Case Nos: **1303740/2022**

EMPLOYMENT TRIBUNALS

Between:

Mr G Whyman	**and**	Nuffield Health
Claimant		**Respondent**

Held at: Midlands West

On: Monday 30 October 2023

Before: Employment Judge Faulkner (sitting alone)

Representation

For the Claimant: in person
For the Respondent: Mr P Bownes (Solicitor)

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 was agreed to be 16 September 2020 to 13 April 2022.

2. The Claimant was throughout the relevant period a disabled person as so defined by reason of the impairment of mixed anxiety with depressive disorder with obsessive compulsive disorder tendencies.

REASONS

1. Reasons for the above Judgment were given orally at the conclusion of this Hearing. These written Reasons are provided in response to a request made orally by Mr Bownes.

Hearing

2. This one-day Public Preliminary Hearing was convened by Employment Judge Steward to deal with the following issues:

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

2.2. Questions related to time limits.

2.3. Finalising the issues to be determined at the Final Hearing.

3. In the circumstances rehearsed in detail in Case Management Orders sent to the parties separately, it was agreed that I could not – and should not – deal with questions related to time limits. There was insufficient time to deal with finalising the issues for the Final Hearing, and so a Case Management Hearing has been listed to deal with that, and any related amendment issues.

4. These Reasons therefore deal only with the question of disability.

5. The Respondent provided a bundle of 87 pages, all of which I read. It included the Claimant's impact statement. I heard oral evidence from the Claimant, given in response both to cross-examination by Mr Bownes and a number of questions from me (adopting the inquisitive approach to this issue enjoined by the case law). I also heard very brief evidence, elicited in the same way, from the Claimant's wife. I then heard submissions from both parties.

6. 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.

Issues

7. The Respondent disputed every aspect of the Claimant's case that he was a disabled person under the Act. It was agreed that I should take an expansive view of the Claimant's case (that is, before any amendment issues are decided), so that the relevant period was 16 September 2020, which was the date of the first alleged act of discrimination, to 13 April 2022, the date of the last alleged act. It was agreed that I had to decide:

7.1. Whether, throughout the relevant period or at any point during that period, the Claimant had the impairment on which he relies for the purposes of this Claim – described by him as mixed anxiety with depressive disorder with obsessive compulsive disorder tendencies.

7.2. If so, whether the impairment had an adverse effect on his ability to carry out normal day to day activities.

7.3. If so, whether that effect was substantial.

7.4. If so, whether that effect was long-term.

Facts

8. It is not necessary for me to record any detail of the Claimant's substantive complaints or the background to them. In short, he was employed by the Respondent as Sales and Services Manager, from 4 January 2017 to 13 April 2022, based in Leamington Spa. In his Claim Form submitted on 23 August 2022, he indicated that he complains of unfair dismissal, age discrimination and disability discrimination, and that he was also owed arrears of pay and other payments. At the Hearing before EJ Steward, he confirmed that he was not pursuing any complaint of age discrimination. The Respondent says it dismissed the Claimant because of an irretrievable breakdown in the relationship with his manager.

9. I set out first the medical evidence, then a summary of the Claimant's impact statement, before turning to the Claimant's oral evidence.

10. At page 67 is a letter from Dr J Walter, of the Department of Cardiology, Milton Keynes University Hospital, following a referral of the Claimant on 17 September 2020. It is not really relevant to the issues before me, as it dealt with the Claimant's experience of chest pain over a three-week period. I note only that Dr Walter indicated that the pain may be stress-related and that the Claimant took Citalopram (20 mg) daily.

