Case Nos: **1302652/2022**

# EMPLOYMENT TRIBUNALS

**Between**:

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| Miss H Greenaway | **and** | (1) The Shrewsbury and Telford Hospital NHS Trust<br>(2) Angela Cooper |
| **Claimant** | | **Respondents** |

**Held**: By Cloud Video Platform (Midlands West)

**On**: Thursday 1 June 2023

**Before**: Employment Judge Faulkner (sitting alone)

**Representation**

**For the Claimant:** in person
**For the Respondent:** Mr B Williams (Counsel)

# RESERVED JUDGMENT

1. The relevant period for the purposes of assessing whether the Claimant was a disabled person within the meaning of the Equality Act 2010 is agreed to be March 2020 to May 2022.

2. The Claimant was a disabled person as so defined by reason of the impairment of hypothyroidism from before March 2020 until April 2021.

3. The Claimant was a disabled person as so defined by reason of the impairment of chronic rhinosinusitis from November 2020 until May 2022.

4. The Claimant was not a disabled person as so defined by reason of the impairment of anxiety disorder at any time during the relevant period.

# REASONS

**Hearing**

1. This one-day Public Preliminary Hearing was convened to deal with the following issues:

1.1. Whether the Claimant was at the relevant times a disabled person within the meaning of section 6 of the Equality Act 2010 ("the Act").

1.2. Whether the beliefs on which she relies for complaints of religion or belief discrimination were beliefs within the meaning of section 10 of the Act.

1.3. Whether the Claimant required permission to amend her Claim to add complaints of health and safety detriment within the meaning of section 44 of the Employment Rights Act 1996 ("ERA") and protected disclosure detriment within the meaning of section 47B ERA, and if so, whether permission should be granted.

1.4. Whether the Tribunal has jurisdiction to hear certain of the Claimant's other complaints.

1.5. Finalising the issues to be determined at a Final Hearing.

1.6. Fixing a date for that Final Hearing.

1.7. Making Case Management Orders to enable the parties to prepare for that Hearing.

2. It was abundantly clear that a one-day listing was wholly inadequate for dealing with all of the above, the matters at paragraphs 1.1 to 1.4 above being fully contested. It was agreed therefore that I should focus on dealing with the question of whether the Claimant was a disabled person. Evidence and submissions on that issue alone did not conclude until after 4.00 pm (so that Judgment had to be reserved). I therefore listed a further Public Preliminary Hearing and made Case Management Orders accordingly, details of which have been provided to the parties separately.

3. The parties provided a bundle of 649 pages. I read the first 140 pages before the Hearing commenced, which included the Claimant's impact statement dated 11 November 2022. I made clear that, not least to have any hope of concluding evidence and submissions on disability in the time available, I would not read or take into account any further documents unless explicitly taken to them by either party. This included the Claimant's GP records and any other medical documents. I heard extensive oral evidence from the Claimant, given in response both to cross-examination by Mr Williams and a number of questions from me (adopting the inquisitive approach to this issue enjoined by the case law) and was taken to various additional documents as a result. I then heard submissions from both parties.

4. The findings of fact set out below are based on this evidence and made on the balance of probabilities. Any page references below are references to the bundle. I

have read during my deliberations the entirety of any document I was taken to in oral evidence, including entries around the various GP records referred to, so as to ensure I consider them in context, though of course I have not read the GP records in their entirety. Whilst there are two Respondents to this Claim, all references in these Reasons to "the Respondent" are to the First Respondent. I will refer to the Second Respondent as Ms Cooper.

5. I should also record that on a couple of occasions the Claimant said she felt like she was being "interrogated" by Mr Williams and that this was unfair. As I explained, being questioned about one's case is an ordinary part of employment tribunal litigation, I saw nothing improper in the Respondent disputing that the Claimant was a disabled person in this particular case, and there was certainly nothing unfair or improper about the content of Mr Williams' questions or the manner in which he put them. The Claimant became distressed at times when giving her evidence and was given opportunity for a break in order that she might feel more composed.

**Issues**

6. The Respondent accepts that the Claimant had, from March 2020 to May 2022 ("the relevant period"), the physical impairments of chronic rhinosinusitis and hypothyroidism and the mental impairment of anxiety disorder. I briefly discussed with the parties at the outset the question of the relevance of hypothyroidism and anxiety disorder to the Claimant's complaints. It quickly became evident that this was not a point capable of swift resolution and it was therefore agreed that all three impairments should be considered – though that is an issue that may need to be revisited at the further Public Preliminary Hearing.

7. Accordingly, in relation to each impairment, it was agreed that I had to decide:

7.1. Whether, throughout the relevant period or at any point during that period, it had an adverse effect on the Claimant's ability to carry out normal day to day activities.

7.2. Whether that effect was substantial.

7.3. Whether that effect was long-term.

8. The Claimant referred in her evidence to a broader auto-immune disease but confirmed that she does not rely on it in relation to this Claim.

**Facts**

9. It is not necessary for me to record in any detail the Claimant's substantive complaints or the background to them. These were largely set out in a Case Management Summary from a Hearing in December 2022. She is employed as a Ward Sister on the Oncology Ward at the Shrewsbury Hospital, having been employed by the Respondent since 2015. After ACAS Early Conciliation from 23 March to 4 May 2022, she submitted a Claim Form on 27 May 2022 which included complaints of disability discrimination. At the heart of her Claim is the wearing of surgical masks as part of the response to the Covid-19 pandemic and, chronologically later of course, the

requirement for the Covid-19 vaccination. She has not been in the workplace since October 2020, for part of that time working from home.

