documents, which included those referred to by the claimant.

16. I then heard from the claimant with his submissions. He too spoke to his written skeleton argument, and I do not repeat it all here. He accepted that Miss Brown had made an appealing argument. This concession was short lived for in his later letter to me he said: “The respondents

brutally twisted my honest words even though I had taken an affirmation." Nevertheless, he submitted that I should find that he was an honest and truthful witness. He urged me to look at the overall position and be open-minded about it. He submitted that s.6 of the EQA meant that I should look at the impairments collectively at the same time. He directed me to the deduced effect, and in relation to his eye problem the aids of glasses and contact lenses did not correct the problem. In relation to his mental health, he accepted that there may be an unconscious magnification of the symptoms, but this was part of the symptomatology of his impairment, and I should read the EAT decision on this point. He drew my attention to specific parts of the bundle which he submitted provided evidence of a substantial adverse effect with mood disturbance at the relevant time. If I did the things he asked of me and looked at disability collectively then the threshold in s.6 is met. He then touched upon the case law briefly. In relation to Goodwin, he submitted that this case supported his argument over adverse effect, the fact that he took his medications intermittently did not detract from his case, and once again he assured me that he was being honest with me. Turning then to Elliott, he asked me to adopt this case as the current approach to the analysis, which required me to look at what a claimant cannot do, and this includes his low self-esteem. Then looking at the DLA case, I should accept that he is predisposed to depression. That case also directed me to look at the cumulative effect. The case of Leonard was relevant because the claimant in that case had depression, as he does, with a dosage of 20mg of amitriptyline. He rounded off his submissions by urging me again "to be open-minded".

17. My conclusions and reasons. I apply the law to the facts and explain my analysis. I remind myself that the burden of proof is on the claimant to show that he satisfies

the definition of disability. The EQA is different to prior legislation, and a non-exhaustive list of examples of how the effects of an impairment might manifest themselves in relation to those capacities is contained in the Guidance at the appendix. It is considered that the effect of the change in the law with the EQA makes it easier for a claimant to show that an impairment has a substantial adverse effect on normal day-to-day activities.

18. The material time for establishing disability is the date of the alleged discriminatory act or acts. This is the time to determine whether the impairment had a long-term effect. In this case I must consider the period from 14 April 2019 to 27 August 2019 which time span was agreed between the parties at the outset of the hearing.

19. I recite some parts of the Guidance which influenced my decision, taking into account the way the case was put by the claimant.

Meaning of likely

C3 and C4.

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. (In deciding whether a person has had a disability in the past, the question is whether a substantial adverse effect has in fact recurred.) Conditions with effects which recur only sporadically or for short periods can still qualify as impairments for the purposes of the Act, in respect of the meaning of 'long-term' (Sch 1,

Para 2(2), see also paragraphs C3 to C4 (meaning of likely).)

C6.

For example, a person with rheumatoid arthritis may experience substantial adverse effects for a few weeks after the first occurrence and then have a period of remission. See also example at paragraph B11. If the substantial adverse effects are likely to recur, they are to be treated as if they were continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term. Other impairments with effects which can recur beyond 12 months, or where effects can be sporadic, include Menières Disease and epilepsy as well as mental health conditions such as schizophrenia, bipolar affective disorder, and certain types of depression, though this is not an exhaustive list. **Some impairments with recurring or fluctuating effects may be less obvious in their impact on the individual concerned than is the case with other impairments where the effects are more constant.** [My emphasis].

'A young man has bipolar affective disorder, a recurring form of depression. The first episode occurred in months one and two of a 13-month period. The second episode took place in month 13. This man will satisfy the requirements of the definition in respect of the meaning of long-term, because the adverse effects have recurred beyond

12 months after the first occurrence and are therefore treated as having continued for the whole period (in this case, a period of 13 months).

C7.

It is not necessary for the effect to be the same throughout the period which is being considered in relation to determining whether the 'long-term' element of the definition is met. A person may still satisfy the long-term element of the definition even if the effect is not the same throughout the period. It may change: for example activities which are initially very difficult may become possible to a much greater extent. The effect might even disappear temporarily. Or other effects on the ability to carry out normal day-to-day activities may develop and the initial effect may disappear altogether.

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

Likelihood of recurrence

C9.

Likelihood of recurrence should be considered taking all the circumstances of the case into account. This should include what the person could reasonably be expected to do to prevent the recurrence. For example, the person might reasonably be expected to take action which prevents the impairment from having such effects (e.g. avoiding substances to which he or she is allergic). This may be unreasonably difficult with some substances.

C10.