11. At pages 70 to 72 is the first of two occupational health ("OH") reports commissioned by the Respondent. This one was dated 29 July 2021 and was commissioned, as the report says, because the Claimant was off sick. It recorded that the Claimant had reported:

11.1. Having an anxious and low mood, in relation to work pressures, specifically changes in work volume and long hours.

11.2. Feeling exhausted, tired and lacking in energy.

11.3. Experiencing an increase in palpitations and chest pain, though these had subsided somewhat.

11.4. Being on medication for anxiety and having spoken with his GP about "other talking therapy support".

12. In the opinion of the OH adviser, the Claimant was fit to return to work on a phased and supported basis when his fit note expired on 30 July 2021. She went on to say, "In my opinion the issues in this case are not primarily medical. Graeme states that he is suffering from an acute stress reaction to events at work and my advice is that a resolution would be better achieved by discussion with management, as opposed to intervention from occupational health. An early resolution to the workplace issues will be fundamental in his recovery". She recorded that she had discussed with the Claimant personal coping strategies to prevent perceived stress resulting in ill health. She did not plan any further review.

13. The second OH report is at pages 73 to 75 and was dated 20 January 2022. The reason for the referral was said to be work-related stress and palpitations. The OH Advisor said that the Claimant had reported that:

13.1. Pressure of work had increased over the last two years, impacting on his mental health.

13.2. A breakdown in working relationships more recently had caused symptoms of low mood and affected his sleep.

13.3. He had experienced palpitations and chest pain and, on his return from sickness absence and annual leave, fatigue.

14. The Advisor stated that the Claimant remained fit for work in her opinion, and went on to say, "As the documented absence is reportedly related to stress within the workplace, the cause of the absence is not primarily medical" and that workplace intervention would be fundamental in his recovery. She further stated, "Mr Whyman does have a health condition which is likely to be considered under the disability provision of the Equality Act (2010). However, this is my opinion and not a legal decision".

15. At page 69, there is a letter dated 27 July 2023 (note, this is outside of the relevant period) from the Claimant's GP. It stated, "I confirm that this patient has a diagnosis of mixed anxiety and depressive order with obsessive compulsive disorder tendencies", that the diagnosis was established in March 2012, and that the Claimant had been in receipt of medication and talking therapy for managing it. The GP went on to say that the Claimant finds everyday activities including simple tasks challenging and this takes him longer to accomplish things, that his concentration is affected and he can be easily distracted, and that his symptoms leave him feeling exhausted. The letter added that the Claimant has developed coping strategies including avoiding certain triggers for his mental health.

16. There is a further GP letter, dated 4 October 2023 (and therefore also outside the relevant period) at page 86. It stated that the Claimant had "a longstanding history of anxiety disorder which provokes physical symptoms including palpitations". It further stated that in the GP's opinion the disorder has a substantial and adverse effect on the Claimant's ability to carry out activities of daily living and should be considered as a disability within the Act. The letter added, "This is a chronic disorder for which he continues to be reviewed under our care".

17. The Claimant's impact statement, which is undated, is at page 76. It says that mixed anxiety and depressive disorder, with obsessive-compulsive disorder, was recognised by his GP over 10 years ago. The statement highlights the following:

17.1. He has regular high levels of anxiety, and as anxiety increases so does his OCD.

17.2. When the Claimant carries out an activity or task, he needs to do this in a certain order, or in a certain way. Otherwise, he has to go back and repeat the task, even if it was completed. He needs to check and recheck if he has done something, often

multiple times. He needs to place certain objects in order, or in a pattern, or in a certain place.

17.3. He has many unwanted “OCD thoughts” during the day. He repeats phrases or counts, in order to be able to cope.

17.4. He has sensitivity to certain high-frequency or repetitive noises. He has to stop what he is doing until the noise stops and gets anxious about it restarting.

17.5. If he does not carry out his OCD behaviours, he feels more anxious and stressed and yet at the same time those behaviours distract him from activities. They disrupt his daily routine, such as getting ready for work or starting an activity and can make him late for work and appointments.

17.6. When his anxiety and OCD is high, he avoids certain situations which cause him to feel more anxious. OCD leaves him tired and exhausted.

17.7. Anxiety has physical symptoms, including being unable to relax. When it is very high, he experiences sweating and also has palpitations which make him feel light-headed.

17.8. He manages his anxiety with a combination of medication, therapy and other supportive techniques, but the techniques do not help with depression. Depression makes him feel tired, affects his concentration and makes it difficult to think clearly and make decisions. When depressed he avoids going out and often skips meals. It can last for months.

