EMPLOYMENT TRIBUNALS

Claimant: Ms S. A. Lees

First Respondent: Bellway Homes Limited

Heard at: Midlands (East) Region

Heard on: 29 March 2023

Before: Employment Judge Broughton

Representation
Claimant: In Person
Respondent: Ms Vittorio - solicitor

RESERVED JUDGMENT ON A PRELIMINARY ISSUE

The claimant's claim that she is a disabled person for the purposes of section 6 of the Equality Act 2010 by reason of Post-Traumatic Stress Disorder is not well founded and is dismissed.

RESERVED REASONS

Background

1. The claim form refers to three pleaded conditions; stress/ anxiety/depression, Post Traumatic Stress Disorder (PTSD) and Sarcoidosis.

2. At a previous preliminary hearing before me on 23 February 2023 listed to determine whether the claimant was disabled at the relevant time (amongst other issues), the claimant confirmed that the only two relevant conditions for the purposes of her claim are stress/ anxiety/depression disorder and PTSD. The respondent conceded that the claimant had a medical impairment namely stress/anxiety/depression which amounted to a disability for the purposes of section 6 Equality Act 2010 (EqA) at the relevant time but did not concede that the claimant had PTSD at the relevant time.

Relevant period

3. The relevant period it was agreed between the parties at this hearing on 29 March 2023, is **15 October 2021** which is the date when the claimant's employment commenced (although the claimant argues the respondent had knowledge of her pleaded disabilities from the date she completed a health questionnaire on 7 October 2021) **to 7 March 2022** (when her employment ended).

4. At the 23 February preliminary hearing the claimant was (and remains) unrepresented. On reviewing the evidence, the medical evidence and her impact statement, I expressed a preliminary view at the commencement of the hearing, that the medical evidence failed entirely to address the 'relevant period' and she had also failed to deal in her impact statement with how the alleged PTSD had affected her normal day to day activities during that period. The claimant was able to identify a GP report but this was dated June 2022, after the end of the relevant period (and after the impact of her dismissal). The claimant explained that she had not appreciated the need to address the relevant period but had focussed merely on establishing whether she had a disability. The claimant was permitted a short adjournment to consider (and take advice if she wished) whether she wanted to proceed with the hearing or apply for an adjournment in order to give her a further opportunity to address the effects of the condition during the relevant period. The claimant made an application to adjourn and although opposed by the respondent, for reasons given to the parties at that prior preliminary hearing and as set in my record of that hearing, I determined that it was necessary to adjourn to enable the claimant to put her case fully. The respondent accepted there was no prejudice to it of adjourning other than the costs it had incurred in attending that hearing. I made orders making it clear what evidence would be required from the claimant at today's reconvened hearing.

5. Today's hearing was to determine the outstanding issue of whether the claimant's condition of PTSD met the definition of a disability at the relevant time, the respondent conceding in any event that she was disabled by virtue of depression/ stress/ anxiety.

6. It was agreed with the parties at this hearing, that we would not deal with the issue of the effects of the stress/anxiety/ depression disorder and the alleged substantial disadvantage it caused the claimant, but address only at this stage the disputed disability of PTSD.

Issues

7. The issues for this Tribunal to determine at this hearing are therefore as follows;

11.1 Did the claimant have a physical or mental impairment namely PTSD at the relevant time?

11.2 Did the impairment have a substantial adverse effect on her ability to carry out day to day activities at the relevant time?

11.4 Did the claimant have medical treatment or take other measures to treat or correct the impairment at the relevant time?

11.5 Would the impairment have had a substantial adverse effect on her ability to carry out normal day to day activities without the treatment or other measures at the relevant time?

11.5.1 Were the effects of the impairment long term?

11.5.2 Did they last for 12 months or were they likely to last 12 months at the relevant time?

11.5.3 If not, where they likely to recur?

Evidence

8. This was an attended hearing. The parties did not request any adjustments to the hearing.

9. The parties produced a joint bundle of documents numbering 287 pages. The claimant sought to introduce a number of text messages between her and a colleague which essentially she argued referred to her feeling upset about a complaint from a customer and a reference to not being able to sleep on an occasion. The respondent objected to the late disclosure. The claimant had no explanation for not having provided copies to the respondent in advance and had not brought any copies. The claimant informed me that she did not consider that the text messages would assist in determining whether she was suffering from PTSD at the relevant time.

10. The claimant and respondent made submissions on the documents and I was not persuaded that the documents were relevant or in any event necessary for a fair determination of the issues before the Tribunal today and on balance and for reasons given orally to the parties at the hearing, the application to admit these text messages was refused. No other documents were produced during the hearing. Reference in this judgment to numbers in brackets are to pages in the agreed joint bundle.

11. I heard evidence from the claimant who affirmed that her evidence was the truth. The claimant produced a disability impact statement and no other witnesses were called.

Findings of fact

12. I make the following findings of fact on a balance of probabilities about the pleaded condition of PTSD.

13. The findings as 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 but set out those findings of fact considered material to the issues to be determined.

October 2017

14. The claimant was subject to a work place assault in October 2017 while employed by a previous employer. The claimant alleges that she experienced PTSD which started 1 or 2 weeks after that assault. She does not allege that she had experienced PTSD prior to this date.

15. The GP records (p.102) record a prescription for anti-depressant medication namely Sertraline. The first recorded entry is on **25 October 2017** (1 daily) at 50mg.

16. There is an entry in January 2018 recording work stress, reference is made to the assault and that the claimant; *"is not sleeping and feels stressed out"*. The claimant under cross examination gave evidence that she suffered with problems with her sleep

for about 3 weeks and it was most significant in January 2018; *"January was the sleeping problem" and "The headaches were on and off from the beginning of 2018 and had them regularly, a couple of times per week*". She described how the headaches would not be relieved by painkillers and occasionally a headache may last as long as 2 days. Those effects were not disputed.

17. In her impact statement she refers to the headaches starting a few weeks after the assault and hardly sleeping for about 3 months and this being at its worst from November 2017 to March 2018.

18. She describes in her impact statement becoming isolated at the beginning of 2018; "*I was refusing to take calls from friends and work colleagues. I couldn't speak to anyone…"(p.101)*

19. The GP records in January 2018 record *(p.102);"She is not sleeping and feels stressed out, Plan; thinking of increasing Sertraline – that is fine, sleepers in case she needs it. Can't go off sick as it will trigger a disciplinary. Work stress".*

20. She gave oral evidence that she suffered nightmares about the assault which started and were severe in 2018; "*the nightmares started shortly after the assault, I can't remember when exactly but I would say approximately a few weeks later*". (p.101).

