EMPLOYMENT TRIBUNALS

Claimant: **Ms. Darja Gurvic**

Respondent: **DAU Draexlmaier Automotive UK Limited**

Heard at: **Birmingham Employment Tribunal** **On: 13 February 2023**

Before: **Employment Judge V. Jones**

Representation

Claimant: Mr McHugh, counsel
Respondent: Mr Lovejoy, legal executive

JUDGMENT

The Claimant was at all material times a disabled person for the purposes of the Equality Act 2010.

REASONS

1. By her ET1 presented on 7 January 2022 after a period of ACAS conciliation, the Claimant claimed unfair dismissal and disability discrimination. This was a Preliminary Hearing to determine whether the Claimant was at all relevant times a disabled person under Section 6 Equality Act by reason of anxiety.

2. The Claimant was represented by Mr McHugh of counsel and the respondent by Mr Lovejoy, legal executive.

3. There was an agreed bundle of documents (pp 1-184) and references, in this Judgment, to page numbers are to pages in that bundle. I read a witness statement and heard evidence from the Claimant. At the start of the Hearing, I heard an application by Mr McHugh to adduce late evidence in the form of a medical report dated 28 October 2022 from Dr. Meetu Singh, Consultant Psychiatrist of the Oak Tree Clinic. I refused that application for reasons given orally at the Hearing.

4. The Hearing was listed for half a day. After hearing the evidence and submissions, I reserved my decision due to time constraints.

Findings of Fact

5. From the evidence I received and heard, I made the following Findings of Fact.

6. The Claimant suffered a period of anxiety in 2015/2016 but recovered from it

without substantial long term effects. The earliest medical evidence she submitted was dated 14 August 2019. On that date she consulted her GP about issues with her balance, dizziness, and panic attacks in public places. She was referred for an MRI brain scan which was unable to identify a physical cause for her symptoms (pp 141,154).

7. On 15 October 2020, the Claimant went to the emergency department of Good Hope Hospital after experiencing dizziness and palpitations for a day. She said she had taken her blood pressure which was high, though on admission hospital staff found her blood pressure was normal. The suspected diagnosis was "hypertension" and the claimant was discharged without treatment (pp 89-90).

8. On 21 October 2020, the Claimant had a GP appointment, presenting with "anxiety with panic attacks and globus sensation" (difficulty swallowing). She admitted having problems with anxiety issues. Her GP discussed options for managing the condition and recorded that the Claimant would benefit from a self-referral to Wellbeing (p153).

9. On 30 October 2020, had a further GP appointment. The notes (p152) record she had suffered palpations for some time and had attended A&E but blood and ECG tests had all come back normal. The GP thought her symptoms were due to anxiety and noted they had discussed her situation the previously week. The claimant said she was not particularly anxious and was worried that there might be an underlying physical cause. She was experiencing occasional palpitations with mild chest pain and shortness of breath, following which she would begin to hyperventilate and get dizzy. She said the symptoms often occurred at work. She was not sure if it was due to anxiety and thought it might be something to do with her lungs. The GP referred her for a chest x-ray. The referral reads the claimant had "a long history of anxiety with shortness of breath…patient requesting a chest X-ray".

10. On 1 November 2020, the Claimant attended Good Hope Hospital emergency department reporting head pain, chest pain, shortness of breath, dizziness, limb weakness and nausea. Extensive tests were carried out (p92) with nothing abnormal detected. The suspected diagnosis was "tension headache" and the Claimant was discharged without treatment and referred to her GP with the request that the GP do repeat blood tests due to her ongoing symptoms.

11. A referral letter from the GP to Cardiology dated 2 November 2020 states "this woman has a history of having palpitations for some time with mild chest pain and SOB on occasions. She says it feels like she cannot get oxygen into her lungs. She then begins to hyperventilate and gets dizzy. The symptoms often occur when she is at work" (page 94).