17.9. He has been taking medication for over 10 years.

18. The Claimant’s oral evidence can be summarised in three parts, namely brief comments on some general issues, the question of the impact of the alleged impairment on his ability to carry out normal daily activities, and the question of medication and other treatments. It is for any witness’s individual conscience whether they give truthful evidence, as no court or tribunal observes the relevant events directly. In this case, I found the Claimant wholly believable, and I was satisfied that he was doing his best to give me an accurate account, including as to the impact of the alleged mental impairment on his normal life.

19. Beginning with the general points, the Claimant confirmed that he was not seen either by Dr Walter or by OH; all of those appointments took place by telephone. The OH appointments each lasted around thirty minutes. He accepted that neither OH report referred to OCD, but said that OCD is a symptom of anxiety, which OH did mention. In any event, the context of his referrals to OH was that the work-related events which the reports referred to had made his mental health worse. At least as far as the Claimant was concerned, the purpose of the referrals to OH was to secure management intervention to reduce the pressure of those workplace events.

20. As to the impact of the alleged impairment on daily life, the Claimant confirmed that it has been more or less as described below since 2012, including during the relevant period, and up to the date of this Hearing. I made clear that the alleged impact after the relevant period, including at the date of this Hearing, was essentially to be put out of account in my assessment, but given that he said there has been little variation over the years and for ease of description I have set out the Claimant's evidence in the present tense. I also directed the Claimant to describe to me his account of normal day to day activities without serious external pressures such as the increase in workload and working hours he says he encountered with the Respondent. What is set out in the following paragraphs summarises his evidence given with that in mind. He said that when serious external pressures arise, the impact on daily life described below is more intense, to the point where his coping mechanisms no longer function effectively.

21. The Claimant says he experiences tiredness several days each week, essentially for two reasons. The first is what he described as excessive thinking and the need to control that excessive thinking with his coping mechanisms – other thoughts, repetitive phrases, counting, tapping. The second is having to ensure everything is orderly, for example at home. If any task, even making a cup of tea, is not done in the right order, he has to go back to the beginning and start over again. The result of this is that he wakes up more tired than when he went to bed.

22. He is late for 95% of appointments, at any time of day, though it is worse in the morning. This is because to leave the house, he has to go to a certain room, take a sip of water, turn off a certain light switch, put his bag in the car in a certain way, recheck that the door is locked, ensure all curtains in the house are open and so on. The Claimant says these are just examples, and that he has hundreds of OCD behaviours. He then gets anxious because he is running late, which then leads to more OCD behaviour and so it self-perpetuates.

23. He can only concentrate on one thing at a time. If his wife is making breakfast, he has to wait until she has finished before they can have a conversation even of a casual nature. Further, he could not have any conversation without first for example putting the toaster back in the right place and ensuring the washing machine is not on. As another example, when he hears the daily post arrive, he is distracted from the task at hand because he has to see what it is. If something troubles him, such as the noise of a reversing vehicle, he has to remove himself from the situation but even when it subsides, he is then anxious about whether and when it will restart, and ends up focusing on that rather than concentrating on the task before him.

24. There are other issues in relation to noise. At home and elsewhere he has to leave the room because of the sound of certain people eating or drinking or the sound of cutlery. He also avoids going anywhere he knows there is building work going on, and if this is outside his home, he gets anxious.

25. A combination of the above issues affects his social life. He often cancels things, once or twice a week, because of tiredness or the need to do things repeatedly at home.

26. He has palpitations several times a month. He goes lightheaded and will have to stop writing an email or sweeping up, for example, for 30 seconds or a few minutes.

27. As to medication, he has been on a daily dosage of 20 or 30 mg Citalopram since 2012. He has tried to come off it. When I asked him to explain to me what that was like, he was reluctant to say, stating that it is a coping mechanism not to speak about it. He was only willing to say that at those times he has had "a tendency to do certain things he would not want to do". He then needs support.