21. She referred to needing to increase her Sertraline in February when; " *I wasn't coping very well, I wasn't sleeping and had sleeping tablets prescribed."*

February 2018

22. There is a record from her GP practice dated 8 February 2018 (p.283) which refers to a diagnosis of depression and includes the following entries;

"Struggling to function
Wonders if should increase sertraline
Suffering with poor sleep
Issued Zopiclone
No suicidal or self-harming thought';

And;

"problem so bad that ***normal life is impossible***". Tribunal stress

23. In her evidence in chief the claimant described how in 2018 her stress was at its worst, she was having headaches sometimes for 2 days at a time not alleviated by painkillers and that during 2018 she was not motivated to do any housework, had no interest in gardening or cooking and had no motivation to get out of bed. In 2018 she described her symptoms as at their peak and being withdrawn, having nightmares, and that she could not concentrate long enough to cook. She says these symptoms continued for about a year to 18 months and during that time she did not socialise and avoided going out. She would walk the dog in the evenings to avoid seeing people but one occasion did not walk the dog for 3 or 4 days because she could not get dressed or face going out. She described how the symptoms overlap with stress and depression but there were certain factors indicating that the impairment at this time was specifically PTSD namely she felt on edge and restless and felt 'alert' and was ruminating on the assault.

24. The Sertraline prescription is increased to 2 doses daily at the same dosage (50mg) and a fit note on 8 February 2018 restricts her duties to office duties due to insomnia (p. 103) which is changed (following her employer insisting on a full Fit Note) as not fit for work from 8 February to 18 February 2019 with a diagnoses of : "*work place stress and depression following lack of support by the company following an assault in the work plac*e". That fit note is then extended on a number of occasions (p.107/ 108/111/120).

25. On the 28 March 2018 her GP records that she is '*anxious and reclusive'*.

26. The sickness absence for stress and depression continues into May 2018 with repeated prescriptions for Sertraline . Throughout this period the claimant is being investigated for right iliac fossil pain with symptoms initially considered to be gynaecological. On 3 May 2018 there is a report from Dr Lawson, Consultant Gastroenteritis and Herpetologist (p.130/131) which records a diagnosis of ;

    "Possible somatisation syndrome secondary to post traumatic stress disorder"

27. Dr Lawson records the current medication as Omeprazole and Sertraline now 100mg and records:

    "Her faecal calprotectin of 21 is against there being an inflammatory problem within the bowel and this is likely to be a functional bowel problem made worse by recent traumatic experiences. We have agreed that it would be sensible to do an MRI small-bowel study to further reassure ourselves that there is no problem with the bowel leading to pain and bloating. This is likely to be a functional abdominal problem relating to her assault by passenger and subsequent handling of that by her line manager. I think it is likely that physical symptoms or manifestation of a post-traumatic stress disorder and I think she would benefit from seeing a clinical psychologist to help her deal with this and in turn help the symptoms"

28. In a further report from Mr Lawson on 17 May 2018 (p.132), this refers to a symptoms being unchanged, the results of faecal elastase being normal and;

    "*The plan now would be to repeat the CT scanner in approximately three months with repeat liver function tests and LDH. In the meantime I think she needs the input the clinical psychologist to help with a probable somatisation syndrome secondary to post-traumatic stress disorder…"*

29. Essentially the diagnosis was that the claimant was experiencing psychological distress in the form of physical pain.

30. There is no material change in a follow up report on 24 May 2018 (p.134) and by 14 June 2018 (p.147), the medical evidence is still recording a diagnosis of probable somatisation syndrome secondary to PTSD.

31. The claimant remained absent on sick leave from **15 May 2018** with a diagnosis as recorded in her GP records of "work place stress".

    June 2018

32. The claimant was referred to psychologist Dr Aftab Laher, Consultant Clinical Psychologist from the Spire Leicester Hospital on **4 June 2018** (p.136) .

33. The claimant described having nightmares regularly which became less frequent from summer 2018 when she was receiving support from Dr Laher, perhaps once or twice per month. Her evidence was that she possibly suffered the last nightmare in 2019 at the time she decided to leave her previous employment. Her evidence was that the adverse impact on her other activities such as gardening and housework lasted for about 3 to 4 months with things starting to ease when she saw Dr Laher.

34. The claimant has produced a letter from Dr Laher dated **15 June 2022. (p61-53).** The claimant did not meet with him in 2022 but called his receptionist and asked for Dr Laher to send a letter detaining his clinical findings and appointments. This is the only medical evidence which relates directly to the relevant period.

35. He states that the claimant is a former patient and he saw her at his Nuffield Health Derby clinic in **2018** when she was referred to him by her GP in June 2018. The claimant was suffering with some gastric and liver related difficulties and the treating gastroenterologist , Dr Lawson suggested a psychological assessment as he felt that some of her physical health difficulted were being exacerbated by a stress related problems.

36. Dr Laher first saw the claimant on **13 June 2018** (p.137) when she was working for her previous employer and recorded that she had presented;: "*with significant stress-related difficulties and mood disturbance primarily related to her work".*

37. He refers to the claimant having been signed off work with stress from mid- February 2018 following disciplinary action as a result of the investigation into the incident which resulted in her being assaulted, only for that to be overturned on appeal, but leaving her feeling "*quite aggrieved and resentful about how she had been treated*". Dr Laher had advised a phased return to work at the end of June 2018. He states in this letter:

    *"**Diagnostically, at my initial assessment her pattern of symptoms was consistent with post- traumatic stress disorder (PTSD**) arising from the workplace assault which she suffered in October 2017 **and** **the subsequent ongoing stress** about how that was handled" Tribunal stress*

38. He then lists the symptoms. It is not clear from his report which of these are linked to PTSD and which are linked with the *"subsequent ongoing stress*" or whether he is reporting that the PTSD was caused by both the assault and the ongoing stress from the way her previous employer handled the situation however, the symptoms are reported to be:

    "*Physically, she reported headaches, fatigue, sleep difficulties, various headaches and pains and exacerbation of the gastric difficulties*

    Emotionally, she reported low moods, anxiety, irritability and a sense of anger about what had happened

    Cognitively, she kept ruminating about what had happened, she found it difficult to focus, she experienced some flashbacks and nightmares and she was slowed down in her thinking

    Behaviourally, should become more cautious in what she did and felt more on edge

    Socially, should become a bit more disengaged, withdrawn and less confident about

interacting with people."