12. On 3 November 2020, West Midlands Ambulance Service was called out to the Claimant at 7.33am (pp98-100). The Claimant was complaining of abdominal pain, vomiting, black stools, chest pain and racing heart. She was taken by the ambulance to George Eliot Hospital where extensive tests were carried out (p102). The Claimant told the hospital she had been experiencing the symptoms for three weeks and was awaiting the outcome of GP blood tests. The Claimant was discharged at 12.35pm apparently without treatment, though I was unable to read the record of this admission (at p103) as it was largely illegible.

13. On 7 November 2020, (p102-103) the Claimant attended the emergency Department of University Hospital of Derby and Burton complaining that she had suffered with a headache for the previous five weeks, involving the right side of her face and hard pallet. She said she had experienced nausea and dizziness and had a few episodes of panic attacks due to the pain. The record of this visit reads:

"today, the (Claimant) was in the kitchen when she had another episode of severe pain which caused urine and fecal incontinence. She is constantly struggling because of this pain".

The Claimant was given 15 litres of oxygen via a non-breather mask. When she was reviewed after 15 minutes she was feeling better. However she wanted to be referred to Neurology for detailed investigations. She was prescribed co-codamol and referred to her GP for review. The GP was asked to expedite her appointment with the Mental Health Service. The record states "no investigations done. no treatment needed".

14. On 9 November 2020, the Claimant was again taken by ambulance to Good Hope Hospital emergency department (p107). The ambulance report (p 109) reads "PC (presenting condition) lower back pain, HPC patient has ongoing issue with head pain, palpitations and dizziness. Today patient has had sensation of a surge of adrenalin with racing heart and sudden rush of blood to the head, followed by a loss of control of the legs. Also complaining of lower back pain and shooting down legs, pain in neck, back of head, pins and needles in feet and fingers…"

15. The hospital record reads:

"feeling palpitations 3 times per day for the last 5 weeks. Today feeling off legs and has no control of legs, pain in lower back and legs with development goosebumps. Has presented with similar symptoms before…."

The Claimant was admitted as an in-patient and extensive tests were carried out, These included an ECG, MRI scan on her spine, CT scan on her head and blood tests. Nothing abnormal was detected. Various medication was prescribed including cocodamol and prochlorperazine (p 114). The claimant was due to be discharged on 13 November 2020 but discharged herself a day early because her husband had arranged to take her to Lithuania for medical tests.

16. Between 17 November and 25 November 2020, the Claimant was seen by a number of medical professionals at the Kardiolita Clinic, Vilnius, Lithuania. The reports relating to her visit are at pp115-123. The claimant saw a number of consultants who conducted physical health investigations and was referred to a psychiatrist for anxiety (p118) She saw a psychiatrist at the clinic on 25 November 2020. She found the Claimant had extremely high levels of anxiety and diagnosed her with "F41.3 other mixed anxiety disorder". She prescribed Alprazolam for 2-3 weeks. The record shows that a prescription for Escitalopram was also to "be discussed". The Claimant said in oral evidence that she did discuss Escitalopram with the Psychiatrist the following day and was given a prescription for five months supply to enable her to continue her medication on return to the UK. However, there was nothing in the medical reports from Lithuania to support this and the claimant's GP record (p150) indicates she was not taking medication between January and May 2021. I also note she says in her witness statement that she was prescribed "short term" medication in Lithuania and went onto Escitalopram in May. I therefore reject her oral evidence to the contrary.

17. The Claimant returned to the UK on 3 December 2020.

18. The claimant next saw her GP on 4 May 2021. The record reads (p150) *"in Lithuania diagnosed anxiety disorder. Two types of medication offered then decided only one as did not want long-term tablets. Started Alprazolam as could not eat, sleep, panic attacks 5-8 times per day and decided to put on the tablets so could reduce, high level anxiety as adrenaline too high".* The record says that Alprazolam was prescribed for 4 weeks and the Claimant was offered Citalopram (an antidepressant) as well but was scared to go on to long term tablets and thought she would manage herself. She said she was "really ok when returned to

UK 3 December 2020 and had reduced stressful situations". The note continues *"at present the Claimant has a bad situation at work regarding redundancy and … symptoms are returning, she feels antidepressants will help."*

19. The GP advised the claimant to start on Escitalopram again and continue for at least three months of feeling well. They also discussed counselling and the availability of a 24hr support service from the Community Mental Health Team and a contact number for Samaritans.

