RESERVED

**Case No. 2409779/22**

# EMPLOYMENT TRIBUNALS

**Claimant:** Ms A Safaru

**Respondent:** Qiagen Manchester Limited

# RECORD OF A PRELIMINARY HEARING

**Heard at:** Liverpool (in private; by CVP) **On:** 4 September 2023
28 September 2023 (in chambers)

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

**Representatives**
For the claimant: Mr Famutimi, partner and legal representative
For the respondent: Mr Sangha, counsel

## RESERVED PRELIMINARY HEARING JUDGMENT

The judgment of the Tribunal is that:

1. The claimant was disabled in accordance with section 6 of the Equality Act 2010 with the physical and mental impairment: anxiety and insomnia during the relevant period January to July 2022.

2. By consent, Mr Famutimi was disabled in accordance with section 6 of the Equality Act 2010 with severe anxiety, fibromyalgia, small fibre neuropathy and brain fog between January and June 2020, the relevant period.

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# REASONS

Preamble

1. This has been a remote preliminary hearing by video which has been consented to by the parties. The form of remote hearing was CVP video fully remote. A face to face hearing was not held because it was not practicable and all issues could be determined in a remote hearing. The documents that the Tribunal was referred to are in a bundle of 172 pages, the contents of which I have recorded where relevant below, in addition to the claimant's unsigned and dated impact statement together with her supplemental witness statement, the claimant's email dated 3 September 2023 seeking to expand on para.13 of her impact statement, and the written statement submissions received from both parties, for which I am grateful.

2. The hearing is to decide whether the claimant and Mr Famutimi were disabled within the meaning of the Equality Act 2010 at relevant times by reason of anxiety (claimant) and severe anxiety, fibromyalgia, small fibre neuropathy and mild depression (Mr Famutimi). The relevant time for the claimant is January to July 2022 and the relevant time for Mr Famutimi is July 2022. The respondent has conceded Mr Famuttimi is disabled for the purpose of section 6 of the EqA and there is no longer any requirement for me to consider this issue.

3. The respondent's knowledge in relation to Mr Famutimi and the claimant is still in issue and will be dealt with at the final hearing.

4. Finally, it was agreed between the parties that the time in which the respondent is to file amended Grounds of Response will be extended to **18 September 2023**.

Issues

5. We discussed and agreed the issues to be decided at this preliminary hearing as follows;

a. Did the claimant have a disability as defined in section 6 of the Equality Act 2010 at the time of the events the relevant period is January to July 2022. The Tribunal will decide:

(i) Did she have a physical or mental impairment: anxiety and insomnia?

(ii) Did it have a substantial adverse effect on her ability to carry out day-to-day activities?

(iii) If not, did the claimant have medical treatment, including medication, or take other measures to treat or correct the impairment?

(iv) If so. would the impairment have had a substantial adverse effect on her ability to carry out day-to-day activities without the treatment or other measures?

(v) Were the effects of the impairment long-term? The Tribunal will decide:

(a) did they last at least 12 months, or were they likely to last at least 12 months?

(b) if not, were they likely to recur?

Claimant's disability issue

6. In order for the complaints of disability discrimination to succeed, the claimant will need to establish that she had a disability within the meaning of section 6 of EqA, and this is the issue before me today.

7. Oral evidence has been heard on oath from the claimant who confirmed the contents of her impact statements were true. She was found to be a credible witness whose evidence was to some extent support by the medical records. The claimant relies on long-term anxiety as the mental impairment and Mr Sangha, on behalf of the respondent, submitted that she is not relying on sleep impairment as a second disability. With reference to para. 22 of the Grounds of Complaint it is apparent that the claimant's case is she has anxiety (from 2014) which affects her level of concentration, focus and insomnia as a result. In other words the anxiety and insomnia are linked. My focus is on what the claimant cannot do without establishing causation, whether it be caused by anxiety, ADHD or any other medical condition on the basis that impairments can be established without establishing causation: Millar v ICR [2005] SLT 1074, [2006] IRLR 112, the Court of Session held that a physical impairment can be established without establishing causation and, in particular, without being shown to have its origins in any particular illness.