10. Before dealing in turn with the Claimant's evidence regarding each impairment, I note that I am conscious of the need to assess their cumulative impact (see further below). In any event it is not possible to deal with each impairment entirely discretely given how the evidence was presented. I should also say a brief word about the evidence generally and the approach that I have taken to it.

11. I do not accept the Respondent's submission to the effect that I should disregard the Claimant's oral evidence about the impact of her impairments given that they were not spelt out in the impact statement. I say this because she is a litigant-in-person with no previous experience of the employment tribunal, it is perhaps unsurprising as a nurse that she would focus on symptoms of the impairments rather than the impact on day-to-day activities which is the focus of the legislation, and furthermore I was sure on hearing her that she was doing her best to recount the impact truthfully and accurately. I do however accept the Respondent's submission that it is important to pay due regard to the contemporaneous documentary evidence. If and where that contradicts the Claimant's oral evidence, I prefer the contemporaneous record, given in particular that the Claimant's evidence was at times unclear, but it must be said that on careful consideration what the Claimant told me was in various significant respects borne out by what she said to medical professionals and the Respondent at the time as my findings of fact make clear.

**Chronic rhinosinusitis**

12. This impairment was diagnosed on 30 April 2021.

13. The Claimant provides in her impact statement a long list of the symptoms of the impairment, including insomnia, blurred vision, headaches, nasal drip and anxiety. It reads like a list of the symptoms of the condition generally, but I am prepared to accept it as the Claimant's description of the symptoms she experiences, noting however that the statement does not identify, at least not with any precision, the effects of the impairment and its symptoms on her ability to carry out normal day-to-day activities. The Claimant's evidence in that regard was elicited in her oral testimony.

14. The Claimant says that breathing became a "massive problem" after a nose operation in November 2019. She had to mouth-breathe because of congestion/obstruction in the nasal passages. She says not being able to breathe properly made (and still makes) everything more difficult:

14.1. She did not sleep well, waking up because she could not breathe. As a result, she frequently went to bed early.

14.2. As a result of not sleeping well, she was more tired and her socialising reduced, for example attending motorbike racing which she had previously enjoyed.

14.3. She says that another result of her tiredness was that she was more prone to anxiety and memory problems.

14.4. When she gets a sinus infection, she has to go to bed, because of fatigue and headaches (light creates a problem for her). At present, this happens a couple of times a month; she cannot recall its frequency in 2020 and 2021. These episodes usually resolve within 48 hours using anti-inflammatory herbs and nasal rinses (see below).

14.5. She could not wear her spectacles comfortably for 18 months after the nose surgery.

14.6. She also could not smell or taste properly.

15. The effects on the Claimant were made worse if she wore a face mask or covering, which made her feel like she could not breathe, which in turn she says impacted on her concentration both at work and outside of work.

16. At page 364 there is a record of a discussion between the Claimant and Ms Cooper, prepared and signed by the latter. It is dated 28 February 2020 in the heading but signed 1 July 2020. I take the latter as the correct date, given both the detailed discussion of Covid-19, which in February 2020 was only just emerging as a national issue, and the reference to the Claimant's imminent explant surgery which took place in August 2020 (see below). The note includes reference to wearing of facemasks. The Claimant is recorded as saying that she had "persevered with it and [was] managing with more breaks". She told me that it was agreed she could wear them just under her nose, so that there was no breathing issue, but was later told she had to wear it properly which made her unwell. She also described to Ms Cooper having had Covid, making her the "most unwell [she had] ever been".

17. On 13 November 2020 (pages 325-6), the Respondent's Occupational Health Service ("OH") reported the Claimant as saying that she was unable to wear a mask for longer than five minutes due to pain, and that since an operation on her nose in November 2019 she had experienced pain, difficulty breathing and pins and needles. The Claimant says this does not mean her breathing difficulty was only related to her nasal problem, as in 2021 her GP advised her that it was because of her body's reaction to her auto-immune disease, namely hypothyroidism.

18. A report of an ENT specialist, Mr R Harris, dated 30 April 2021 is at pages 453-4. He referred to the Claimant's symptoms of nasal obstruction, saying that her air flow was poor and her nose "extremely rhinitic" and that most of her symptoms were "due to inflammation within the nose and sinuses". He recommended Flixonase (an inhaler, to be sprayed into the nasal passage) and a nasal rinse, Nelimed (to flush the nasal passage). He also said that on examination the Claimant was "systemically well". In respect of that last comment, the Claimant says Mr Harris is not a medical expert, by which she means in relation to issues other than those within his specialism. As already indicated, she insists the problems wearing a mask were caused by hypothyroidism as well (see below).

19. The notes between December 2019 and 25 August 2021 (pages 150 to 156) show that the Claimant informed her GP she had no problem with her chest, but had breathing issues, constant middle head pain, a croaky voice, nasal discharge and pain wearing a mask. There is no reference to sleep or memory issues in these particular

entries in the records, though the Claimant says she must have told the GP about those things. The records also indicate the Claimant saying that her sinus issue was worse after her nose surgery. The OH report dated 29 November 2021 (pages 333 to 336) recorded the Claimant as saying that "nasal rinses have vastly improved symptoms of congestion and nasal drips", and dairy-free eating had also improved her nasal symptoms.

20. The Claimant manages the effects of this impairment by for example reducing her exposure to irritants, an anti-inflammatory diet (not eating gluten is important), and exercise. As noted above, in April 2021, Mr Harris recommended Flixonase and Nelimed. A nasal steroid spray, Fluticasone, was first prescribed on 25 September 2021. The Claimant tries to treat the condition by taking CBD (a legal cannabis-derived product without the side effects of cannabis itself), when required, and an analgesia. The steroid reduces inflammation so that the Claimant can breathe more easily.