39. Dr Laher recommended the claimant for psychological therapy incorporating cognitive behavioural therapy CBT.

40. The report referred to the initial plan being that see her for a course of 12 to 16 sessions of individual therapy but due to various factors including changes to her work he only saw her further four consultations. The last time he saw her was on **18 July 2018.**

41. He refers to how the claimant had been during therapy, he referred to her engaging well, teaching her coping strategies and continues to have distressing memories of the traumatic assault.

42. He concludes;

"It would be ***understandable if she continues to have unresolved trauma and stress*** *from what happened with her work 2017 and 2018. As such, whilst I do not have information about specific type of counselling she is currently accessing, it would be appropriate for her to have some ongoing sessions trauma focused CBT.* ***If her PTSD symptoms are no longer florid and severe, her current pattern of symptoms are still likely to meet the diagnostic criteria for another stress-related disorder – namely, adjustment disorder with mixed anxiety and depressed mood." Tribunal stress***

And:

"Whilst not a qualified prescriber, it is also worth noting that the PTSD or adjustment disorder symptoms, it is often fruitful the patients to have adjunctive psychotropic medication through their GP or through consultant psychiatrist". (p.63)

43. Unfortunately the handwritten records of Dr Laher clinical notes of 13 June 2018 (p.140 -146) are not legible. The claimant had not requested typed copies and did not attempt to suggest what they may say.

14 June 2018

44. The reports from Dr Lawson change from a diagnosis of *probable somatisation syndrome secondary to PTSD* (the last being a diagnosis in his report of 7 June 2018) to "p*ossible somatisation syndrome secondary to* ***adjustment disorder"*** *i*n his report on 14 June 2018 in which he states (p.148);

"… I was pleased to hear that she has started her sessions with a clinical psychologist . She was told testing indicated increased levels of stress and that symptoms may reflect ***an adjustment disorder*** *…"*

12 July 2018

45. The report from Dr Lawson on 12 July 2018 (p. 166) records again that the claimant still has '*probable somatisation syndrome secondary to* ***adjustment disorder" and***

records ; (p.167)

"I was pleased to hear that she has found the appointments with Dr Laher (clinical psychologist) to be very positive. There has clearly been some improvement in her physical symptoms. She still reports some episodes of pain and when these occur when she is not under stress, then these still concern her. She does recognise however that the strategies to help her deal with ***anxiety*** *are helping her physical symptoms. She is now due to return to work…"*

August 2018

46. On 31 August 2018 (p.59) Dr Ian Wilson, Aviation Medical Examiner from the Occupational health (OH) department conducted a telephone assessment on 29 August 2018 and recommended that the claimant was fit to return to work on a phased return basis, he referred to her having attended clinical psychologist appointments and that these have been very positive for her. The recommendation however is that it is likely she will be suffering fatigue for "*some significant time*" and a phased return should take place over a 6 week period during which her duties were to be very limited with no more than two duties per week and at least 24 hours rest in between. She is still at this stage being prescribed Sertraline.

April 2019

47. The claimant in her oral evidence states that in 2019 she experienced the same symptoms that she had experienced in 2017/2018 and made an NHS 111 Health Advisor Call and her insomnia returned in 2019.

48. She gave oral evidence that she was unwell for about 2 years and would be angry with everyone during that period which led to a traumatic breakdown in family relationships and then she made a decision to leave her employment with her previous employer.

49. A report dated **26 April 2019** (p.198) from Dr Marsden to Dr Norton, Consultant Gastroenterology refers to various issues including abdominal pain and in terms of current medicine records Sertraline 50mg (2 daily) for "*what I believe is a* ***stress related problem"*** but in terms of the abdominal pain he refers to having examined her on 16 April 2019 and sending her to A & E because of the pain that same day and; "*We are awaiting a formal letter but the impression given to the patient verbally was that the Professor felt her symptoms were more to do with infection being treated by antibiotics rather than sarcoidosis."*

50. According to the undisputed medical evidence, the claimant was still being prescribed Sertraline in April 2019 (p.191/186).The GP notes record her however taking herself off the medication around **mid-May 2019** (p.205);

"…*took self-off sertraline and not had for 1 – 3 /12".*

June 2019

51. Her GP notes in June 2019 (p.205) record an Acute Stress Reaction at a time when she was representing herself in a grievance and had concerns about a breach of company policy . The GP prescribes a **short script for Diazepam** in view of the severity of her distress but otherwise records that :

"mood appears stable.- took self-off sertraline and not had for 2-3 /12"

52. On 13 June 2019 the GP records state that the plan as to continue with diazepam but advised; "*final hearing re grievance is next week 18th – hopes will feel a lot better after that* ..."

53. The claimant was signed off work from 7 to the 20 June 2019 with "*acute **stress reaction"*** (p.211)

54. On the 20 June 2019 the GP records report that she has decided to leave her job and records still "*Acute Stress Reaction*".

55. The claimant is then signed off again with acute stress reaction from work from 20 June 2019.

56. A letter from Trent PTS , an NHS service which provides psychological therapies dated **31 July 2019** (p.217) records;

    "*Client stated she has struggled with **low mood** and feelings of isolation, not being able to cope and anger since event at work two years ago. Client stated she feels so humiliated and hurt. Client stated she has down days where she struggles to get out of bed, and finds herself avoiding going out and people [sic]. Client has not told anyone the extent of what been going on at work … does not want people to know. Client stated she is currently worried about everything and is struggling to see a way forward….*

    We will be offering the claimant CBT"

57. The GP entries in July 2019 record that she is suffering stress due to work, that she is leaving her employment reluctantly (p.213) and records an episode where the claimant considered ending her life. She is signed off work until her employment is due to end on 1 October 2019.

58. By 1 August the GP notes record;

    "*No further thoughts of self-harm, was an impulsive action last week… has plans for future. Appears much more possible in surgery today … thinking about future employment*…"

59. The GP notes in August 2019 record her being prescribed Sertraline and being on this medication since a prescription of "*1st August again this year*" (p.181) indicating a break in medication and a return to taking Sertraline on 1 August.