In addition, it is possible that the way in which a person can control or cope with the effects of an impairment may not always be successful. For example, this may be because an avoidance routine is difficult to adhere to, or itself adversely affects the ability to carry out day-to-day activities, or because the person is in an unfamiliar environment. If there is an increased likelihood that the control will break down, it will be more likely that there will be a recurrence. That possibility should be taken into account when assessing the likelihood of a recurrence. (See also paragraphs B7 to B10 (effects of behaviour), paragraph B11 (environmental effects); paragraphs B12 to B17 (effect of treatment); and paragraphs C3 to C4 (meaning of likely).)

Assessing whether a past disability was long-term

C12.

The Act provides that a person who has had a disability within the definition is protected from some forms of discrimination even if he or she has since recovered or the effects have become less than substantial. In deciding whether a past condition was a disability, its effects count as long-term if they lasted 12 months or more after the first occurrence, or if a recurrence happened or continued until more than 12 months after the first occurrence (s 6(4) and Sch 1, Para 2). For the forms of discrimination covered by this provision see paragraph A16.

Section D: Normal day-to-day activities

This section should not be read in isolation but must be considered together with sections A, B and C. Whether a person satisfies the definition of a disabled person for the purposes of the Act will depend upon the full circumstances of the case. That is, whether the adverse effect of the person's impairment on the carrying out of normal day-to-day activities is substantial and long term.

D1.

The Act looks at a person's impairment and whether it substantially and adversely affects the person's ability to carry out normal day-to-day activities.

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.

This section provides guidance on what should be taken into account in deciding whether a person's ability to carry out normal day-to-day activities might be restricted by the effects of that person's impairment. The examples given are purely illustrative and should not in any way be considered as a prescriptive or exhaustive list.

D16.

Normal day-to-day activities also include activities that are required to maintain personal well-being or to ensure personal safety, or the safety of other people. Account should be taken of whether the effects of an impairment have an impact on whether the person is inclined to carry out or neglect basic functions such as **eating**, drinking, **sleeping**, keeping warm or personal hygiene; or to exhibit behaviour which puts the person or other people at risk [**My emphasis on the 2 words**].

A man has had paranoid schizophrenia for five years. One of the effects of this impairment is an inability to make proper judgements about activities that may result in a risk to his personal safety. For example, he will walk into roads without checking if cars are coming.

This has a substantial adverse effect on his ability to carry out the normal day-to-day activity of crossing the road safely.'

20. The claimant, during his submissions, asked me to say something kind about him in my judgement. He also asked me to find that he was not exaggerating. The

claimant presented to me as articulate and intelligent. He had a good understanding of the law and procedure. For a litigant in person, he was quite adept at presenting his case. However, he did not develop the detail that I thought he might do in the way he explained his case. He presented as courteous to me, Miss Brown and my clerk. In many ways, the claimant has an engaging personality. Unfortunately, he is not always reliable. This manifested itself in various ways, and I refer to 2 of them. Firstly, when considering his GP notes, it was quite apparent that the claimant made a number of appointments which he simply failed to attend. Secondly, he was given a fairly straightforward task to undertake and did not carry it out. This was quite apparent when Judge Findlay ordered him to provide a copy of a letter that he or his solicitors wrote to Dr Misra which caused her to write the letter of 29 January 2021. This was to be done by 2 January 2023. The claimant said this on 4 January 2023: "I have not been able to provide the letter because the solicitor firm have told me they are not able to locate the file. As there is a lot of information in my file." It would have been easy for the claimant to have asked Dr Misra for a copy of the letter. The claimant appeared to have lost interest in the subject. The claimant explained his frequent failure to attend appointments by reference to his depression and anxiety, but this seemed improbable. He was not always a good witness in his own cause. The claimant was not a convincing witness. He lacked attention to detail on the issue I had to decide, although I bear in mind, he is representing himself and this is not always an easy task. He also went off at a tangent on a number of occasions during cross examination.

21. I will look at the three impairments individually and collectively. Turning to the claimant's eye condition of keratoconus first of all. I record the fact that the respondent accepted the claimant has the condition, and

that it is long-term. However, the respondent does not accept that there is a substantial adverse effect because the claimant wears contact lenses or glasses which correct the problem. As Baroness Hale of Richmond (as she then was) said succinctly in SCA, although in relation to the previous legislation:

"48. Most important for our purposes is paragraph 6(1): "An impairment which would be likely to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities, but for the fact that measures are being taken to treat or correct it, is to be treated as having that effect."

In other words, if a person has an underlying impairment within the meaning of the Act, the effect of medical treatment and other corrective measures which enable the person concerned to function more normally is to be ignored. A blind person who can get about with a guide dog is still disabled. A person with Parkinson's disease whose disabling symptoms are controlled by medication is still disabled. An amputee with an artificial limb is still disabled. (This provision does not apply to people with poor eyesight which is correctable by spectacles or contact lenses: otherwise no doubt most of the population would be disabled.)"