Findings of Facts: Medical history

8. The GP and other medical records confirmed the following:

7.1 On 1 August and December 2019 there is a reference to a diagnosis of attention deficit hyperactivity disorder ("ADHD"). It is notable in oral evidence on cross-examination the claimant stated she "no longer had" ADHD. There is no medical evidence to support this, and as I am not a medical expert cannot reach any conclusions on whether the condition of ADHD once diagnosed is permanent or not. However, Dr Tint, a consultant psychiatrist in adult ADHD produced a report dated 6 December 2019 confirming the claimant's "**lifelong** symptoms of difficulties in concentration, focus…initial and **middle insomnia…a history of depression** for which she has been prescribed anti-depressants and therapy…functional assessment scale indicates significant effects of ADHF symptoms on multiple areas of her life" [my emphasis]. He confirmed that the claimant had ADHD since childhood going into adulthood.

7.2 In a report dated 1 October 2020 from the treating consultant psychiatrist it appears that the ADHD medication was resulting in improvements and by 27 May

2021 he confirmed that the claimant had sessions of hypnotherapy and no longer wished to take ADHD medication, but continued to have difficulties with sleep.

7.3 The claimant was referred to a consultant psychiatrist on the 21 August 2021 concerning ADHD diagnosed in 2020 with a view to restarting medication. ADHD medication was prescribed on the 9 December 2019.

7.4 15 June to 16 August 2021 insomnia. On the 24 June 2021 the claimant was referred to the sleep clinic. A report was sent to the GP dated 3 December 2021 which confirmed a diagnosis of "sleep initiation and maintenance insomnia which has persisted over time." Reference was made to the claimant being aware anxiety and worries affect sleep, and to her using "a variety of strategies" including Melatonin and Nytol.

7.5 In August 2022 the claimant was diagnosed with the active problems of mixed anxiety and depression. The 15 August 2022 GP entry confirms the claimant was "started on fluoxetine by doctor whilst aboard several weeks ago, was started for anxiety…**has been struggling with anxiety for a few years also suffers with poor sleep, agitation, states she had previously been diagnosed with ADHD a few years ago, stopped ADHD meds over 1 year ago as she does not want to be taking for the rest of her life**…" [my emphasis]. Reference was made to the claimant's partner "he has significant health issues himself, she finds supporting her partner affects her mental health! And she found the termination of her employment "stressful." Fluoxetine and Zopiclone were prescribed.

7.6 The claimant was prescribed fluoxetine on the 5 August 2022 "helping keep calm and helping with sleep."

7.7 2 August 2022 GP records confirmed "confirmed started fluo on holiday."

7.8 Whilst the claimant was on holiday she experienced, in addition to a number of other conditions, palpitation and insomnia. The report confirmed "**it was concluded that insomnia which she had been suffering from for 7 years was due to intense anxiety**" [my emphasis]. Prozac was prescribed and other medication that could not be deciphered from the hand-written record dated 9 July 2022.

7.9 In a note dated 7 September 2022 the claimant's doctor confirmed she was admitted with a number of complaints including fatigue, palpitation and insomnia "**she has been suffering for 7 years was due to intense anxiety**"[my emphasis]. Prozac was prescribed.

7.10 The claimant's GP record dated 18 October 2022 confirmed "mixed anxiety and depressive disorder doing OK on medication. Mood ok, sleep is an issue…gets anxious about sleep also.

9. It is undisputed between the claimant and respondent that at work she was underperforming and the issues with her performance were acknowledged by the claimant when giving oral evidence today. The claimant attributes her

underperformance with her anxiety which adversely affected sleep to such an extent that she experienced insomnia and felt tired during the day as a result. The claimant relies on the candidate information form dated 4 September 2021 dealing with her health completed when she applied to work for the respondent confirming in the past 5 years she had depression and that she was "receiving or waiting for an appointment or treatment" for insomnia.