**Hypothyroidism**

21. The Claimant received a diagnosis of hypothyroidism, which she describes as an auto-immune disease, on 2 September 2019. Again, she provides in her impact statement a long list of the symptoms of the impairment, including cold sensitivity, low metabolism, constipation, decreased concentration and memory, and joint pain. Again, it reads like a list of the symptoms of the condition generally, but I am prepared to accept it as the Claimant's description of the symptoms she experiences, noting again however that the statement does not identify, at least not with any precision, the effects of the impairment on her ability to carry out normal day-to-day activities, though it does refer to difficulty sleeping, spending a lot of time alone, low energy, and the ability to focus and make decisions at work. Again, the Claimant's evidence in that regard was principally elicited in her oral testimony.

22. The Claimant says, and it was not disputed, that the impairment arose from the insertion into her body of medical devices in 2013, which within six months (see page 272) caused a reaction. They were removed (an "explant") on 14 August 2020, which the Claimant says helped enormously, setting her on what she describes as her healing journey. There was some immediate improvement, including in relation to her breathing and her sight; other things improved gradually. She says she was generally in a lot better health a year after the explant.

23. The Claimant says that this impairment resulted in the following – though she was largely imprecise as to over what period, something I return to in my analysis:

23.1. The impairment made her immune system hyper-sensitive, causing tiredness and issues with concentration and processing of information, which was made worse if (because of the nasal condition) she did not get enough oxygen. She would have to write things down to ensure she did not forget to do things for patients. Outside of work, she would forget that food was in the oven, to put the fuel cap back on her car, and how to get to places. This was not a consistent impact, but periodic, depending on the extent of the inflammation. She describes a progressive decline in memory from 2013. She was not able to return to work in 2016/2017 whilst she was concerned about lapses in memory and concentration.

23.2. She also says her fatigue affected her relationships as she was not socialising, because she had to sleep a lot more in order to get to work. She no longer enjoyed watching movies or cooking good food and did not do the house cleaning – all of which had been high priorities for her previously (she described healthy eating and tiredness as having been "obsessions"). She also used to love reading but that changed because she would forget what she had read.

23.3. She could not do her nightshifts (which had previously been her normal working pattern).

23.4. She could not lift heavy objects because of the surgery.

24. At page 154 there is a GP note dated 28 February 2020 recording the Claimant's statement that she had felt fatigued for a long time, "but worse last 6 months". The further GP note dated 19 February 2020 (page 155) records, "Hypothyroidism, still feeling tired, hair loss, concentration difficult", whilst at page 156 on 17 December 2019, the note describes "various issues over the past 5 years, fatigue, headaches, depression, bloating, hypothyroid etc.".

25. At pages 270 to 273, there is an email from the Claimant to her GP dated 30 June 2020, in which she said that before the implant surgery in 2013, she had good health, was carefree and had a busy social life, running between 5 and 10 km two or three times a week and going to the gym. She described that after the implant surgery she had issues with phlegm, regular night sweats, deterioration in her eyesight, knee pain, and mood swings. She stopped going out at weekends, becoming more and more isolated. She relocated back to Shropshire from Manchester, was helped by buying a dog and through "sheer determination and God's great mercy" stopped taking all medication, returned to the gym and determined to get well again. She said that "from 2017 to present my mood has been stable". She recorded that she did however have tiredness and memory issues, forgetting how to get to destinations she had been to before. She referred also to the GP's diagnosis of hypothyroidism and the advice that she would be on medication for her lifetime. The GP then wrote a letter to a surgeon in July 2020 (page 276), leading to the August 2020 explant surgery.

26. The file note of the conversation on 1 July 2020 between the Claimant and Ms Cooper at page 364 records difficult personal circumstances for the Claimant, and the Claimant saying that the implants were poisoning her.

27. The OH report of 22 September 2020 (pages 316-7) describes the Claimant as "functioning well day to day" after the explant surgery and recorded that she had said she felt ready to return to work, though she does not accept that the symptoms of the condition had subsided, saying she had carried on working with them for years, because she had ways of coping (see below). She says that "functioning well" meant she was able to look after herself at home.

28. The Claimant managed the effects of this impairment by sleeping (she says excessively) and, as she puts it, looking after her weight. As to medication, she took levothyroxine from June 2019 (see page 157) until August 2020 when she had the explant surgery, following which she transitioned to using natural medication, namely

iodine. She had acupuncture for two months. She also took pain relief (her statement refers to co-codamol).

**Anxiety disorder**

29. In her impact statement at page 136, the Claimant describes her anxiety disorder as "longstanding", saying at page 139 that she suffered from anxiety and depression in 2002, after giving birth to her first child and when her mother was terminally ill. She experienced another "bad spell of depression and anxiety" for fifteen months from August 2015. I was taken to no other evidence at all about those earlier periods of time.

30. In her file note of 1 July 2020, Ms Cooper was "worried about [the Claimant's] mental state".

31. Whilst the Respondent says she wore a face mask in clinical areas until 13 October 2020 when she reported to Ms Cooper that it was too painful on her nose, the Claimant says that being "put under duress" as she sees it, to wear a mask, made her very anxious, and I note again her evidence that she had been wearing it below her nose until challenged about that. The Claimant was assessed by OH in respect of her mental health on 28 October 2020 (pages 323-4), having been referred because of increased anxiety when wearing a mask due to her sinus problem. The OH specialist recorded that she said "her only anxiety is around wearing a mask in the workplace", which the practitioner described as normal and not something she would consider to be "a mental health difficulty", suggesting that she be reviewed for an assessment of mask-wearing on her physical health.

32. The GP notes at pages 148 and 149 show that the Claimant discussed a "stress-related problem" and "anxiety disorder" with her GP in December 2021. She next discussed this with the GP in June 2022, reporting that she felt very low, was not sleeping and was anxious. She did not want any anti-depressant medication, taking herbal medicines instead.