60. Trent PTS notes on 8 August 2019 (p.219) record:

    "*Client appeared relaxed and stated she had felt you had made progress .Client stated she has only had a couple of down days … Client has been able to recognise a shift in thinking and gaining control of her thoughts…"*

61. The GP records record on 30 August 2019 a continuing prescription for Sertraline throughout the rest of 2019 (p.180) until she stopped taking it in **January 2020 (p.229).**

62. The GP notes record to her being signed off unfit to work until the official finishing date of her previous job on 1 October 2019 (P.181). The Fit Note issued in July through to

October 2019 refers to **stress** due to work (p.215 -221)

63. The prescription for Sertraline is now 50mg (1 daily).

64. On **24 October 2019** (p.218) the PTS Trent notes record a consultation where the claimant " *hit a very low point about three weeks ago when she had to go back into work and hand her uniform in … Since then however, client has managed to get two jobs, and be headhunted for a job commencing next year. Client has also started her own business in travel which she had put steps in motion already".*

November 2019

65. In cross examination the claimant gave evidence that she had set up a business in November 2019 giving travel advice, she denied it was customer facing but more email based. She ran that business for about 5 months. She could not recall informing PTS Trent counsellors about any details of the business other than it was in travel. She also began working for a small house building company around end of 2019 /2020, she could not recall when but for a period this was work in addition to running her business.

66. The claimant gave oral evidence that she had further 6 sessions of counselling in 2019 .A letter dated 28 November 2019 confirms that she had completed a course of psychological therapy (p.226).

67. The claimant gave no evidence about the likely impact of her condition without the counselling.

68. By **28 November 2019** after leaving her previous employment, Trent PTS notes record:

"Client stated she has been feeling back to herself, has had no periods of low mood and is enjoying life. Client started her business has really taken off… Client stated she feels in a completely different place and cannot believe her progress…"

" Risk Review - "no risk identified"

69. The above issues with her stress and the initial diagnosis of PTSD according to her evidence and as supported by the medical records, were all linked with the situation at work, the initial assault and the ongoing problems with the working relationship as a result of the employers perceived lack of support and internal disciplinary and grievance proceedings.

70. The last reference to PTSD rather than stress or anxiety, is **July 2018** and by 28 November 2019, she is reporting as back to her "*herself* " with no periods of low mood (p.226).

71. In a record from her GP practice in January 2020 (p.229) it records that the claimant; " *has done very well regarding posttraumatic stress, has completed counselling and now off sertraline"* and that her previous job had "*continued to cause **anxiety** about a year after the assault…"*

72. The claimant gave evidence that the Sarcoidosis resolved itself at the beginning of **2020.**

February 2020 to February 2022

73. There is a gap in the medical records produced and it is not alleged that there are relevant records for this period.

74. The next entry in the medical records produced is not until **15 March 2022.**

75. Despite the guidance given at the last preliminary hearing, the claimant has still failed to produce any medical evidence which deals with the relevant period other than a brief comment by Dr Laher in his report dated 15 June 2022. Dr Laher had not been treating the claimant during the relevant period and indeed had not been involved in her care since 2018, and he did not carry out any assessment or even conduct a consultation with her prior to preparing that letter/report. There are also no GP records covering the relevant period for Dr Laher to make reference to. Otherwise, the only evidence is the limited evidence direct from the claimant which centres on her feeling upset and distressed when dealing with "*abusive and highly confrontational customers".*

March 2022

76. The claimant has produced copies of her GP records from 15 March 2022 (which is after the relevant period).

77. On the **15 March 2022** the records refer to : *"Work stress*" and records the following comments from the claimant during a telephone consultation (p.287) :

- "*started new job in October re house sale, has been dealing with lots of aggressive clients, complaints, angry complaints* ***which had been getting her down for the lays 6 – 8 weeks****" (*which would be mid to late January 2022)

- *"…last Monday dismissed on probation as he has been asking for a witness when been dealing with clients. Didn't get out of bed for a good few days* ***after this****, didn't wash/get dressed …"*

- *" Diagnosis:* ***work stress****" Tribunal stress.*

78. The claimant is then signed as not fit for work from 27 April to 24 May 2020 (p.286); " *Diagnose: work related stress leading to low mood. Currently looking for new job*"

79. The entry on 11 May 2022 (p.286) records work stress again with no reference to PTSD;

"slow improvement but still feeling low, definitely less tearful";

" sleep remains poor – generally as overthinking or can be ***down to low mood****, last night struggled to get to sleep but as had been feeling better started to job hunt until 10:45pm"* Tribunal stress

And

"continue with Sertraline".

80. It records on 15 March 2022 that the claimant did not get out of bed for a good few dates and did not wash or dress, the claimant confirmed that this related to the period after dismissal.

81. Her evidence was that she restarted Sertraline only after the date of dismissal (and had stopped taking it in the summer of 2019).

82. The claimant confirmed that the GP records produced for 15 March 2022 onwards include no reference to a reoccurrence of PTSD and the diagnosis which is made, is stress.

83. The claimant confirmed in response to a question I asked, that the symptoms of PTSD, (although she described them as overlapping with stress and depression), are specifically the nightmares and re- enacting in her mind of what had happened.

84. The last date in her impact statement (prior to working for the respondent) which describes PTSD systems as she explained them to be, is in July 2019 (para 61) when she described still reliving the assault. In her impact statement states that during the relevant period when employed by her respondent, she describes her symptoms as (para 66);

    "I couldn't cope with the aggression that I faced from these clients. I wasn't sleeping and I was upset at each and every one as they happened.."; And

    (para 67)

    "…when faced with abusive and highly confrontational clients/ situations , it could result in her becoming extremely anxious , even panic like state, It was how the abuse made her feel and react. Flashbacks to the assault, fast speech, talking over clients, anxiety, not listening, becoming emotional, racing heartbeat and defensive actions and needing to defend herself with proof of incident to her employer. All of which are reasonable actions after having been assaulted previously…"

85. The claimant refers to going to a *"very dark place* " following the act of dismissal.

86. The claimant gave oral evidence that when she is with aggressive clients her symptoms of PTSD return, she said it peaked at the end of **January 2022** . It was from January 2022 when she had problems with her sleep: "*it was about a "handful of times in last few weeks",* she did not however go to see her GP in those last few weeks of her employment because as she explained under cross examination;

    "it was just beginning to start, not just complaints, they were every aggressive in nature, symptom just beginning to surface, I thought I could take control of it …"

87. Under cross examination she described how she was subject to "*mouthfuls of abuse"* from a client and the effects would take a week: "*they would be coming on, I couldn't get a GP appointment. I tried to ride it out".*

88. The claimant also confirmed that she but she did not go to see her GP at all during the relevant period and she took no medication. She said in the last few weeks of her employment she became very anxious and withdrawn and was losing confidence and having difficulty sleeping and was going over in her mind what she had been through. She went home after work and did not want to see anyone, had flashbacks and was overthinking . She did not in her evidence however explain what those flashbacks and overthinking prevented her from doing.