10. It is notable that on 3 December 2021 the claimant was referred for a sleep apnoea review to deal with a diagnosis of "sleep initiation and maintenance insomnia likely to be multifactorial." There was no definition of what the multitude of factors were that resulted in the claimant "**having poor quality sleep both difficulty in initiating and maintaining sleep which has persisted over time for her…she is aware anxiety and worry** can certainly affect initiation. **She has used a variety of strategies including medicatio**n and music to relax and at time uses Melatonin…or Nytol to help her sleep" [my emphasis]. The medical record corroborates the claimant's oral evidence that she was struggling with insomnia because of her anxiety, and for a period of time refused to take medication. She had taken the advice from a holistic health professional on anxiety and insomnia and was advised against taking drugs on prescription for any length of time, advice she followed.

11. Mr Sangha submitted that the report did not refer expressly to the claimant's anxiety; I do not agree having taken into account the entire paragraph read as a whole which suggests the claimant was anxious and worried and used a number of different strategies, which supported the claimant's credible evidence that her anxiety and insomnia were interlinked, one condition affecting the other. This had been the state of affairs over a number of years and the claimant had tried various remedies to help her take control of the situation, which did not work long-term, including following "Sleep Hygiene" tips.

12. In the GP record 26 August 2021 reference is made to "I need to discuss having some sleep medication on repeat as lack of sleep is causing a lot of stress." The claimant was prescribed propranolol "a months' worth and you can take it before bed if you are feeling anxious or stressed about not being able to sleep."

13. The 16 August 2021 GP entry records "**Difficulty with sleep has been an issue since 2014 when diagnosed with depression and anxiety. Since then has tried many forms of therapy for both mental health and sleep**. Seraline 6 months was of little help and not keen to start medication for anxiety and depression. CBT found to be helpful, now has coping strategies for anxiety which she used regularly like meditation. Is not concerned with mental health currently is more concerned about poor sleeping causing stress which results in a vicious cycle. Has tried Nytol, melatonin, %-HT, Valium, hypnotherapy and acupuncture for sleep disturbance…is having ongoing difficulties with being able to get to sleep and waking I the middle of the night and not being able to get back to sleep. Recently improved when not doing night shifts. Recently prescribed short course of zopiclone…feeling anxious about poor sleep and the stress this causes, prior to going to sleep can feel anxious with a racing heart and clammy hands…propranolol may be good to reduce physical symptoms of anxiety prior to sleep" [my emphasis].

14. The GP entry 15 June 2021 records the claimant's "trouble getting to sleep and trouble going back to sleep when she wakes up at night…has had problem since early 2015." Medication was discussed including natural sleep aids, acupuncture and homeopathic remedies taken by the claimant who wanted to "function better…I was even on sertraline a while back when suffering from depression…I feel like [it] is anxiety that doesn't allow me to sleep properly… " A 7-day course of Zopiclone prescribed.

15. The medical record dated 6 January 2020 refers the claimant's diagnosis of ADHD 12 months previously for which she was medicated "**has ongoing lifelong symptoms of difficulties** in concentration, focus, fidgetiness and impulsivity. She struggles with task completion…**she has both initial and middle insomnia…she has a history of depression for which she has been prescribed antidepressants aid therapy…I can validate a formal diagnosis of ADHD, childhood diagnosis of ADHD**…" [my emphasis].