28. He has had various talking therapies since 2012 on and off. He says without them, because his coping strategies do not help with depression, that is what he would have sunk into, resulting in him being exhausted and having a lack of interest in anything.

29. Mrs Whyman added that there was another side to the lateness issue, in other words at the other end of the day. The Claimant is currently off work due to his health, but when at work would come home very late on a daily basis because of his need to do everything obsessively at work as well as at home. He would not reply to messages she sent him when at work which she believes was because of his need to get a task done before he could do so. She described him as very introverted when suffering and full of character when his tasks are done.

Law

30. 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*".

31. 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*".

32. 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 …*".

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

34. 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.

35. **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.

36. Mr Bownes briefly referred to **Herry v Dudley Metropolitan Borough Council [2017] ICR 610**, specifically the EAT's comments 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*". In other words, there is a difference, as the EAT indicated, between an adverse reaction to life events and the impact of a mental impairment on a person's ability to carry out normal daily activities, as rehearsed in **J v DLA Piper UK LLP [2010] ICR 1052**.

37. 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:

37.1. 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.

37.2. 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.

37.3. 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.

37.4. 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.

38. 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.

39. 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*".

40. 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".

41. 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

42. I begin my conclusions with a few general observations:

42.1. 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.

42.2. The burden was on the Claimant to establish that he was a disabled person, including establishing that the impairment(s) had an adverse effect on his ability to carry out normal day-to-day activities.

42.3. The multiple effects of an impairment and/or the combined effects of various impairments if there is more than one, are important to consider in answering the adverse effects question and the question of whether they are substantial.

42.4. The case law makes clear (see specifically **J v DLA Piper**) that particularly with mental impairments, it is perfectly acceptable to begin with the questions of adverse effect and whether that was substantial and come back to question of impairment, though of course that question cannot be ignored. That was my approach.

43. I addressed first therefore whether there was an adverse effect on the Claimant's ability to carry out normal daily activities. I make the following general observations in relation to that before turning to the specifics:

43.1. Mr Bownes sensibly did not contest that what the Claimant addressed in his oral evidence and impact statement related to normal day to day activities. I need say nothing further in detail about that, though see below.

43.2. An effect on daily activities does not have to be constant in order to be adverse. Indeed, the legislation, case law and Guidance explicitly recognise that it can be variable and still be adverse, including where it is likely to recur. Mrs Whyman's evidence in particular suggests that there are some variations in the impact on the Claimant's normal activities, though it must be said that what he described was a frequent, if not daily experience in all, or most, respects.

43.3. The focus needs to be on what the Claimant cannot do or can only do with difficulty.

43.4. It may also be relevant to consider whether what he describes is no more than the differences one would expect to see in that respect between people in the population at large.

44. The Claimant essentially described the impact of the alleged mental impairment in four main ways. The first was having to do certain tasks in a certain order and in a particular way, leading to regular lateness. Arriving somewhere on time is a normal feature of ordinary daily life and what the Claimant experiences clearly impacts that. As I have said, he gets anxious because he is running late, which then leads to more OCD behaviour, which further increases his lateness, in turn further increasing his anxiety and so on. He is thus late for 95% of appointments. That is on any measure an adverse effect.

45. Secondly, tiredness is an almost daily experience for the Claimant. He wakes up more tired than when he went to bed. That impacts on his ability to get moving in the morning, which combined with his need to combat anxious thoughts means that he cannot complete his morning routine in same way or as effectively as might ordinarily be expected of others. He also experiences significant tiredness when he has a bout of depression.

46. Thirdly, there is what might be called a social impact. Most notable is the impact on his ability to remain at a family meal because of sensitivity to noise leading to anxious thoughts and feelings, and his inability to converse even with those close to him, even on a casual basis, unless they are not doing anything else and all other things are in order and noises reduced or removed. Mixing at mealtimes with others and casual conversation with loved ones are plainly daily activities and the Claimant is very obviously adversely affected in his ability to perform them. The Claimant also faces limitations on where he feels able to go because of fear of certain external noises, which others might be expected to take in their stride.