33. Whilst the Respondent suggests that the Claimant's anxiety was caused by her disputes at work, in particular in relation to mask-wearing, the Claimant says that her pre-existing anxiety was exacerbated by the Respondent's actions, including – as she sees it – pressurising her to get the Covid-19 vaccination even though she was at home. She has had a long period away from the workplace and says she now has anxiety about returning to work.

34. She says in her impact statement that social anxiety has forced her to withdraw from activities and describes insomnia, fatigue, chest pains, panic attacks and low concentration. Whilst again, I am prepared to accept that the Claimant has experienced these symptoms, I note once more that the effects of the impairment on day-to-day activities are not (or at least not clearly or in any detail) set out in the statement. There was no oral evidence of note from the Claimant as to the effects of this impairment.

35. The Claimant was prescribed 10 mg amitriptyline for low mood and anxiety in February 2016, 50mg sertraline for anxiety and depression in September 2016,

diazepam (2.5 to 5 mg) for anxiety with depression in October 2016, and also attended counselling. After counselling, and joining a religious group, her depression lifted and prescribed medication was discontinued because of what she describes as her strong belief in natural homeopathy. Whilst medication has been offered to her repeatedly since 2016, she dislikes the side effects and so has taken "Rescue Remedy", CBD oil and magnesium.

36. Counselling and Improving Access to Psychological Therapies ("IAPT") have led to the Claimant socialising more. The OH report dated 29 November 2021 (pages 333 to 336) recommended that she access cognitive behavioural therapy ("CBT") as this was likely to "stop negative cycles by breaking down perceptions/barriers she has regarding wearing masks". She recently completely 16 weeks of CBT.

37. Finally:

37.1. In relation to all three impairments, there was no medical opinion before me of what the effects on the Claimant would have been of removing any of her medication. The Claimant herself says that she desperately needed it and could not function without it. When she has forgotten or been unable to take iodine for example, she has felt more tired and when she has not taken magnesium, she has felt more anxious.

37.2. The Claimant referred in closing submissions to a report from a consultant in occupational medicine at pages 645 to 646. It appears to be in connection with her application to another Trust for bank work. As she says, it indicates the consultant's view that she is a disabled person under the Act (though it seems not in relation to anxiety). I can attach no weight to it however, because it was written in May 2023, a year after the relevant period. In any event, it does not clearly state which conditions the consultant is referring to in making his assessment.

**Law**

38. Section 6(1) of the Act provides that:

*"A person (P) has a disability if –*

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

39. Schedule 1 to the Act provides at paragraph 2 that "*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*". Paragraph 2 goes on to say that "*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*".

40. Schedule 1 also provides at paragraph 5 that "*(1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if – (a) measures are being taken to treat or correct it, and*

*(b) but for that, it would be likely to have that effect. (2) Measures includes in particular medical treatment …*".

41. Section 212 of the Act provides that "*substantial*" means "*more than minor or trivial*".

42. In **Kapadia v London Borough of Lambeth [2000] IRLR 699**, the Court of Appeal accepted a submission that it was for a claimant to prove that the impairment had a substantial adverse effect on his/her ability to carry out normal day-to-day activities or to prove that the impairment would have had such an effect but for the fact that measures were being taken to treat or correct the condition. Having in mind that burden, the Tribunal's task is to look at the evidence presented to it and decide the question on the balance of probabilities.

43. **Goodwin v Patent Office [1999] ICR 302** is well-established and well-regarded Employment Appeal Tribunal ("EAT") authority for the questions to be asked in determining disability, encouraging Tribunals to take an inquisitorial approach to the issue. The EAT stated that the legislation requires a tribunal to look at the evidence by reference to four different conditions. Taking account of amendments to the legislation since the decision, the questions are stated by the EAT as follows: "*(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 ... 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?*". The EAT stated that it would be useful (though subsequent case law makes clear it is not essential) for tribunals to consider these questions in sequence, though it remains necessary to make an overall assessment and not "*take one's eye off the whole picture*". The EAT went on to give guidance in respect of each question. In respect of the adverse effect condition, it stated that "*the focus of attention ... is on the things that the applicant cannot do or can only do with difficulty, rather than on the things that the person can do*". This should be compared with what he/she could do without the impairment.

44. Mr Williams referred me to an employment tribunal decision in **Convery v Bristol Street Fourth Investments Limited 1807364/2020**, in which it was held that wearing of face masks constituted a normal day-to-day activity for the purposes of the Act. Whilst of course the decision is not binding on me, the point to be made is that Mr Williams agrees that it was such an activity, which seems to me a sensible concession given that the relevant period in the case before me, or at least a large part of it, was when the country – indeed the world – was grappling with various waves of the Covid-19 pandemic and mask-wearing became a normal part of everyday life.

45. Mr Williams also briefly referred to **Herry v Dudley Metropolitan Borough Council [2017] ICR 610**, specifically the EAT's comment that "*experience shows that there is a class of case where a reaction to circumstances perceived as adverse can become entrenched; where the person concerned will not give way or compromise over an issue at work, and refuses to return to work, yet in other respects suffers no or little apparent adverse effect on normal day-to-day activities … an Employment Tribunal is not bound to find that there is a mental impairment in such a case.*

*Unhappiness with a decision or a colleague, a tendency to nurse grievances, or a refusal to compromise (if these or similar findings are made by an Employment Tribunal) are not of themselves mental impairments: they may simply reflect a person's character or personality*". The Respondent before me concedes that the Claimant had the mental impairment of anxiety disorder. Mr Williams' point therefore seems to have been that it did not have a substantial effect on her ability to carry out normal day-to-day activities which was long-term, because it was the (transient, as he would say) result of her dispute with the Respondent over mask-wearing.