16. The 21 August 2019 GP record refers to the claimant's ADHD and "poor management…can't multitask works as a lab assistant…"

17. In a letter from a consultant psychiatrist the claimant is described as having "struggled with the symptoms of ADHD" and not wanting to go on medication long term." On the 9 December 2019 treatment for ADHD was prescribed and in a report clinic date 6 December 2019 by Dr Tint, consultant psychiatrist in adult ADHD the claimant was described as having "lifelong symptoms…" and in the report clinic date 1 October 2020 confirmed the claimant reported improvement and current medication was to continue. In the report clinic date 4 February 2021 Dr Tint confirmed the claimant had not made contact, medication was put on hold, and in the report dated clinic date 27 May 2021 that the claimant has had sessions of hypnotherapy "which have helped him [her] well. He [she] no longer wishes to take ADHD medication. However, Mr [Ms] Sufaru reports that he [she] continues to have difficulties with sleep…I have discharged…if he [she] wishes to take ADHD medication in the future please re-refer him [her]." The claimant incorrectly described as Mr Safaru has not taken ADHD medication since, the oral evidence was that she felt better and no longer had ADHD despite the medical report that it was a "lifelong" condition the claimant had since childhood into adulthood.

18. Taking into account the medical evidence, I find on the balance of probabilities that the claimant had experienced anxiety for a number of years and in 2015/2016 she was prescribed sertraline for 6-months, took part in a number of therapies ranging from cognitive behaviour therapy to self-help natural remedies including advise from holistic health professionals as the claimant did not want to take prescribed medication in case it became habit forming or gave her nightmares, as was the case. She has undertaken a number of coping strategies including mindfulness, yoga, yoga nidre (guided meditations), diet and a number of other coping mechanisms including salsa dancing to life mood, which she sometimes cancelled due to tiredness. When working the claimant slept in at weekends because she was so tired. At work the claimant made simple mistakes, "al lot of mistakes; basic things" including "mixing wrong samples" and this was due to tiredness as a result of the insomnia. .She experienced lack of attention and concentration as a result of "brain fog" during the relevant period.

19. Over the years the claimant's insomnia resulting from her anxiety and the anxiety worsened as a result of insomnia, described as a "self-feeding cycle" has not only affected how she performs at work (as recorded in the GP records when the claimant had issues and absences from other employers not the respondent) but in her ability to perform when working for the respondent including in the relevant period January 2022 to July 2022 before dismissal on the 7 July 2022 which according to the respondent was for poor performance, including clocking in late and a number of other issues. Her long-standing condition deteriorated further with the poor health of her partner, and insomnia negatively affected her day to day life. The claimant's evidence that insomnia was the result of the underlying anxiety condition is accepted, and this is a thread which runs through the medical evidence. The medication prescribed, Propanol, gave the claimant nightmares and her insomnia not only affected work but also her private life, including being late, cancelling meetings with friends, being unable to manage all of the household chores like cooking, washing and tiding which the claimant could not cope with, although her ability to do so was variable.

20. In short, I accepted as credible the claimant's evidence that for a number of years she had experienced and continued to experience insomnia and anxiety which she attempted to manage through a variety of different therapies ranging from acupuncture, therapy sessions, guidance of a holistic health professional and medication prescribed by her GP. The claimant was left with a pattern of feeling tired/chronic fatigue and stress which adversely affected normal day to day activities including a pattern of underperformance at work, and life's events exacerbated her long standing condition.

Law and conclusion: Disability status

3 S.6(1) of the Equality Act 2010 ("EqA") provides that a person, 'P', has a 'disability' if he or she 'has a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.'

4 Schedule 1 of the EqA 2010 sets out factors to be considered in determining whether a person has a disability. S.6(5) of the EqA 2010 provides for the issuing of guidance about matters to be taken into account in deciding any question for the purposes of determining who has a disability. When considering whether a person is disabled for the purposes of the EqA regard should be had to Schedule 1 ('Disability: supplementary provisions') and to the Equality Act (Disability) Regulations 2010, and the 'Guidance on matters to be taken into account in determining questions relating to the definition of disability' under 6(5) of the Equality Act 2010 should be taken into account.

5 The relevant time to consider whether a person was disabled is the date of the alleged discrimination; see the well-known case of McDougall v Richmond Adult Community College *[2008] IRLR 227,* [2008] ICR 431.

