EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: 4103525/2023

Held in Edinburgh by Cloud Video Platform (CVP) on 21 March 2024

Employment Judge L Murphy

Mr M Rafiq	**Claimant** **Represented by:** **Mr G Bathgate - Solicitor**
The City of Edinburgh Council	**Respondent** **Represented by:** **Ms F Ross - Solicitor**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

The judgment of the Tribunal is that the claimant was a disabled person for the purposes of section 6 of the Equality Act 2010 (EA 2010) at the material times, namely between July 2022 and June 2023 inclusive.

A Preliminary Hearing on case management shall be listed to discuss how the proceedings should progress.

REASONS

Introduction

1. The claimant brings complaints under sections 13, 15, and 20 of the Equality Act 2010 ("EA") under claim number 4103525/2023. He avers he was, at the material times, a disabled person for the purposes of EA and the respondent disputes this. His case has previously been conjoined with the claim brought under case number 4103527/2023 by his colleague, Mr Singh, against the respondent. A substantive preliminary hearing (PH) took place on 21 March 2024 by CVP. The purpose of the PH was for the Tribunal to decide was whether the claimants were disabled persons within the meaning of section 6 of EA during the material period, namely the period from July 2022 to 30 June 2023.

2. Specifically, the issues for determination in relation to C1 are (with reference to the specified period):

   (i) Did he have a physical or mental impairment?

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

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

   (iv) Would the impairment have a had a substantial adverse effect on his ability to carry out normal day to day activities without the treatment or other measures?

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

      i. At the material times, had they lasted at least 12 months, or were they likely to last at least 12 months?

      ii. If not, were they likely to recur?

3. So far as relevant to the PH, C1 makes the following complaints. He complains about R's failure to progress a disciplinary procedure and grievance process. He complains this omission amounted to direct disability discrimination and that it was unfavourable treatment because of something arising in consequence of his disability. C1 further complains that R failed to make reasonable adjustments in relation to the processes. C1 says that the discrimination began from July 2022 onwards. He lodged his ET1 on 30 June 2023. R resists C1's discrimination complaints both on the basis that R says he was not disabled at the material times and, in any event, on the merits.

4. I heard evidence from each of the claimants. C2 gave evidence first and C1 was not present while C2 gave evidence by agreement between the parties. A joint inventory of productions running to 277 pages (for both cases) was referred to during the evidence. I am grateful to both Ms Ross and Mr Bathgate for their assistance to the Tribunal with the case.

5. I have prepared separate judgments for each claimant. This does not affect the continuing Order to conjoin the claims. Throughout this Judgment, the claimant, Mr Rafiq, is referred to as C1 and the respondent is referred to as R. Insofar as Mr Singh is mentioned, he is referred to as C2.

Findings in Fact

6. After careful consideration of the evidence, the following facts, and any further facts found in the 'Discussion and decision' section, were found to be proved on the balance of probabilities (or were agreed by the parties).

7. R has employed C1 as a Housing Property Surveyor since 29 January 2018 and he remained in R's employment at the date of the PH.

8. He went off sick on 25 June 2019 and has remained absent since.

Symptoms over the period from April 2019 to June 2023

9. The following findings are focused on the period ending 30 June 2023 as C1's claim is not concerned with subsequent periods. During the period from around April 2019 until June 2023, C1 experienced a number of symptoms which affected him in his daily life. He experienced anxiety and at times feelings of panic. The anxiety affected his social life. He previously had been comfortable with meeting new people and striking up conversations but in the period mentioned he experienced more difficulty with social interactions. This made him more withdrawn. He felt particular anxiety about the possibility of bumping into his colleagues in R's employment as he lives locally in the city of Edinburgh and has a good many colleagues employed locally by R. He became and remained reluctant to go out and, when he did, he was inclined to take practical steps like trying to dress in a way that might make him less recognisable including wearing a scarf and hat at times or (during the period of the pandemic, a Covid mask).

10. C1's eating habits also changed over this period and his weight fluctuated.

11. C1 had problems with a disrupted sleeping pattern from around April 2019 and thereafter throughout the period to June 2023. He experienced wakefulness during the night often on two or three occasions.