46. I have noted the following paragraphs from the 2011 Guidance on matters to be taken into account in determining questions relating to the definition of disability ("the Guidance") in relation to the question of substantial adverse effect:

46.1. Paragraph B4 says it is important to consider whether an impairment's effects on more than one activity, when taken together, could result in an overall substantial adverse effect.

46.2. Paragraph B6 (see also **Ministry of Defence v Hay [2008] ICR 1247**) says that where there are multiple impairments, any one of which would not have a substantial adverse effect, account should be taken of whether they do when they are taken together.

46.3. Paragraph B7 says that account should be taken of how far a person can **reasonably** [emphasis original] be expected to modify his or her behaviour, for example by use of a coping or avoidance strategy, to prevent or reduce the effects of an impairment on normal day-to-day activities.

46.4. Paragraph B9 says account should be taken of where a person avoids doing things which, for example, cause pain or fatigue, or avoids doing something because of a loss of energy. It would **not** [emphasis original] be reasonable to conclude that a person who employed an avoidance strategy was not a disabled person.

47. As indicated above, Schedule 1 paragraph 5 of the Act requires consideration of how an impairment would affect day to day activities if medical treatment ceased. According to the House of Lords decision in **SCA Packaging v Boyle [2009] ICR 1056**, what must be asked is what the effect of the impairment would be if treatment stopped. Whether it is likely that the impairment would have the required effect in that situation means it "*could well happen*" – see also paragraph C3 of the Guidance. The EAT in **Fathers v Pets At Home Ltd and another [2013] UKEAT/0424/13** said that "*relatively little evidence may in fact be required to raise this issue*", in other words to require a tribunal to consider and address the point of the effects in the absence of medical treatment. Of course, what a tribunal makes of the evidence before it on this issue very much depends on the individual case. Where treatment has permanently reduced or extinguished the effects of the impairment, that treatment is not to be discounted in making the assessment of the effects on the ability to carry out normal day-to-day activities.

48. In **Royal Bank of Scotland PLC v Morris [2012] UKEAT/0436/10**, the EAT upheld an appeal against the tribunal's decision that the Claimant was a disabled person. On the question of the effect of medication (what is sometimes known as

"deduced effects"), the EAT found there was no explicit evidence and stated, "*This is just the kind of question on which a tribunal is very unlikely to be able to make safe findings without the benefit of medical evidence*". Similarly, "*it would be difficult for the Tribunal to assess the likelihood of [the risk of recurrence of the required effects under paragraph 2(2) of Schedule 1] or the severity of the effect if it eventuated, without expert evidence*". The EAT concluded, "*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 cognate 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*".

49. As to whether the required effects of an impairment were long term, again the **SCA Packaging** judgment makes clear that where a tribunal is required to assess whether those effects are "*likely*" to last for at least 12 months, this means that it "*could well happen*". As paragraph 2 of Schedule 1 to the Act says, and paragraph C7 of the Guidance confirms, it is not necessary for the effect to be the same throughout the period being considered. What has to be considered is whether the effects were "likely" to recur, that word again meaning "could well happen".

50. All of the questions I have to consider, including the long-term question, have to be assessed as at the time of the alleged discriminatory treatment - **Cruickshank v VAW Motorcast Limited [2002] ICR 729, EAT**. The Court of Appeal said in **McDougall v Richmond Adult Community College [2008] ICR 431** that in assessing the likelihood of effects lasting for at least 12 months, tribunals should only consider the evidence available at the time of the discriminatory acts. The assessment thus requires a prophecy of future events at those points, rather than recourse to actual evidence of subsequent events. This is reflected in paragraph C4 of the Guidance. In similar vein, on the question of whether the required effect had lasted 12 months, the EAT in **Tesco Stores Limited v Tennant [2019] UKEAT/0167/19**, held that it is the date of the alleged discriminatory act(s) at which this must be assessed, with the question being whether at that point there has been "*12 months of effect*".

## Analysis

51. My conclusions on the questions identified above are of course based entirely on the facts as I have found them and the application of the law to those facts. The Respondent concedes the impairment question, so that I need say nothing further about that. I make a few preliminary comments about the remaining questions:

51.1. First, the burden is on the Claimant to establish that she was a disabled person, including establishing that the impairments, or at least one of them, had an adverse effect on her ability to carry out normal day-to-day activities.

51.2. Secondly, the Claimant agreed that the three key effects on her ability to carry out normal day-to-day activities were related to the following symptoms:

51.2.1. Difficulty breathing, which she says was connected to both chronic rhinosinusitis and hypothyroidism.

51.2.2. Tiredness, which she said was connected to the same two impairments.

51.2.3. Memory and concentration issues, which arose from not sleeping and were again connected to the same two impairments.

She also said that variation in her mood was a key effect of the impairments but gave no oral evidence in relation to that and other than its being referenced in the impact statement, I was taken to no documentary evidence relating to it either. I therefore discount it.

51.3. Thirdly, it is irrelevant that the hypothyroidism and (to some extent at least) the chronic rhinosinusitis arose from surgery which the Claimant chose to undertake.

51.4. Fourthly, in relation to the explant, given the apparently permanent benefits of that surgery for the Claimant, I am not required to consider what the effects on her ability to carry out normal day-to-day activities would have been if she had not had it and if the Claimant was a disabled person by reason of hypothyroidism before it, I am required to assess whether that remained the case thereafter.

51.5. Fifthly, I remind myself of what is stated above, namely that the multiple effects of an impairment and/or the combined effects of the various impairments, are important to consider in answering the adverse effects question and the question of whether they are substantial.