6 Paragraph 5(1) of Schedule 1 to the EqA provides that 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 measures are being taken to treat or correct it and, but for that, it would be likely to have that effect. In this regard, *likely* means 'could well happen.'

7 Mr Famutimi referred to Boyle v SCA Packaging Ltd (Equality and Human Rights Commission intervening) [2009] ICR 1056, HL In assessing whether there is a substantial adverse effect on the person's ability to carry out normal day-to-day activities, any medical treatment which reduces or extinguishes the effects of the impairment should be ignored. medical treatment and measures have not been taken to treat or correct her condition.

8 For any claim to succeed, the burden is on the claimant to show, on the balance of probabilities, something an 'impairment' whether it is a mental or physical condition. In the case of Millar v ICR [2005] SLT 1074, [2006] IRLR 112, the Court of Session held that a physical impairment can be established without establishing causation and, in particular, without being shown to have its origins in any particular illness. The focus should be on what the claimant cannot do, and this test is particularly relevant the claimant's case given the issue concerning the "life-long" ADHD prognosis and the claimant's belief that she no longer had ADHD. It is not appropriate to have an examination for the purposes of discovering the causes of an alleged disability, since, whatever the cause, a disability which produces the effects specified in legislation will suffice. In considering what amounts to an 'impairment', its effect, not cause is what is of importance. This approach is set out in the Guidance issued under the EqA 2010, where (at para A8) it is stated that 'it is not necessary to consider how an impairment is caused, even if the cause is a consequence of a condition which is excluded.

9 Mr Famutimi referred to Goodwin v Patent Office [1999] ICR 302, EAT. The EAT said that of the four component parts to the definition of a disability and judging whether the effects of a condition are substantial is the most difficult. The EAT went on to set out its explanation of the requirement as follows:

'What the Act is concerned with is an impairment on the person's ability to carry out activities. The fact that a person can carry out such activities does not mean that his ability to carry them out has not been impaired. Thus, for example, a person may be able to cook, but only with the greatest difficulty. **In order to constitute an adverse effect, it is not the doing of the acts which is the focus of attention but rather the ability to do (or not do) the acts**. Experience shows that disabled persons often adjust their lives and circumstances to enable them to cope for themselves. Thus a person whose capacity to communicate through normal speech was obviously impaired might well choose, more or less voluntarily, to live on their own. If one asked such a person whether they managed to carry on their daily lives without undue problems, the answer might well be "yes", yet their ability to lead a "normal" life had obviously been impaired. Such a person would be unable to communicate through speech and the ability to communicate through speech is obviously a capacity which is needed for carrying out normal day-to-day activities, whether at work or at home. If asked whether they could use the telephone, or ask for directions or which bus to take, the answer would be "no". Those might be regarded as day-to-day activities contemplated by the legislation, and that person's ability to carry them out would clearly be regarded as adversely affected.'

10 Appendix 1 to the EHRC Employment Code states account should be taken not only of evidence that a person is performing a particular activity less well but also of evidence that 'a person avoids doing things which, for example, cause pain, fatigue or substantial social embarrassment; or because of a loss of energy and motivation' (our stress) — para 9. This was an issue in the claimant's case given the effect of fatigue caused by insomnia on ordinary day-to-day activities.

11 The focus must be on the extent to which the impairment adversely affects the claimant's ability to carry out normal day-to-day activities. Substantial is defined in S.212(1) EqA as meaning 'more than minor or trivial'. In determining whether an adverse effect is substantial, the tribunal must compare the claimant's ability to carry out normal day-to-day activities with the ability she would have if not impaired. Appendix 1 to the EHRC Employment Code states: 'The requirement that an effect must be substantial reflects the general understanding of disability as a limitation going beyond the normal differences in ability which might exist among people' — para 8. This should not be interpreted as meaning that in order to assess whether a particular effect is substantial, a comparison should be made with people of 'normal' ability — which would be very difficult to ascertain.