47. Fourthly there is an impact on the Claimant's concentration, which he says is a feature both of the depressive element of the alleged impairment and of the OCD symptoms of anxiety. I have already referred to the social impact, but the Claimant's inability to hold a conversation when something as routine as making breakfast is taking place also evidences an adverse impact, in this case on concentration. It is background noise and activity which makes this difficult or impossible for him.

48. The second question is whether the adverse impact is substantial, namely more than minor or trivial, taking the impacts I have just described overall, rather than assessing each impact in isolation from the others. I tend to think that, whilst no doubt unnerving and unpleasant, the Claimant having his concentration interrupted for a couple of minutes by palpitations is not substantial, but the combination of everything else I have referred to clearly describes a more than minor or trivial impact on the Claimant's ability to conduct an ordinary routine, to be punctual, to enjoy engagement in routine family and social life, and to focus on such engagements or any task at hand.

49. I acknowledge that he has coping mechanisms, which clearly help combat anxiety and OCD symptoms, but in my judgment, I do not have to consider whether they are

mechanisms the Claimant could reasonably be expected to adopt to alleviate the overall substantial adverse effect, because as his testimony makes clear, they do not make it less than substantial, they just stop it becoming even worse. Indeed, the coping mechanisms contribute to his tiredness and have a social impact for the Claimant, such as when he removes himself from mealtimes.

50. As to what the position would be if medication and other treatment had not been in place, there was no expert medical evidence before me on this question and I was conscious of the caution highlighted in **Morris**. That did not alter my conclusion however for two reasons. First, the question of "deduced effects" does not arise, because I have found that even with the medication and other treatment in place, there is (and was at the relevant times) a more than minor or trivial effect on the Claimant's ability to carry out normal day to day activities. Secondly, this Claimant has tried life without his medication, and he was barely able to verbalise what the impact was for him. I am in no doubt that it would be markedly beyond minor or trivial in the absence of medication and the various talking therapies he has benefitted from.

51. As to whether the substantial adverse effect was long-term, the Claimant says that it has been an essentially consistent situation since 2012. That is borne out by the GP correspondence which dates the diagnosis of his condition back to the same date and highlights some of the impacts I have referred to. The combination and consistency of that evidence leads me to conclude that the substantial adverse effect the Claimant describes has persisted since then and therefore covered the whole of the relevant period.

52. That leaves the impairment question. Mr Bownes submitted that the focus of the Claimant's written and oral evidence was OCD, and that this is not mentioned in the medical evidence. I took that submission to be making two points: first that the Claimant's evidence was not supported by the medical evidence and secondly that whatever he has experienced was not due to the impairment he relies on. Mr Bownes emphasised in particular the two OH reports, both of which were in the relevant period and neither of which mentioned OCD. I was satisfied that this is no way undermined the Claimant's case for the following reasons:

52.1. As highlighted in my findings of fact, the OH referrals were made for a particular reason, namely that the Claimant was off sick because of his reaction to work-related issues. The second report makes that particularly clear, stating (my emphasis), "the cause of the absence is not primarily medical". Very obviously, given that the referrals were made by the Respondent, the purpose of the Claimant's meetings with OH was to discuss the causes of his absence (these are set out in the reports – demands of work, for example) and to consider how he might make a successful return. Further, as the Claimant says, they were thirty-minute appointments. Given that limitation and the focus of the referrals and conversations, I find it entirely unsurprising that neither OH report referred to OCD. Their purpose was not to provide a general assessment of the Claimant's health, mental or otherwise, but to tackle a specific issue. The same is true for the cardiologist report in 2020. Given the specialist's remit and expertise, it is again wholly unsurprising that OCD was not referred to.

52.2. As the Claimant also says, he did discuss anxiety with the OH Advisors as their reports show, and OCD was a symptom of that.

52.3. The Claimant could have asked that OCD be mentioned when reviewing the reports before they were shown to the Respondent, but as he said in evidence his focus was on getting management intervention.