89. In oral evidence she asserted that her PTSD reoccurs when she is dealing not with

disgruntled customers but when people are ; "*shouting and screaming complaints*" and she struggles with "*irate customers*".

90. The claimant under cross examination accepted that she had in her impact statement (para 66) set to out in only general terms that she was not able to cope with aggressive clients but had not set out the date of the alleged incidents, there is no detail of each incident and how the customers behaved toward her and how each incident had impacted on her. The claimant referred to this information as being set out in her probationary review however she had not produced at this hearing any documents relating to her probationary review.

91. There is some evidence in her particulars of claim where she described these incidents. She refers to the outburst of a client on 17 January (Villiers) and that she was in tears as a consequence, that she was anxious and stressed.

92. The claimant also referred in her claim form to an incident on 20 January 2022 when a client had been given the wrong completion date and they were screaming and shouting and the claimant was told to put the phone down however she chose not to do so, she wanted to deal with the client the best she could (para e) but this incident had "*upset*" the claimant and she had stated she was not "*coping with these outbursts*". She does not go on to describe the effects of these outbursts in any more detail.

Submissions

Respondent

93. The respondent submits that it does not accept the claimant was disabled due to PTSD at the relevant time or the effects of it. While the cumulative effect with other conditions is relevant, she needs to suffer the impairment at the relevant time and it argues that she did not suffer with PTSD.

94. The medical evidence it is submitted stated that the claimant may have somatisation which manifests stress with physical symptoms however the claimant does not rely upon that condition which is a physical not mental disorder.

95. There is no medical evidence other than Dr Laher report it is submitted, that she had PTSD or no evidence that it reoccurred after 2018.

96. The report from Trent PTS in July 2019 stated that she had moderate depression and by 28 November 2018 no mental health symptoms. The other medical reports postdate the relevant time and make no reference to PTSD. It is submitted that PTSD was a short term condition.

97. It is submitted that there is no evidence to suggest the claimant suffered adverse consequences and an inability to deal with disgruntled client but if she did it was very short term.

98. Counsel refers to *Royal Bank of Scotland plc v EAT Morris EAT 0436/10* where, an employment tribunal upheld the claimant's disability discrimination claim, but the EAT held on appeal there was insufficient medical evidence to do so:

"63. We accordingly hold that it was not open to the Tribunal on the evidence before it to find that the Claimant was disabled during the relevant period. It might well be that the Claimant could have filled the evidential gap by agreeing to the suggestion made during the case management process that expert evidence be sought which directly addressed the questions which the contemporary reports did not cover. But he made a deliberate – and perfectly rational – choice not to do so: see paragraph 55 above. The fact is that while in the case of other kinds of impairment the contemporary medical notes or reports may, even if they are not explicitly addressed to the issues arising under the Act, give a tribunal a sufficient evidential basis to make common-sense findings, ***in cases where the disability alleged takes the form of depression or a cognitive mental impairment, the issues will often be too subtle to allow it to make proper findings without expert assistance.*** *It may be a pity that that is so, but it is inescapable given the real difficulties of assessing in the case of mental impairment issues such as likely duration, deduced effect and risk of recurrence which arise directly from the way the statute is drafted."*

Claimants submissions

99. The claimant submits that there are references to PTSD from January 2018 (p.284) when she was struggling to function, had poor sleep and she saw Dr Laher in June/July 2018 and he sets out the symptoms and effects and she submits these were more than substantial.

100. Dr Wells talked of extreme stress and referred to traumatic events

101. She submits it would be reasonable say PTSD had been long term and it was clear in the last few weeks of her employment the effects were being to surface again with problems with insomnia and low mood and the medical evidence refers to her reporting problems 6 to 8 week before she left.

The Law

Disability

102. 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.

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103. The Government has issued 'Guidance on matters to be taken into account in determining questions relating to the definition of disability' (2011) ('the 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*****.**

104. 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.

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

Section 6. Disability

(1) A person (P) has a disability if—

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

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

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

(3) In relation to the protected characteristic of disability—

(a) a reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability;

(b) a reference to persons who share a protected characteristic is a reference to persons who have the same disability.

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

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

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

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

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

106. **'Substantial'** is defined in section 212 (1) EqA as meaning 'more than minor or trivial'.

107. In determining whether an adverse effect is substantial a tribunal, must compare the claimant's ability to carry out normal day to day activities with the ability the claimant would have if not impaired. The Guidance provides that the requirement for any adverse effects to be substantial reflects the 'general understanding of disability as a limitation going beyond the normal differences in ability which may exist among people'.

108.

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—

(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.

(7) 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.

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

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

Effect of medical treatment

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

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

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

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

Past disabilities

9(1)A question as to whether a person had a disability at a particular time ("the relevant time") is to be determined, for the purposes of section 6, as if the provisions of, or made under, this Act were in force when the act complained of was done had been in force at the relevant time.

(2)The relevant time may be a time before the coming into force of the provision of this Act to which the question relates.

PART 2 GUIDANCE

Preliminary

10 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)

109. 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. In many cases, there will be no dispute whether a person has an impairment. Any disagreement is more likely to be about whether the effects of the impairment are sufficient to fall within the definition and in particular whether they are long-term. Even so, it may sometimes be necessary to decide whether a person has an impairment so as to be able to deal with the issues about its effects.

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....

*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.*

The way in which an activity is carried out B3.

Another factor to be considered when assessing whether the effect of an impairment is substantial is the way in which a person with that impairment carries out a normal day-to-day activity. ***The comparison should be with the way that the person might be expected to carry out the activity compared with someone who does not have the impairment.***

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.