22. The claimant's evidence to me was that for many years he had not worn glasses, as they did not improve his sight. He was moved on to use contact lenses. However, in recent years, he has not been able to wear a lens in his right eye because of the irregular shape of the surface and it is very sensitive. Accordingly, he asserted his eyesight in his right eye remained uncorrected. I considered this very carefully. The issue is not discussed in the way the claimant presented his case in the documentation in the bundle, and the claimant asked me to accept his oral evidence. The documents referred to

"lens" and "lenses". Judge Findlay's list of issues refers to "lenses". The claimant did not correct that when the order was sent to the parties. I have already found that the claimant can be unreliable. The issue is finely balanced. Am I prepared to accept that the claimant has established that the eye condition falls outside the exemption because his right eye is not corrected by glasses or lenses at the relevant time? It is a good argument to advance. The claimant has a substantial adverse effect on normal day-to-day activities in that he cannot ride a bike, cannot go swimming, has difficulty with ironing or making tea, and has difficulty in navigating the footway at night. He is at risk of contracting an infection called "microbial keratitis." He has had this in the past and will be at risk of getting it in the future; and when he has it, he is unable to drive and is unable to identify family members by facial recognition. I was able to observe the claimant whilst he was giving his evidence. He used a laptop in the hearing. Frequently, he held this a couple of inches away from his eyes to be able to read a document. The issue of the right eye not being corrected by glasses or lenses is not developed in the 2 impact statements. I could see no reference to it in the GP notes. Perhaps the most significant contemporaneous document was an Occupational Health Assessment report dated 19 July 2019 (original date) and 24 July 2019 (altered to include amendments provided by the claimant) which includes this (at page 146):

"At work, [the claimant] says that he has no problems seeing the display on the handheld digital devices he uses and if he uses display screen equipment (DSE) he adjusts the brightness and text size.

He tells me that it was whilst he was adjusting **one of his contact lenses** [my emphasis] that a picking error occurred, and this is what led to his dismissal."

The claimant did not amend this part of the report. I conclude that the problems the claimant now has with his

right eye were not present at the relevant time. If they had been, they would have been noted in various places (and the claimant certainly would have made sure of that) and I would probably have found the claimant to be disabled because of this condition. However, my conclusion is that he does not fall outside the exemption and therefore was not disabled because of keratoconus at the relevant time. I concluded the claimant was plainly not telling me the truth over this issue.

23. I then turned to the issue of chronic jaw pain. The respondent accepts that at some stage the claimant had this condition. However, it disputes that it was long-term and asserts that there were no substantial adverse effects. The claimant had an accident in 2014 when he tripped on a pothole in the pavement and landed on the side of his face. He had surgery which included having a plate inserted. This was removed in further surgery in 2018. The claimant complained of ongoing problems, which included: difficulties in eating food properly (the claimant was not going to restaurants as people laughed at him on account of the way that he eats and drinks), losing sensation in the left side of his face, his mouth locking and being painful. These things cause him to become agitated. He has been prescribed zopiclone to help with sleep and pain. He has also been prescribed amitriptyline as a painkiller and antidepressant.

24. The claimant relies upon medical reports from Mr Bernard Speculand dated 12 July 2017 and 1 October 2019. In between these reports the claimant was involved in a road traffic accident on 15 September 2018, although this does not appear to have had an impact upon the issues being discussed by the expert. The second report refers to the claimant being seen on 20 May 2019 by Mr K McMillan, consultant oral and maxilio facial surgeon (page 64). It was noted that the claimant was suffering with chronic pain. There was some muscle spasm and the

claimant resisted wide mouth opening. Some altered sensation on the left side was noted. "The impression was of a very significant myofascial (muscle spasm) component. He was recommended to try amitriptyline 10 mg at night (to help with jaw muscle relaxation) and would be seen in four months." Of course, this is during the relevant time. The comments and prognosis are at pages 67 to 70. Stated shortly, the claimant complains of discomfort and numbness or altered sensation over his left cheek area, both intra-orally and extra-orally. The consultant accepted a 60% overall reduction in feeling in the relevant areas, directly due to the index injury. Once the consultant asserted that most nerve recovery occurs within the first 18 months after injury, he advised that there was no prospect of further improvement over time with regard to those symptoms and saw that a consultant psychiatrist might be of assistance to help develop a coping strategy and to address the claimant's low mood and low self-esteem. It is confirmed that the claimant's mouth opening was reduced and had tenderness on two of the four main jaw muscles on the left side. Unfortunately, the claimant has poor oral hygiene adversely effecting his gums, with chronic marginal gingivitis. It was down to him to sort this out. Once this has been done the consultant said: "…he can consider some treatment for his TMJ problem which is consistent with temporo-mandibular joint dysfunction." Using a five-point grading scale, the consultant assessed the claimant as being at stage 2 for TMJ. Some non-surgical approaches were suggested, and the claimant was advised it would be helpful to resume his amitriptyline 10mg at night. Again, these were described as an antidepressant, also providing jaw muscle relaxation and pain relief. It was indicated that it might be better for the claimant to see a consultant psychiatrist before resuming amitriptyline.