52.4. The OH Advisor said in January 2022 that the Claimant had a disability within the meaning of the Act. That is in no sense binding on me, but I note that this statement can only have been made in relation to the Claimant's mental health as that was the focus of the report.

52.5. Between them, the reports refer to tiredness, exhaustion and lack of energy, and palpitations, which is consistent with the Claimant's evidence about adverse effects, or putting it another way, even though it does not reflect the totality of the Claimant's evidence it is not inconsistent with it.

52.6. The July 2021 report referred also to the Claimant's medication and talking therapy for anxiety, again consistent with his oral evidence.

53. Mr Bownes also submitted that the only mention of OCD in the medical records is in the GP letter of 27 July 2023 and that this fell outside the relevant period. As to that:

53.1. The GP gave a specific diagnosis, which is precisely what the Claimant relies on, stating, "I confirm that this patient has a diagnosis of mixed anxiety and depressive order with obsessive compulsive disorder tendencies".

53.2. Crucially, they say that the diagnosis was established at a very specific point, namely in March 2012.

53.3. This is confirmed, albeit without mention of OCD, by the more recent GP letter, which describes a "longstanding history of anxiety disorder which provokes physical symptoms including palpitations" and refers to the disorder as chronic.

53.4. Both letters are indeed outside the relevant period but they provide evidence which it is perfectly in order for me to take into account in that they explicitly address the mental disorder the Claimant relies on by reference to his long history. This is very obviously information that would have been taken from the Claimant's medical records.

53.5. I note also the paragraph in the July 2023 letter supporting the Claimant's description of the impact on his normal life, specifically related to concentration and tiredness.

54. As to **Herry**, Mr Bownes' point was that what the Claimant describes resulted from a life event, namely what the Claimant felt were undue work pressures and not an underlying mental impairment. I disagree for the following reasons:

54.1. Both OH reports said that "the issue" was not primarily medical and described the Claimant as suffering an acute stress reaction to work events. I repeat what is said above however about the context in which the reports were written – "the issue" was the Claimant's absence due (he says) to his experiences at work, and the purpose of the referrals to OH was to address that.

54.2. Unlike in **Herry**, both what the Claimant has told me and the letters from the GP surgery provide evidence of an underlying mental impairment and the daily effects of that.

54.3. As the Claimant put it, work events (in his view) made worse the adverse effects on daily life he has described. That does not diminish the effects on his daily life in what might be called normal circumstances, that is when he does not feel any extreme external pressures. It is the worsening effect that OH commented on, not the underlying condition.

55. The Claimant's evidence was very clear, namely that his OCD is a symptom of his anxiety disorder. He is unable to separate the two. He also described, in his impact statement and briefly in his oral evidence, the impact of depression, as I have set out above.

56. In short, there may be relatively limited medical records, but there is no inconsistency between them and the evidence given by the Claimant, for the reasons I have set out. In my judgment, the best evidence of the impairment creating the long-term substantial adverse effect is what is set out in the GP letter describing the diagnosis made in 2012. Accordingly, whether what is there described is best assessed as a combination of impairments or, as seems to me more accurately, a single impairment, I am satisfied that they or it led to (and lead(s) to) what the Claimant has described.

57. It is well-known that some disabilities are not seen by all. It does not weigh against the Claimant's case therefore that he told me some of his friends may not know he has the disability. It is also well-known that disabled people can work effectively, in very demanding roles. The fact that the Claimant appears to have been able to do that does not weigh against him either. He was at the relevant times a disabled person under the Act by reason of mixed anxiety and depressive disorder with OCD tendencies.

58. Of course, that conclusion does not mean the Respondent knew or ought to have known that he was a disabled person at the points at which the Claimant says he was discriminated against in any way contrary to the Act. It also does not mean that he was in fact discriminated against. Those are matters to be determined at the Final Hearing.

Employment Judge Faulkner
6 November 2023

Note

All judgments and written reasons for the judgments (if provided) are published, in full, online at www.gov.uk/employment-Tribunal-decisions shortly after a copy has been sent to the parties in a case.