B5. For example, a person whose impairment causes breathing difficulties may, as a result, experience minor effects on the ability to carry out a number of activities such as ***getting washed and dressed, going for a walk or travelling on public transport****. But taken together, the cumulative result would amount to a substantial adverse effect on his or her ability to carry out these normal day-to-day activities.*

The guidance gives the following example:

A man with depression experiences a range of symptoms that include a loss of energy and motivation that makes even the simplest of tasks or decisions seem quite difficult. He finds it difficult to get up in the morning, get washed and dressed, and prepare breakfast. He is forgetful and cannot plan ahead. ***As a result he has often run out of food before he thinks of going shopping again. Household tasks are frequently left undone or take much longer to complete than normal.*** *Together, the effects amount to the impairment having a substantial adverse effect on carrying out normal day-to-day activities.*

Effects of behaviour

B9. Account should also be taken of where a person avoids doing things which, for example, cause pain, fatigue or substantial social embarrassment, or avoids doing things because of a loss of energy and motivation.

It would not be reasonable to conclude that a person who employed an avoidance strategy was not a disabled person. In determining a question as to whether a person meets the definition of disability it is important to consider the things that a person cannot do or can only do with difficulty.

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'****. The practical effect of this provision is that the impairment should be treated as having the effect that it would have without the measures in question (Sch1, Para 5(1)). The Act states that the treatment or correction measures which are to be disregarded for these purposes include, in particular, medical treatment and the use of a prosthesis or other aid (Sch1, Para 5(2)). In this context, medical treatments would include treatments such as counselling, the need to follow a particular diet, and therapies, in addition to treatments with drugs.*

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.*** *If the final outcome of such treatment cannot be determined, or if it is known that removal of the medical treatment would result in either a relapse or a worsened condition, it would be reasonable to disregard the medical treatment in accordance with paragraph 5 of Schedule 1.*

The following example if given in the guidance:

A person with long-term depression is being treated by counselling. The effect of the treatment is to enable the person to undertake normal day-to-day activities, like shopping and going to work. If the effect of the treatment is disregarded, the person's impairment would have a substantial adverse effect on his ability to carry out normal day-to-day activities.

B16. ***Account should be taken of where the effect of the continuing medical treatment is to create a permanent improvement rather than a temporary improvement.*** *It is necessary to consider whether, as a consequence of the treatment, the impairment would cease to have a substantial adverse effect. For example, a person who develops pneumonia may be admitted to hospital for treatment including a course of antibiotics.* ***This cures the impairment and no substantial effects remain.***

B17. However, if a person receives treatment which cures a condition that would otherwise meet the definition of a disability, the person would be protected by the Act as a person who had a disability in the past.

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.*

The guidance provides two examples:

A man experienced an ***anxiety disorder****. This had a substantial adverse effect on his ability to make social contacts and to visit particular places. The disorder lasted for eight months and then* ***developed into depression****, which had the effect that he was no longer able to leave his home or go to work. The depression continued for five*

months. As the total period over which the adverse effects lasted was in excess of 12 months, the long-term element of the definition of disability was met.

A person experiences, over a long period, adverse effects arising from two separate and unrelated conditions, for example a lung infection and a leg injury. These effects should not be aggregated.

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****. (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' (Sch1, Para 2(2), see also paragraphs C3 to C4 (meaning of likely).*

The guidance sets out the following examples:

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.***

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).

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-today 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.

D12. In the Appendix, examples are given of circumstances where it would be reasonable to regard the adverse effect on the ability to carry out a normal day-to-day activity as substantial. In addition, examples are given of circumstances where it would not be reasonable to regard the effect as substantial. In these examples, the effect described should be thought of as if it were the only effect of the impairment. Equality Act 2010 Guidance on matters to be taken into account in determining questions relating to the definition of disability 38

Appendix

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.

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 substantial adverse effect of the impairment on normal day to-day activities is long term. In the following examples, the effect described should be thought of as if it were the only effect of the impairment.

[the following examples appear relevant to this case]

- ***Difficulty going out of doors unaccompanied,*** *for example, because the person has a phobia, a physical restriction, or a learning disability;*

Difficulty using transport; for example, because of physical restrictions, pain or fatigue, a frequent need for a lavatory or as a result of a mental impairment or learning disability;

- ***Persistent general low motivation or loss of interest in everyday activities;***

- *Frequent confused behaviour, **intrusive thoughts**, feelings of being controlled, or delusions;*

- *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;*

- .

110. The Guidance stipulates that an event is likely to happen if it ' could well happen' (C3) which has been interpreted as something that is a real possibility: Baroness Hale : **Boyle v SCA Packaging Ltd 2009 ICR 1056 HL.**

111. 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 treated as continuing to have that effect if the effect is ' likely to recur.'

Case Authorities

112. 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.

113. **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.

114. 108. The cumulative effects of an impairment must be considered , even if it ode snot have as substantial adverse effect on a person in any one respect. . 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**

115. 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 the EAT said: –

"39 …. Both this tribunal and the Court of Appeal have repeatedly enjoined on tribunal's the importance of following a systematic analysis based closely on the statutory words, and experience shows that when this injunction is not followed the result is too often confusion and error."

"40. Accordingly, in our view the correct approach is as follows: –

(1), it remains good practice in every case for a tribunal to state conclusion separately on the questions impairment and other adverse effect (and in the case of adverse effect, the questions of substantiality and long-term effect arising under it), as recommended in Goodwin v Patent Office (1999 ICR 302)

(2), however, in reaching those conclusions the tribunal should not proceed by rigid consecutive stages. Specifically, in cases where there may be a dispute about the existence of an impairment it will make sense, for the reasons given in paragraph 38 above, to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adverse to be affected (on a long-term basis), and to consider the question of impairment in the light of those findings.

(3) These observations are not intended to, and we do not believe that they do, conflict with the terms of the Guidance or with the authorities referred to above…"

116. 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.

117. 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.** In **Brown v Beth Johnson Foundation ET Case No.1304755/15 B** relied upon the collective effects of the conditions of chronic fatigue syndrome, myalgic encephalopathy, fibromyalgia, hypothyroidism, anxiety and depression. The employment tribunal inferred from the evidence that both the depression and hypothyroidism would affect B's ability to carry out day-to-day tasks '*to some degree'* in the absence of medication, and that she experienced aches and pains which substantially affected her mobility and concentration. The tribunal concluded that the aches and pains — whether by themselves or together with the deduced effects of depression and hypothyroidism — had a substantial adverse effect on B's ability to carry out day-to-day tasks.