51.6. Finally, the question before me is of course nothing to do with whether the Respondent knew or should reasonably have known that the Claimant was a disabled person, by reason of any of the impairments or all of them, but whether I conclude she was in fact a disabled person based on the evidence presented to me.

52. I now turn to consider the remaining **Goodwin** questions in relation to each impairment, before returning to review the whole picture emerging from the impairments taken together. As subsequent case law makes clear, it does not especially matter which order the statutory questions are dealt with, provided each is addressed.

**Hypothyroidism**

53. I deal with hypothyroidism first, as on the evidence presented to me, this impairment arose first in time chronologically.

54. The first question is whether this impairment at any time in the relevant period had an impact on the Claimant's ability to carry out normal day-to-day activities. Struggling to remember one's daily responsibilities is clearly an adverse effect on an everyday task. Remembering daily responsibilities at work is so commonplace as to be routine, and I note too the Claimant's evidence of things she forgot to do outside of work, which were in themselves routine, such as putting a petrol cap back on a car and getting to familiar places. Reading a book is also a normal daily activity and forgetting what one

has read, thus giving up on reading, is an adverse effect. These effects on the Claimant's memory and concentration appear to have been periodic, but they need not have been constant to be adverse, and I find that they were. The Claimant being fatigued meant that she had limited engagement in social activities, did not cook healthy food or thoroughly carry out cleaning tasks at home. Again, those are plainly normal daily activities which were adversely affected.

55. The Claimant's case that her difficulties with concentration and tiredness (and their effects as just summarised) resulted from hypothyroidism is confirmed by the GP notes from December 2019 and February 2020, and underlined by her long email to the GP on 30 June 2020, which highlighted the impact on her socialising in particular, whilst in relation to memory problems she specifically recorded what she told me, namely that she would forget how to get to familiar places. I record therefore that I am satisfied that the adverse effects on normal daily activities referred to above resulted from this impairment.

56. For completeness, I discount the Claimant's difficulty lifting heavy objects, partly because she provided no detail of it, but also because this was evidently the result of the explant operation, and therefore (a question I come to below) not a long-term effect of the hypothyroidism. I also discount the fact that the Claimant did not continue working nightshifts, in part because I am hesitant to conclude that this is an everyday activity (I accept many people do it, but it is an activity specific to certain roles) but principally because even if it was a day-to-day activity, again the Claimant gave me no detail about it, most importantly over what period she was unable to work on this basis, which is of course highly relevant to the long-term question. Finally, whilst the Claimant says that her breathing difficulties were in part due to hypothyroidism, saying her GP advised her that was the case, I was not taken to any evidence of that and so discount that also.

57. Were the adverse effects I have considered substantial in nature, namely more than minor or trivial? The answer to that is obviously yes. First, this is the case when one considers the change in the Claimant's activities, from someone who was very active socially, very keen on home-cooking and cleanliness and who also experienced no notable issues with her memory prior to the implant surgery. Secondly, when one takes the various effects together – avoiding social activities, being too tired to carry out key household tasks as well as before and forgetting things as basic as how to get to a place one has been to several times – it is plain that these are not minor or trivial changes which the impairment brought about in the Claimant's daily life, even if they were variable rather than constant.

58. I will return shortly to the question of deduced effects, namely the impact of this impairment on the Claimant's daily activities without medication, but will deal first, for reasons that will become obvious, with the question of whether the substantial adverse effects were long-term.

59. The Claimant was diagnosed with hypothyroidism on 2 November 2019, but was plainly experiencing the adverse effects before then, essentially within 6 months of the implants in 2013. I note that on 28 February 2020 she told her GP that her fatigue had been worse for the previous 6 months (that is, from September 2019), but the long-term nature of the impact of this condition on her daily life is confirmed by what she

reported to her GP on 17 December 2019, when she said that she had been experiencing the various issues she described for 5 years, and by her email to the GP of 30 June 2020. I am in no doubt therefore that as at the date of the explant surgery on 14 August 2020, hypothyroidism had had a substantial adverse impact on the Claimant's ability to carry out day-to-day activities for much more than 12 months. She was from March 2020 to that point plainly a disabled person by way of this impairment.

60. It is equally plain that the explant surgery brought about a transformation in her symptoms, and thus her ability to carry out day-to-day activities, and that this was permanent in its beneficial effects. That means that I must assess from when that was the case, because at that point it seems clear that the statutory definition was no longer satisfied. The Claimant was then in a position equivalent to someone who has had a pin inserted in a bone for example, permanently correcting what was previously wrong.

61. I accept what she says in response to Mr Harris' statement that she was "systemically well" in April 2021, namely that he did not meet her to discuss hypothyroidism, nor could he comment on its effects. It is however the clearest objective indication I have of how the Claimant was presenting, 9 months after the explant. She herself says she was generally in much better health a year after, in August 2021, and was in no doubt about the transformative effects of the surgery.

62. There is a brief reference to her immediate post-explant condition in the OH report of 22 September 2020, which described the Claimant as functioning well day-to-day and feeling ready to return to work. The Claimant says this was because of her coping mechanisms and only meant that she was able to look after herself at home. I am more than prepared to accept that her feeling able to return to work is not evidence that at this point there was no adverse impact on her ability to carry out daily activities. Quite obviously, many disabled people work, and do so successfully. As to the phrase "functioning well", that clearly signals an improvement in what the Claimant was now able to do, but it was self-evidently not a detailed statement, providing no understanding of how she was managing to function well, which she says – and I accept – was only by sleeping excessively. The adverse effects of the impairment had, even by her own evidence, abated to some extent immediately after the explant, but whilst someone with this condition can reasonably be expected to ensure they sleep normally, having to sleep excessively as a coping mechanism is not in the same category. Accordingly, whilst by her own admission she was able to look after herself at home, so that I can safely conclude she was at that point able to cook and clean more like she did before the impairment first arose, I accept at face value her evidence that the wholesale positive effects of the explant were not immediate, but more gradual: as I have said, I am clear she was seeking to provide me with a straightforward account. There did come a point however when the full benefits of the surgery were realised. The evidence is limited, but it seems to me, even accepting the caveats provided by the Claimant, that Mr Harris' comment in April 2021 is instructive in this regard. It is also not far removed from the Claimant's own case that she was generally in much better health a year after the surgery.