20. On 12 May 2021, the Claimant called the Ambulance Service suffering from a panic attack. Her legs had become weak, her chest tight and painful and she was having difficulty breathing. She was cold and had pins and needles. The Claimant was not taken to hospital. The ambulance service record (p 124) reads "history of panic attacks, the last was in November/December 2020. Previously treated in Lithuania but has not yet had any ongoing continuing treatment in the UK. Her GP has recently prescribed medication". The note records under the heading "impressions": anxiety disorder.

21. On 13 May 2021 the Claimant attended her GP practice for a depression medical review. She was suffering from headaches but wanted to continue with medication as she was not sure whether it was a side effect of the medication or part of the underlying symptoms.

22. The Claimant's medical record continues with a further ambulance call out on 6 July and a referral to Adult Mental Health Services the following day.

23. The Claimant's evidence was that while suffering panic attacks, or heightened anxiety, she was unable to carry out basic tasks such as washing herself, working or cooking". The anxiety caused heavily disruptive sleep. It caused a constant state of fear, anticipating the potential for a severe panic attack. Most attacks occurred at night or after meals which left her fearful of sleeping and eating. Prior to taking medicine, she was fearful of leaving the house, even to go into her own back garden. The medication has reduced the symptoms but not removed them completely. The medication itself can cause headaches, nausea, disruptive sleep and drowsiness.

24. The Claimant said that between the "massive panic attacks" which resulted in her calling an ambulance or attending hospital, she still experienced anxiety issues. She lived constantly with an attitude of "waiting for something to happen". She found it hard to be alone at home and could not go anywhere without her phone or without somebody with her, even to the toilet or shower. She had no energy. When she went to work, she was scared to walk from the office to the quarantine cage and vice versa. She had to walk close to the walls and have somebody with her. She was in a constant state of anxiety about what would happen. She said this was happening at least once a day before she went to Lithuania. Sometimes she could not drive to work and had to ask her husband to take her.

25. Summarising her evidence the Claimant said her first panic occurred in 2015/16, 1.5 years after starting work for the Respondent. After this, nothing "massive" occurred for 2-3 years. This was a period where there were positive changes at home (buying a house) and work (a new role). She was able to function day to day during this period. The attacks returned in 2018/19 and began to increase from once a week a week to twice a week. Things escalated at the end of 2020 and were at their worst before she went to Lithuania. When it was put to her that what the claimant had suffered from in 2020 was a series of physical conditions which caused her to be anxious the claimant said it was in fact the other way round. Until it was explained to her by her doctors that her underlying condition was anxiety she used to think she had something seriously wrong with her, for example at one stage she was convinced she had liver cancer. Often she thought she was dying.

she came to realise the physical symptoms were all down to her anxiety. She has continued to experience panic attacks since returning and is now on permanent medication. Since she has been taking medication for anxiety most of her physical symptoms have disappeared.

26. The Respondent produced a report (pp72-81) from Doctor Constantinos Loumidis, Consultant Clinical Psychologist, dated 20 September 2022. Dr Loumidis did not see the claimant but was asked to respond to questions about the claimant's medical evidence and impact statement.

27. Doctor Loumidis could not confidently confirm or refute whether on 25 November 2020 the criteria for 6A73 mixed depression and anxiety disorder, or indeed any other disorder, were met or are still met. (6A73 has replaced F41.3 as the categorization.) He could not confidently confirm or refute whether during any time (from for example May to August 2021) any Clinician would have been able to predict or expect the Claimant would experience substantial adverse effects for any given length of time. He could not on the basis of a diagnostic label make inferences on the outcome of any given treatment He was unable to provide an opinion on a "typical" patient because each patient presents with a unique individual constellation of problems. However he said most patients he sees tend to improve with 10-20 weekly sessions, unless unrelated factors occur (paras 11.3; 11.4).