12 The test is whether an adverse effect is 'substantial' in the light of the statutory definition: the Guidance and Code are supplementary to this. Section 212(1) EqA 2010 defines it as being something which is *"more than minor or trivial"*. In terms of establishing whether the effect of an impairment is substantial, the Guidance, paragraphs B2-B17 sets out several factors to be taken into consideration as referred to me by Mr Famutimi. These include the time taken by the person to carry out an activity (para B2) and the way in which he or she carries it out (para B3). A comparison is to be made with the time or manner that might be expected if the person did not have the impairment.

13 Another factor to be taken into account, relevant to the claimant's claim, is 'how far a person can reasonably be expected to modify her behaviour, for example by use of a coping or avoidance strategy, to prevent or reduce the effects of an impairment on normal day-to-day activities. In some instances, a coping or avoidance strategy might alter the effects of the impairment to the extent that they are no longer substantial and the person would no longer meet the definition of disability. In other instances, even with the coping or avoidance strategy, there is still an adverse effect on the carrying out of normal day-to-day activities' — para B7 of the Guidance. The Guidance gives the example of a person who needs to avoid certain substances because of allergies who may find the day-to-day activity of eating substantially affected.

14 The Guidance states that it would not be reasonable to conclude that a person who employed an avoidance strategy was not a disabled person (see para B9). In Goodwin (above) the EAT cautioned against accepting claimant's assertions that they can cope with normal daily activities when in fact they may simply have developed avoidance or coping strategies. Paragraph B10 states that if it is possible a person's ability to manage the effects of an impairment will break down so that effects will sometimes still occur, this possibility must be taken into account when assessing the

effects of the impairment. The Guidance gives the example of someone who has dyslexia and whose coping strategies cease to work when he or she is under stress. This is relevant to the claimant who coping strategies broke down when her partner became ill.

15 Paragraph D22 states that an impairment may not directly prevent someone from carrying out one or more normal day-to-day activities, but it may still have a substantial adverse long-term effect on how he or she carries out those activities. The Guidance is relevant to the claimant and her coping strategies.

16 Mr Famutimi also referred to Igweke vs TSB Banks PLc [2020] IRLR 26, College of Ripon and York v Hobbs [2002] IRLR 185, Aderemy v London and South Eastern Railway Ltd [2013] All ER (D) 201 and Lenard v Southern Derbyshire Chamber of Commerce [2001] IRLR 19.

Conclusion – applying the law to the facts.

17 With reference to the first issue, namely, did the claimant have a disability as defined in section 6 of the Equality Act 2010 at the time of the events the claim is about being January to July 2022 on the balance of probabilities I on the balance of probabilities concluded that she met the legal test and was disabled with the cumulative conditions of anxiety and insomnia, with one condition affecting the other.

18 With reference to the second issue, namely, did the claimant's anxiety and insomnia have a substantial adverse effect on her ability to carry out day-to-day activities, I found on the balance of probabilities that it did having accepted the claimant's evidence as credible that her life was adversely affected ranging from straightforward work requirements such as inputting information on to a computer without making mistakes and so on, though to carrying out household chores and taking part in a social life. It is a well known fact that sleepless nights can lead to a number of problems including mental health (anxiety) and feelings of tiredness that result in incapacity. The medical records are clear; the claimant was affected by insomnia for many years, it was ongoing and unresolved despite attempts by the claimant to self-manage and take prescribed medication, which had other consequences for her.