63. Based on the evidence presented to me, I conclude therefore that the Claimant was a disabled person by reason of hypothyroidism from well before March 2020,

through to April 2021. At that point the permanent effects of the explant meant that she was no longer a disabled person on this basis.

64. The remaining question is whether she remained such thereafter, when I take out of account the beneficial effects of medication. She was taking levothyroxine until August 2020, but I do not have to consider how she would have been without that, given my conclusion above. The question is what the position would have been had she not been taking iodine after April 2021. I saw no evidence at all which would provide any secure basis on which to answer this question, other than the briefest comment from the Claimant that she has felt more tired when forgetting to take it. **Morris** urges caution in answering such questions without medical expert input in relation to mental impairments, but I feel similarly unable to answer the question in relation to this physical impairment, without some reference to medically informed comment. I cannot guess or take judicial notice of the position the Claimant would have been in without iodine. My conclusion in relation to hypothyroidism thus remains that the Claimant was a disabled person by way of that impairment from well before March 2020 until April 2021.

**Chronic rhinosinusitis**

65. The Claimant's case is that because of this second impairment, she did not sleep well because she could not breathe through her nose. I have already set out that I accept her oral evidence except to the extent that it is contradicted by any contemporaneous document. In this instance, there is nothing in the documentary evidence I was taken to that contradicts her case. I accept that difficulty sleeping was not mentioned in the GP records from December 2019 to April 2021, but the Claimant did clearly refer to breathing issues in those consultations and it is not difficult to accept that this had an impact on her sleep. Mr Harris' report from April 2021 bears out, at least in terms of setting out what the Claimant explained to him, that she had significant difficulty breathing through her nose. He says in terms that her air flow was poor and that she was extremely rhinitic.

66. One could perhaps get lost in a semantic argument about whether sleep is an "activity", but it is clearly right to proceed on the basis that it is a normal part of daily life and that not being able to sleep as one has before is an impact which can in turn be said to be adverse. Furthermore, it had an adverse impact on the Claimant's ability to socialise, because it caused tiredness and meant that she had to go to bed early. She previously enjoyed attending motorbike racing for example and did not do so subsequently.

67. I have noted and accept that the condition has made the Claimant vulnerable to sinus infections, which currently put her out of action for around 48 hours a couple of times a month. It is likely that her having to go to bed and being out of action for 48 hours with this level of frequency goes beyond what the general population would experience. The effects of an impairment do not have to be constant in order to be adverse. That said, for whatever reasons, the Claimant was not able to provide any answer to the question of whether this was the case in the relevant period, and it must therefore be discounted. The Claimant's memory problems were very much connected by her in her oral evidence to hypothyroidism, and so I also put those out of account in this context. Wearing spectacles is a normal daily activity for large numbers

of people and it may be that not being able to wear them (for 18 months from November 2019) was an adverse effect of the impairment, but the Claimant said nothing about what the impact was or how she coped with and accommodated it. That effect too must be discounted accordingly. Similarly, she said nothing about her sense of taste or smell being impacted, telling me nothing about its extent or how it affected normal day-to-day activities compared to before.

68. Mask wearing is, as I have said, sensibly accepted by the Respondent to have been a daily activity in the relevant period, though even if one were to conclude otherwise, the question of the impact on day-to-day activities during that period would, in my judgment, fall to be assessed based on a mask being worn. The Claimant had worn masks at work for years, so that it seems clear that there was a change in her ability to do this normal day-to-day activity from the point of her nose surgery in November 2019, although it was only a significant issue in practice from around March 2020 when she was required to wear it more extensively because of the measures to combat Covid-19. The Claimant feeling like she could not breathe and thus being unable to concentrate were evidently adverse effects on her ability to carry out day-today activities. The Claimant's evidence in that regard is in no sense contradicted by Ms Cooper's note of 1 July 2020 – as the Claimant says, she had been wearing the mask below her nose as much as possible – and is borne out by what she reported to OH in November 2020.

69. Was the effect substantial, that is more than minor or trivial? I repeat that I do not regard the Claimant's ability to attend at work as an indication that the effects were not substantial, though in this specific context I also take into account the oral evidence she gave of her inability to function whilst wearing a mask at work, which was striking. The combination of the impact on the Claimant's sleep and socialising, and on her concentration when wearing a mask, comfortably exceeded what could properly be described as minor or trivial. She was in effect managing her ability to work by additional sleep and, as a result, avoiding social activities; she could not carry out any of her work functions when required to wear a mask over her nose.

70. This is confirmed by what I regard to be the likely position without medication. The Claimant appears to have used Flixonase or similar, and Nelimed or similar, since April 2021, and a nasal steroid from September 2021. They helped substantially as the OH report of 29 November 2021 states and it seems clear the Claimant has continued to use them for the rest of the relevant period, that is to May 2022. The "substantial improvement" must of course be discounted. It simply confirms to my mind that there was a substantial – the same word – adverse effect without it. It is not clear when the Claimant began using CBD oil, so I can say nothing further about that.

71. The impairment therefore had a substantial adverse effect on the Claimant's ability to carry out normal day-to-day activities. The remaining question is when that was the case and whether (and if so at what point) those effects were long-term.