28. Doctor Loumidis was unable, confidently, to confirm or refute that during any time that the Claimant was experiencing substantial adverse effects, whether they were due to psychological rather than physical symptoms. Finally, he said it was not possible to infer what the prognosis would have been after 12 months with any given treatment.

29. I noted that Doctor Loumidis read the claimant's impact statement and reviewed some but not all of the medical records in the bundle. He saw four records from 2020, he saw four records: 21 October (GP), 30 October (GP), 13 November (hospital) and 25 November (the Lithuanian clinic report). In 2021, he saw six records: 4 May (GP), 12 May (ambulance service), 13 May (GP) 26 June (GP), 6 July (ambulance service), 7 July (GP referral letter), 10 August (GP) and records subsequent to this.

30. Doctor Loumidis sets out seven conditions which he says would have needed to be satisfied in order for the diagnosis of mixed anxiety and depression disorder to be made. They are:

    a. The presence of both depressive and anxiety symptoms for most of the time during a period of two or more weeks.
    b. Depressive symptoms including depressed mood or markedly diminished interest or pleasure in activities.
    c. Multiple anxiety symptoms including feeling nervous or anxious or on edge.
    d. Not being able to control worrying thoughts.
    e. A fear that something awful will happen.
    f. Having trouble relaxing, muscle tension or symptomatic, automatic, autonomic symptoms.
    g. Symptoms resulting in significant distress or significant impairment in personal, family, social, educational or occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

31. Doctor Loumidis refers to NICE guidelines which recommend psychological therapy in the form of cognitive behaviour therapy (CBT) for the condition. Department of Health guidelines state 16 or more sessions are generally

considered necessary for symptomatic relief in more severe cases.

32. Doctor Loumidis says (para 8.3 of the report) Epidemiological Studies have yielded various results regarding the cause and onset of this disorder:

"while there is some evidence to suggest that approximately half of individuals with Mixed Depression and Anxiety Disorder were experiencing remission of symptoms within a year of onset, those who do not remit are at increased risk of developing a mental behaviourable behavioural neurodevelopmental disorder that meets full diagnostic requirements typically for a depressive disorder or an anxiety or fear related disorder".

33. At para 8.4 he says:

"in my view it is not possible to say simply on the basis of a diagnostic label such as MDAD to infer that the condition is likely to last a set duration, be it 3, 6, 12 or 24 months.

Elsewhere in the report he explains this is because positive as well as negative life events and changes can positively or negatively affect prognosis, the cause of the disorder or the outcome of treatment.

34. I have attached little weight to Doctor Loumidis' observations on the matter of "substantial adverse effect". With respect to Dr Loumidis there is no evidence that he is sufficiently well versed in discrimination law to be able to safely reach a finding on what, in legal terms, amounts to "substantial long term effect". Despite his comment that he does not in practice see patients with Mixed Depression and Anxiety Disorder who cannot for example wash, cook, shop get dressed, the factors he lists as requirements for the diagnosis in my view support the Claimant's evidence that there was a substantial, i.e. more than trivial effect, on her ability to carry out day to day activities including social, family, occupational and other important areas of functioning while she was suffering from anxiety attacks.

The Law

35. Section 6(1) Equality Act 2010 provides that a person has a disability if they have a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities. The burden of proving disability is on the Claimant and the standard of proof is the balance of probabilities.

36. Section 212 EQA provides that an adverse effect is "substantial" if it is "more than minor or trivial".

37. Schedule 1 Part 1 of the Equality Act and Equality Act 2010 (Disability) Regulations 2010 contain supplementary provisions for determining whether a person has a disability.