19 Mr Famutimi submitted that the claimant had experienced insomnia for a period of 7 years and referred to Igweke vs TSB Banks PLC (above), without explaining the relevance of the EAT's decision to the claimant. I did not understand from the claimant's evidence that she was relying on life's events (particularly Mr Famutimi's physical and mental impairments severe anxiety, fibromyalgia, small fibre neuropathy and brain fog as conceded by the respondent to fall under section 6 of the EqA) as the thing which established her disability status. The claimant's position was that she had a long-standing medical condition that was exacerbated by Mr Famutimi's illness. For example, he was unable to help her manage and she in turn had difficulties keeping up with the household chores as described above. I accepted the claimant's evidence as credible that she had pre-existing long-term medical conditions which adversely affected day to day activities exacerbated by her partners condition and they were long-term. As the EAT pointed out in the case of Goodwin (above) the claimant may

be able to perform many activities, and the impairment may still have a substantial adverse effect on other activities, with the result that the claimant meets the statutory definition of disability. Mr Justice Elias in Patterson emphasised that, in assessing an impairment's effect on a claimant's ability to carry out normal day-to-day activities, a tribunal should not compare what the claimant can do with what the average person can do. Rather, the correct comparison is between what the claimant can do and what he or she could do without the impairment applying the statutory definition of more than minor or trivial, and I accepted the claimant's evidence as credible that had not managed her condition in the way described above, and had she not suffered from insomnia her performance at work and the way she was able to carry out normal day-to-day activities would have substantially improved.

20 With reference to the next issue, namely, if not, did the claimant have medical treatment, including medication, or take other measures to treat or correct the impairment, the Tribunal found that she did both in the past as recorded in her medical records, during and in the immediate aftermath of the relevant period when her coping mechanisms broke down. I have taken into account the less than clear evidence concerning the medication prescribed, the across the counter medication taken and advice from homeopathic/natural therapists all which appear to overlap, which is not surprising given the claimant's attempt to not become dependent on mediation, especially the ADHD prescription. Given the lengthy history and the medical prognosis set out within the reports and records, I have inferred that without the medication, treatment and other measures referenced above in the findings of facts (which I do not intend to repeat) the effects on the claimant were substantial and remained so, despite her attempts at self-managing because there were periods when the adverse effects on day-to-day activities were worse than others, for example, due to tiredness resulting from insomnia and stress that in turn resulted in further insomnia when her coping strategies failed. In short, the claimant was unable to sustain a number of activities, such as housework and exercise, over a reasonable period of time. The impairment have had a substantial adverse effect on the claimant's ability to carry out day-to-day activities without the treatment or other measures and so I found on the balance of probabilities.

21 Finally, with reference to the last issue, namely, were the effects of the impairment long-term, I found that they lasted at least 12 months, or were they likely to last at least 12 months and also, they were likely to recur given the factual matrix set out above.

22 In conclusion, the claimant was disabled in accordance with section 6 of the Equality Act 2010 with the mental and physical impairment of anxiety and insomnia during the relevant period January to July 2022. By consent, Mr Famutimi was disabled in accordance with section 6 of the Equality Act 2010 with severe anxiety, fibromyalgia, small fibre neuropathy and brain fog between January and June 2020, the relevant period.

Case Management

23 After the hearing we discussed case management and the orders leading to the final hearing together with the possibility of judicial mediation. If the parties wish to

consider judicial mediation they will write into the Tribunal as soon as possible given the preliminary hearing listed for 23 October 2023 to see if it can be converted to judicial mediation, if possible. If this is not possible, the parties will prepare a draft agreed list of issues for the preliminary hearing. If judicial mediation is possible, the parties will prepare a schedule and counter-schedule of loss, an agreed judicial mediation bundle, position statements and draft COT3 having put ACAS on prior notice and the decision makers will be present at the mediation. The claimant is represented by an experienced employment practitioner, however, if the parties require formal case management orders leading to a judicial mediation they will write in as a matter of urgency having confirmed that both are in agreement that judicial mediation should take place if the Tribunal agree.

9.10.23____________
Employment Judge Shotter

RESERVED JUDGMENT AND REASONS SENT TO THE PARTIES ON

10 October 2023

FOR THE SECRETARY OF THE TRIBUNALS