118. The focus should be on what a person cannot do: Goodwin

Conclusions.

119. The claimant was assaulted at work in October 2017and it is reasonable to infer that her GP considered that the claimant was suffering with some mental health issue which was sufficiently serious to require treatment with anti-depressant medication, namely Sertraline because this was prescribed from 25 October 2017.

120. The claimant developed insomnia which was particularly acute during January 2018. The GP reported in February 2018 that normal life for the claimant was now *"impossible"* by that stage.

121. Although the symptoms became more manageable from around June 2018 when she started to receive treatment from Dr Laher, she continued to suffer with sleeping problems and had nightmares on and off until July 2019.

122. While her impact statement and oral evidence was lacking in detail and the only medical evidence pertaining to the relevant period was from a doctor who treated her several years prior, the evidence supports a finding that there were a number of effects on her normal day to day activities which started from around the end of October 2017/November 2017 and continued through to around November 2019 or to the latest, January 2020. Although those effects fluctuated over that period they became acute in January 2018 and included disturbed sleep with insomnia and nightmares and headaches which at times lasted for 2 days and were not ameliorated by painkillers. She did not expand on what the headaches prevented her from doing but she also described a lack of interest in normal day to day activities such as housework, gardening, lack of concentration and a lack of interest in socialising supported by a comment from her GP reporting in March 2018 that she was "*reclusive".*

123. The claimant then experienced some physical pains and while the respondent argues that the claimant is not relying on any physical impairment, the physical symptoms are referred to by May 2018 as secondary to PTSD and on balance I conclude are closely linked and associated with the mental trauma i.e. PTSD and stress and should be considered as part of the effects of those conditions.

124. In June 2018 Dr Laher diagnoses PTSD, identifying the symptoms as set out in his letter with effects impairing her; physically, emotionally, cognitively, behaviourally, and socially. Taking those effects on her normal day to day activities together, I conclude that those effects as described by the claimant and Dr Laher in his report/letter, albeit fluctuating over the period from around October/November 2017, were more than minor or trivial.

125. The evidence supports a finding that while the symptoms were relieved sufficiently by August 2018 to attempt a return to work, this was only on a phased return basis and with very limited duties. OH referred to the claimant suffering fatigue and that she would still do so for some significant time afterwards. By **May 2019** the claimant had decided herself to stop taking Sertraline but the later stress she experienced related to her grievance, meant that her GP prescribed a short dose of Diazepam in **June 2019**. She then restarted Sertraline in **August 2019** until J**anuary 2020**.

126. There is no evidence from the claimant or medical evidence about the deduced effects, namely the impact on her day to day activities without the medication however I consider it reasonable to infer from her Doctor's opinion of her ongoing need for medication (almost exclusively from October 2017 to January 2020), that without the

medication the symptoms she was experiencing would have been more severe. However, the medical evidence does not support a finding that the symptoms would include the effects specific to PTSD and these continued throughout 2019. The claimant confirmed in response to a question I asked that the symptoms of PTSD, (although she described them as overlapping with stress and depression), are specifically the nightmares and re- enacting in her mind what had happened, feeling on edge and alert and restless.

127. The last reference specifically to a diagnosis of PTSD in the medical evidence, rather than low mood, mood adjustment disorder, stress or anxiety, is **July 2018**.

128. I conclude that the claimant had a mental impairment which included secondary physical symptoms and which overlapped with symptoms of other mental health conditions including mood adjustment disorder, depression, stress and anxiety from around **October 2017** through to **January 2020**. She reported as back to her normal self in November 2019 and came off anti – depressant medication in January 2020. The physical symptoms of Sarcoidosis resolved at the beginning of 2020. She did not attend her GP again after February 2020 until March 2022.

129. I conclude that the mental impairments (PTSD and stress/ anxiety/ mood disorder) were closely connected and cumulatively had a more than minor or trivial impact on her normal day to day activities from around October 2017/November 2019 to November2019/January 2020 with fluctuating effects controlled primarily with medication and a course of CBT therapy in June and July 2018, with the adverse effects of the combined conditions lasting for longer than 12 months.

130. I conclude on the evidence that the condition of PTSD however which was a specific reaction to the trauma of the assault in October 2017, on the medical evidence and her oral evidence about the severity and type of some of the symptoms specific to that condition, lasted from about **November 2017 to around July 2018** after which the diagnosis changed to mood adjustment disorder and a stress related condition, rather than the very specific condition of PTSD.

131. The evidence does not support a finding that the claimant was disabled due to PTSD alone for at least 12 months during that earlier period of ill health (in 2017/2018) and thus the condition of PTSD was not long term, however the claimant's normal day to day activities continued to be adversely affected up until about November 2019/January 2020 because of the combined effects of the various mental health conditions (stress/ anxiety/ mood adjustment disorder/ PTSD and the physical secondary symptoms). She therefore had a past mental health disability as a result of the combined effects of those conditions with associated physical symptoms.

The relevant period

132. We now turn to the relevant period. The claimant complains that her normal day to day activities were effected by her mental health from January 2022 through to 7 March 2022 (when she was dismissed), triggered by the confrontations with irate and aggressive clients. The claimant alleges that the effects were a reoccurrence of PTSD and/or otherwise stress/anxiety/depression.

133. Dealing with PTSD and whether that specific condition was likely to reoccur and whether it did reoccur during the relevant period, I have not taken into account the claimant's condition **after** the relevant period other than to consider it in terms of her

credibility.

Likelihood of reoccurrence.

134. The effects specifically of PTSD had not lasted 'long term' during the previous occasion she had suffered with it (circa November 2017 – July 2018).

135. I have considered whether the PTSD was likely to recur and thus whether despite this condition alone not being long term, she remained disabled within the definition of section 6 EqA after July 2018 specifically *because* of PTSD, even if it was in 'remission' from July 2018.

136. The claimant relies on the medical evidence of Dr Laher in support of her case that a reoccurrence of PTSD was likely.

137. Dr Laher did not see the claimant after 2018 and there is nothing within the medical evidence supplied (GP notes) which refers to the symptoms in January 2022 to 7 March 2022 giving rise to a reoccurrence of PTSD (rather than another stress/anxiety disorder).