38. The Government has issued guidance on matters to be taken into account in determining questions relating to the definition of disability (2011) ("The Guidance"). Section D3 of the Guidance deals with the meaning of "normal day-to-day activities". Section B6 of the Guidance states that where a person has one or more impairments, account should be taken of whether, cumulatively, they have a substantial adverse effect on the person's ability to carry out day-to-day activities.

39. The material time for establishing disability is the date of the alleged discriminatory act. That is also the material date for determining whether impairment has a long term effect.

40. In Goodwin v Patent Office 1999 ICR302 the EAT gave guidance to Employment Tribunals on how to approach the question of determining disability. The following questions must be considered, sequentially:

i. Did the Claimant have a mental or physical impairment?
ii. Did the impairment affect their ability to carry out normal day to day activities?
iii. Was that effect substantial?
iv. Was that effect long term?

41. Goodwin was a case under the Disability Discrimination Act 1995 but the above approach has been endorsed in subsequent cases under EQA.

42. Appendix 1 of the Equality and Human Rights Commission's (EHRC's) Code of Practice on Employment deals with the meaning of disability. Para 7 of Appendix 1 states

"there is no need for a person to establish a medically diagnosed cause for their impairment:" "What is important is to establish the effect of the impairment not the cause".

This approach was adopted in MoD v Hay 2008 ICR1247 where the EAT said "the impairment can be an illness or the result of an illness, it is not necessary to determine its precise medical cause, the statutory approach is a functional one".

43. There is no definition of mental impairment in EQA. Para 6 of Appendix 1 to the EHRC Code says it is intended to cover a "wide range of impairments relating to mental functioning". Anxiety and depression are capable of constituting a disability but each case must be considered on its facts.

44. For current impairments that have not lasted 12 months, the Tribunal must decide whether the substantial adverse effects are "likely" to last for at least 12 months. The guidance (C3) says that an event is likely to happen if it "could well happen". This reflects the House of Lords decision in Boyle v SCA Packaging Ltd (Equality and Human Rights Commission Intervening) 2009 ICR 1056HL. Baroness Hale there held that the word "likely" in each of the relevant provisions in the DDA (now EQA) simply means that something is a real possibility in the sense it "could well happen".

45. Para C4 of the Guidance stresses that account should be taken of both the typical length of such an effect on an individual and any relevant factors specific to this individual, such as their general state of health or age. The guidance states that a condition does not have to have a substantial and adverse effect continually in order to satisfy the long term requirement. A person may still satisfy the long term element of the definition even if the effect is not the same throughout the period. The effect may change. For example, activities which are initially difficult may disappear or become easier. If the condition has substantial adverse effects that are likely to recur beyond 12 months after the person developed the impairment, then the definition is satisfied (para C7).

46. Para C11 of the Guidance says that if treatment simply delays or prevents the recurrence of the condition and that would be unlikely without the treatment, the treatment should be ignored and the effect should be regarded as "likely to recur".

Conclusions

47. I am satisfied on the evidence on the balance of probabilities that the Claimant has suffered anxiety attacks from 2015 – 2016. On her own evidence, this initial episode was short term and she was able to function normally for a number of years. Positive life events intervened which no doubt contributed to her apparently making a good recovery. She did not suffer substantial long term adverse effects

from the condition at that time.

48. However, the claimant's symptoms then returned. It would appear that this happened in 2019 as the earliest medical record which mentions anxiety is 14 August 2019. She was suffering from balance and dizziness issues in public places and panic attacks related to this. A brain scan found no physical cause for her symptoms.

49. Then from 15 October 2020 to 12 November 2020 the claimant had a series of attendances at hospital and her GP practice, experiencing a wide range of symptoms including chest pain, dizziness, pins and needles, anxiety and panic attacks. There are 13 medical records during that period, from the ambulance service, various hospitals and her GP. Despite a wide range of investigations including MRI and CT scans, blood tests and a chest x-ray, nothing abnormal was found. The Claimant was referred to her GP for review and to engage Mental Health Services.