72. The impairment was diagnosed on 30 April 2021, but that does not mean that it was only an issue for the Claimant from that point. I see nothing in the contemporaneous documents to doubt the Claimant's case that it was a "massive problem", as she put it, after her nose surgery in November 2019. Mr Harris' report from April 2021 bears that out, at least in terms of recording issues the Claimant

explained to him. Whilst his view was that the issues experienced by the Claimant were not because of the surgery, first of all he does not say whether in his view they pre-dated or post-dated the surgery, and secondly his letter is objective evidence of what the Claimant reported at the time, namely that it was the surgery that brought about the change. The OH report of 13 November 2020 was to the same effect, whilst the GP notes record the Claimant mentioning breathing issues and pain wearing a mask from December 2019 to April 2021.

73. On the evidence presented to me, I conclude that the adverse effects arose in November 2019. Whilst there is a brief mention in the GP record dated 19 October 2020 (page 151) of the Claimant's sinus problems being "worse after than were before" the surgery, that is an insufficient evidential basis for me to reach any conclusions about the period before November 2019. By November 2020 therefore, the substantial adverse effects had lasted for 12 months.

74. It is not possible for me to say that at any point prior to November 2020, the adverse effects were likely to last for 12 months or for the rest of the Claimant's life, as there is simply no evidence on which such a conclusion could be founded. I therefore conclude that the Claimant was a disabled person by reason of the impairment of chronic rhinosinusitis from November 2020 for the remainder of the relevant period, that is until May 2022.

**Anxiety disorder**

75. I can deal with the third impairment somewhat more briefly and begin by saying that I must discount the anxiety issues the Claimant experienced many years before the relevant period. This is not because I lightly dismiss how serious they may have been but because, as I have said, I was given no details about those earlier issues at all, whether in documentary or oral evidence.

76. Ms Cooper's note of 1 July 2020 tells me very little, other than that on the occasion of their discussion the Claimant's mental health was of concern to her. A more important question is what to make of the OH report of 28 October 2020. The Claimant's anxiety is described in that report as confined to wearing a mask in the workplace. I have already made clear the basis on which I conclude that mask-wearing was during the relevant period an everyday activity, or at least one should assess the impact on ability to carry out normal day-to-day activities in that period when a person was wearing a mask. It seems clear however that the OH specialist concluded that the Claimant's anxiety about mask-wearing at work was normal, suggesting that it was no different to what one would expect to see in the population generally. In fact, she went further than that and said it was not a "mental health difficulty" at all.

77. The Claimant's case is that she became anxious because she could not breathe. It is clear to me that the difficulty breathing resulted from her chronic rhinosinusitis (see above). Based on the evidence I was taken to, that is what gave rise to the Claimant's anxiety and thus her impaired concentration. Whilst I do not think that **Herry** is relevant or of assistance in this case, because it was not the dispute between the parties as such which seems to have caused the Claimant to become anxious,

whether about returning to work or otherwise, but the actual requirement to wear a mask, the evidence of an underlying anxiety disorder in the relevant period is scant.

78. The Claimant discussed anxiety with her GP in December 2021 and June 2022, the latter when she said she was not sleeping. She also says in her impact statement that anxiety caused issues with fatigue and concentration and negatively impacted on her socialising. That is not sufficient in my judgment to establish that the Claimant was a disabled person by reason of this impairment. It is notable (on the adverse effects question) that this issue was only raised twice with the GP, six months apart. On the long-term question, it is notable that the first time it was raised with the GP was very close to the end of the relevant period, such that even had substantial adverse effects been established, there was no basis on which I could say that by May 2022 they had lasted or were likely to last for 12 months or for the rest of the Claimant's life. I am also without any evidential basis on which to answer the question of whether the impairment would have given rise in the relevant period to substantial adverse effects that were long term if the Claimant had not had the benefit of herbal medicines, IAPT and counselling (the CBT seems to have fallen entirely outside of the relevant period). I note again the strong warning of the EAT about such matters, particularly in relation to mental impairments, set out in **Morris**.

79. I therefore conclude that the Claimant has not established that she was during the relevant period a disabled person by reason of this third impairment of anxiety disorder.

**Conclusions**

80. I have sought to assess the overall and cumulative effects of each individual impairment in my analysis above. As for the cumulative effects of the impairments taken together, I am satisfied that this does not change the conclusions I have already reached. The required effects are not made out in relation to anxiety disorder. As for the two physical impairments, I have made clear that I accept that the tiredness and concentration/memory issues the Claimant highlights, and the substantial adverse effects she has detailed, resulted from both hypothyroidism and chronic rhinosinusitis. The latter impairment has been shown to be a disability only from November 2020 and there is no evidential basis on which to find a cumulative effect of the two physical impairments prior to then which would change that conclusion. The former impairment ceased to have the required effects from April 2021 for the reasons I have given, and so there is no need to analyse cumulative effects after that date. It adds nothing to my analysis to assess cumulative effects between November 2020 and April 2021, given that I have found both impairments amounted to disabilities in their own right during that short period.

81. In summary therefore:

81.1. The Claimant was a disabled person as defined by section 6 of the Act by reason of the impairment of hypothyroidism from well before March 2020 until April 2021.

81.2. She was a disabled person as so defined by reason of the impairment of chronic rhinosinusitis from November 2020 until May 2022.

81.3. She was not a disabled person as so defined by reason of the impairment of anxiety disorder at any time during the relevant period.

82. How those conclusions impact the Claimant's case, and indeed the Response to it, will need to be explored, if it is necessary to do so, at the next Public Preliminary Hearing, in defining and agreeing a final list of issues for the Final Hearing.

Employment Judge Faulkner
Date: 23 June 2023