25. At this point of the analysis, I conclude the claimant has established a substantial adverse effect on a normal

day-to-day activity, which is more than minor or trivial. The claimant can eat; but with difficulty and is self-conscious when eating in public. The appendix to the Guidance refers to difficulty eating:

“Difficulty eating; for example, because of an inability to co-ordinate the use of a knife and fork, a need for assistance, or the effect of an eating disorder;”

This is a substantial adverse effect caused by the jaw locking and pain. A notable contemporaneous document is a letter dated 22 May 2019 from Mr K McMillan to the claimant’s GP (pages 86-87). This recites the claimant having long-term problems with fairly chronic pain affecting the left mandibular angle region. It continues: “He has ongoing complaints of quite significant trismus as well as generalised altered sensation and discomfort down the left side of his face.” The claimant was found to be “well”, but in “obvious low mood. His mouth opening is restricted, although with stretching there is significant improvement suggesting a strong myofascial component.” Mr McMillan saw the benefit in referring the claimant to mental health services, as he was sure this would benefit the claimant. I find there is a link established between the jaw problem and the claimant’s mental health issues.

26. Turning to the issue of the claimant’s mental health, he produced a report from Dr MJ Whittington dated 20 February 2020 (following examination on 4 February 2020) starting at page 92. In a summary of conclusions Dr Whittington said this: “Mr Rehman developed significant mental symptoms which in my opinion are characteristic of a psychiatric disorder known as a mixed anxiety and depressive disorder-the evidence appears to indicate that his **ongoing jaw problems following his operation in June 2018** [my emphasis] led to an aggravation of his underlying mental symptoms. His mental symptoms have led to significant a) psychological distress b) impairment of

his quality-of-life.” Dr Whittington also said this (at page 108):

“Mr Rehman developed significant mental symptoms exemplified by:

· Persistent emotional distress and upset.

· Felt increasingly fed up and depressed.

· Experienced increasing difficulty sleeping as his mind wouldn’t switch off.

· Felt angry and frustrated.

· Struggled to enjoy life and tended to think more negatively.

· Suffered a loss of self-confidence and self-esteem.

· Felt anxious and unable to relax.

· Felt stressed and worried.

· Felt snappy and irritable.

In my opinion, these mental symptoms are characteristic of a psychiatric disorder known as mixed anxiety and depressive disorder-the evidence appears to indicate that his ongoing jaw problems following his operation in June 2018 led to an aggravation of his underlying mental symptoms.”

Dr Whittington went on to say the claimant’s “Mental Symptoms have led to significant a) Psychological distress b) Impairment of his quality of life.”

27. I find and conclude that the claimant has established that he has mixed anxiety and depressive disorder. What was it that the claimant could not do in the relevant time? I find as follows. He could not eat in public because of

restrictions in his jaw movement and associated pain. He did not socialise. He had problems sleeping, although this was intermittent, and was at least in part due to pain. He had low mood, and again this is something that appears in the Guidance appendix as follows:

“Persistent general low motivation or loss of interest in everyday activities.”

28. The claimant was unreliable. He could not be relied on to keep appointments during the relevant time and misled me about his eye condition. Nevertheless, I find that if the claimant suffers from psychological distress, it has an impact upon his physical symptoms (a point made in a letter dated 29 January 2021-page163-from Dr Misra). That is particularly so in relation to pain and sleep. When these things are more troubling for the claimant, he can use zopiclone and amitriptyline to get through the worst moments. Without them the pain and sleep would be worse and his ability to cope with life would be compromised.

29. I concluded that when I considered the claimant’s jaw problem and mixed anxiety and depressive disorder taken together, they gave a cumulative effect which led me to find that the claimant was disabled at the relevant time.

30. In coming to my conclusions I had regard to the way in which the claimant presented to me. The respondent, for the various reasons advanced, wanted me to find that the claimant could not be believed, and that I should find against him on all 3 conditions. I did find that the claimant was unreliable in a number of ways; for example, by not attending GP and other medical appointments or complying with the order of the tribunal concerning the production of his solicitor’s letter. He misled me over his eye condition. Does that mean that someone who is

unreliable or whose evidence to me in part was unbelievable and contradictory, could or should not be considered disabled? I thought about that point very carefully. However, I conclude that the negative points that I identified about the claimant and his presentation of his case do not preclude him from a finding that he is disabled within the meaning of the EQA.

Employment Judge Dimbylow
on 22 March 2023