138. There is reference to possible somatisation syndrome secondary to PTSD in May 2018 (p.132) and June 2018 (p.139) but by 14 June 2018 this is changed to probable somatisation syndrome secondary to **adjustment disorder** (p.147) and no further diagnosis of PTSD.

139. When deciding whether a claimant has a condition that is likely to recur, a tribunal must ignore even conclusive evidence that the condition did in fact recur during the period between the date of the act complained of and the Tribunal hearing.

140. The claimant had no history of previous trauma induced stress disorder before the assault in October 2017.That illness followed an exceptional and unusual stressful life event. The triggering event for the claimant in 2017 was the assault by a customer in the workplace in October 2017 which placed the claimant in a position where she was at risk of falling from a significant height, with the additional stress of her employer's reaction, namely to institute disciplinary proceedings.

141. The only medical evidence available at the time of the action complained of is the report of Dr Laher in June 2022. The claimant did not seek medical assistance until after the acts complained of.

142. Dr Laher does not say that it is likely that PTSD will reoccur after 12 months, but says that it would be "*understandable"* if she continues to have unresolved trauma and stress from what happened . He refers to her resuming counselling due to various additional **stress** factors in her life and goes on to say *" if "* her PTDS symptoms are no longer 'florid and severe', her current pattern of symptom is still likely to meet the diagnostic criteria for another stress related disorder.

143. The reference to *"understandable"*, in my judgment is akin to something which is foreseeable or expected and essentially meets the test of "*could well happen*".

144. What Dr Laher is describing however is the likelihood of unresolved trauma, but what he does not do is comment on the likelihood that this will manifest as PTSD.

145. I cannot therefore find on the limited medical evidence produced, that in the context of the claimant's medical history, where she has no history of repeated episodes of PTSD, that the specific condition of PTSD was likely to recur.

146. In terms of whether the effects of PTSD did in fact recur and whether they were likely to last 12 months as at the relevant time; the claimant relies on an entry in her medical reports on **15 March 2022** which records her telling her GP that dealing with clients had been "*getting her down in the last 6 to 8 weeks"* i.e. from mid- to the end of January 2022.

147. There is no detail about what the effects are and what she means by "*getting her down*". She does not describe difficulties with her sleep during that 6 to 8 week period and while in her impact statement she described how dealing with abusive and highly confrontational clients ' could' result in her becoming anxious and even in a panic like state and having flashbacks etc she does not address what actually happened in any detail on those occasions and in her particulars of claim she refers to being upset, anxious and stressed and even on one occasion she recalls, that she chose to continue the discussion with the client rather than end the call as it was suggested to her by a colleague she did. While those confrontations no doubt upset the claimant, the evidence provided does not support a finding that the symptoms were attributable to PTSD during this period from January 2022 up to her dismissal on 7 March 2022.

148. The medical records immediately after her employment ends report depression but not PTSD, those records are not relevant to the question of likelihood of PTSD reoccurring but are relevant to the credibility of the claimant's account that she was suffering from symptoms consistent with PTSD in the 8 weeks prior to those assessments taking place. The records do not mention her symptoms being consistent with a diagnosis of PTSD.

149. The Guidance states at 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.*

150. The Guidance at D17 provides that. *Some impairments may have an adverse impact on the ability of a person to carry out normal day-to-day communication activities. For example, they may adversely affect whether a person is able to speak clearly at a normal pace and rhythm and to understand someone else speaking normally in the person's native language.*

151. Her oral evidence is that she became anxious and more withdrawn but her evidence was scant, it was difficult to illicit the detail from her and under oral evidence she accepted she did not seek medical attention because the symptoms were just beginning, she felt she could cope hence she even continued to deal with an aggressive client even when advised to terminate the telephone call.

152. While I conclude that the claimant was disabled during the period November 2017 to January 2022 due to the cumulative effects of PTSD and the other stress/anxiety related disorders and secondary conditions, I do not consider that with

respect to PTSD the specific effects of this condition lasted for 12 months or that PTSD was likely to recur or in fact did so.

153. It is however accepted that the claimant was disabled at the *relevant time* because of stress/ anxiety/ depression.

154. I accept the claimant's oral evidence that when faced with aggressive clients from around the end of January 2022, this interrupted her sleep on and off over a few weeks (but she does not identify the extent of the impact on her sleep) . I also accept her oral evidence on balance of probabilities that she became anxious and withdrawn and was losing confidence and going over in her mind what she had been through and after work and did not want to see anyone, had flashbacks and was over-thinking. The claimant however did not expand on the impact in terms of what it prevented her from doing other than not wanting to see people after work. She described the symptoms as the problems just beginning to surface before she saw her GP on 15 March 2022 and that she thought she could cope.

155. In my judgment, dealing with very upset or irate people (whether colleagues, clients or general members of the public people) is a normal part of daily life, it is not something a specific person may 'regularly' experience but is I consider that sort of 'activity' is regularly carried out by the general population : **Paterson v Commissioner of Police of the Metropolis 2007 ICR 1522 EAT.**

156. I consider that it would be normal to have some adverse reaction to being confronted with hostile clients but given her medical history on balance I accept that she would not cope as well as she would otherwise had done. However, there is no medical evidence to support a finding that the claimant was experiencing a further episode of PTSD during the relevant period and her evidence on the impacts during this specific period does not support a finding that her impact was sufficiently 'florid' and 'severe' to amount to a further episode of PTSD. She herself gave evidence that she was "*feeling down"* but even in the last few weeks when the symptoms began to manifest and she was having a handful of nights of interrupted sleep, she felt she could *"take control of it"* and still continued to deal with an abusive client even when a colleague advised her to terminate the conversation. Given the limited evidence I am not able to make a determination of the extent of the impact on her ability to cope with irate and angry customers, however I do not consider it is necessary to determine that at this hearing because I have concluded that she was not suffering from PTSD at the relevant time and the extent to which this was a symptom of the conceded disability of stress/ depression/anxiety and whether it was substantial, by agreement will be determined at the final hearing.

157. The medical evidence only deals with the deterioration after the act of dismissal and after the relevant period, it does little to assist in the relevant period.

158. In summary and based on the limited medical evidence provided at this preliminary hearing along with the claimant's evidence, the claimant was not disabled because of PTSD at the relevant time, this specific condition was not likely to recur after 2018 and did not in fact recur. The claimant was however disabled during the relevant period because of stress/ depression/anxiety disorder.

Employment Judge Broughton

Date: 27 May 2023

Notes:

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