50. The claimant went to Lithuania at the end of November 2020 where a psychiatrist diagnosed mixed anxiety and depressive disorder. She was prescribed medication for anxiety which she took for a short term (2-4 weeks). I have found she did not at that stage commence Escitalopram for depression. She felt better after her return on 3 December 2020 and tried to manage without long term medication.

51. The Claimant did not at that stage refer herself to Wellbeing or Mental Health Services. There is nothing in her medical records to suggest the claimant was referred to a clinical psychiatrist for treatment.

52. Relying on Dr Loumidis' report, Mr Lovejoy submits that at the time the Claimant was diagnosed, her condition would be expected to last 10-20 weeks. With respect to Mr Lovejoy, I found Dr Loumidis did not find that the claimant would recover in the timeframe he suggests. On the contrary, he made it clear at several points in the report that he could not speculate on how long the condition would last. In relation to patients he sees, most improve after 10-20 weekly sessions of psychiatric treatment. He does not say whether this improvement is sufficient to remove any "substantial" adverse effects of the condition. Specifically he does not say they make a full recovery. He does not say what the outcome would be for patients such as the claimant who were treated with medication. He says this is beyond his area of expertise. He says clearly that he cannot speculate on what the outcome would be with any given form of treatment.

53. Doctor Loumidis does however say (at para 8.3) that there is "some evidence" that around half the patients with MDAD go into remission within a year of onset, with evidence that the remaining half are at an increased risk of developing a mental, behaviourable, neurodevelopmental, disorder that merits full diagnostic requirements including depressive disorder or anxiety or fear related disorder.

54. Taking account of all the evidence including the content of Dr Loumidis' report I have concluded that as at 25 November 2020 when the claimant was diagnosed, it was likely - i.e. it "could well happen" - that the effects of the claimant's anxiety condition would last for more than 12 months and would possibly worsen. I note she Claimant saw her GP again on 4 May 2021 when she was put back on

    Escitalopram for three months and referred to Mental Health Services. She was also given information about the Samaritans and the 24 hour Mental Health Assessment Team.

55. Once the claimant went onto medication the evidence was that her symptoms reduced though she had occasion to call an ambulance out again in May 2021 and July 2021, supporting her evidence that the medication did not remove her

symptoms entirely. But having regard to para C11 of the guidance the effects of the medication the claimant was taking, even if they had removed the symptoms, should not be taken into account.

56. I reject Mr Lovejoy's submission that in 2019 and 2020 the Claimant was experiencing physical problems which were unrelated to each other and she was simply anxious because of those physical problems. The frequency of her hospital admissions and the evidence that on each occasion no physical conditions were found which could give rise to her symptoms, support a finding on the balance of probabilities that throughout the period from 21 October 2020 to her diagnosis her primary impairment was anxiety and she continued to suffer anxiety afterwards. I taken into account that the ambulance reports for the period after her diagnosis show that, despite presenting with a myriad of physical conditions, she was not taken to hospital on those occasions but referred to her GP and to Wellbeing/Mental Health Services.

57. Having regard to all the evidence I have concluded that the Claimant had the mental impairment of anxiety from 15 October 2020. That impairment affected her ability to carry out day to day activities. That effect was substantial, i.e. more than trivial. Taking account of the Claimant's long term experience of episodes of anxiety, the severity of her condition in October and November 2020, her diagnosis on 25 November 2020 and Dr Loumidis' report I find the substantial adverse effects were long term, i.e. likely to last for over 12 months. On the balance of probabilities it "could well happen" that her symptoms would continue or return within that period. The claimant thus satisfied the definition of a disabled person within the Equality Act 2010.

58. The date on which disability should be assessed is the date of the acts complained of, which were the decisions of the Respondent between December 2020 and September 2021. I have therefore concluded that the Claimant was at all times relevant to this complaint a disabled person for the purposes of Section 6 of the Equality Act 2010.

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Employment Judge V. Jones
Dated 12 March 2023