12. C1 experienced effects on his concentration. Where he previously used to be competent at managing things in an effective way, he found it difficult to concentrate in order to do tasks he had previously enjoyed like cooking. He also found it harder to take in and process information when reading. It is not the case that he could not and did not read at all across the whole period. There were periods of some improvement in his mood and his concentration affecting his facility for reading, for instance, in February 2021 and in early December 2021. In December 2021, C1 was taking Sertraline. On the whole, though, across the period from April 19 to June 2023, C1 struggled more than he did in the past with reading day to day documents such as newspapers.

13. During much of this period, C1 was taking antidepressant medication called Sertraline. For some spells in the period from April 2019 to June 2023, C1 came off the Sertraline medication. During these periods, C1 noticed a deterioration in his health. He felt more on edge. On each occasion he referred to his GP practice to resume taking the medication which was provided to him on repeat prescription. His reasons for coming of the Sertraline from time to time related to a concern to see if certain symptoms were side effects of the medication which might be alleviated by coming off it and also, at times, the difficulties he experienced in obtaining GP appointment which prompted him to consider whether he could try managing without. He did not decide to come off the Sertraline for spells because the symptoms and effects described above had completely resolved.

14. C1 also tried using online tools and apps recommended by his doctor to improve his mental health. He tried discussing his symptoms with family members and his local religious leader to try to alleviate these. He also tried taking more exercise at times, such as in around November / December 2021.

15. Notwithstanding the taking of Sertraline and the other measures C1 took to try to improve his health, C1 experienced the symptoms and effects as described in the foregoing paragraphs throughout the period from April 2019 to June 2023. Though there were some periods in that time when

some effects were more alleviated than during others, improvements did not endure for long spells and the symptoms and effects recurred.

2019: Timeline of key work related events and of recorded medical interventions

16. On or about 25 April 2019, C1 lodged a grievance with R in which he alleged bullying and harassment at the instance of colleagues.

17. On 29 April 2019, C1 had a lengthy consultation with his GP. At this appointment, the notes record he discussed various issues including feeling stressed out which he said he felt was related to work. He said he felt anxious and was often awake, thinking about work. He asked for sleeping pills. Throughout the period from April 2019 to June 2023, C1 had various discussions with a variety of different doctors at the GP surgery where he is a registered patient. References in the Judgment to 'his GP' do not necessarily refer to the same individual but simply to a doctor working out of the practice.

18. C1 had not previously experienced stress or anxiety symptoms of such a magnitude as to prompt him to seek a consultation with his GP. C1's symptoms which were the subject matter of his discussion with the GP on 29 April 2019 were substantially prompted by concerns about work.

19. In or around May / June 2019, R told C1 it was investigating allegations of misconduct by C1 concerning the alleged misuse of the clocking in machine, the misuse of parking facilities and C1's alleged absence from his workplace during working hours.

20. On 22 May 2019, C1 had a further consultation with his GP at which the notes record he reported feeling extremely tired and lethargic.

21. On 14 June 2019, C1 had a GP consultation. The GP's notes record he reported feeling very stressed out and described low mood and anxiety which he felt had been building over the past one to two years and felt it was now worse. He reported feeling on edge, having poor sleep, and waking overnight with hot and cold sweats. He reported stress from his work with R. His GP recorded in the notes a General Anxiety Disorder (GAD) score of 21 and noted "appears quite anxious". The doctor recorded in the note of the consultation an "*Anxiety/depression Plan; self-refer for*

counselling, start Sertraline, revie win [sic; review within] *practice next week*". The doctor prescribed C2 Sertraline at this appointment which is an SSRI antidepressant. On this date, he was prescribed 28 x 50mg tablets with the instruction to take one per day.

22. On 21 June 2019, C1 had a further long consultation with his GP. The notes record he reported considerable anxiety and agitation related to problems at work. They record he reported feeling he did not wish to pursue counselling through R's OH support and the doctor gave him details of other counselling services he could contact. The doctor recorded "Med 3 [i.e. fit note] for one month review before then". His GP signed C off sick at this appointment. C1 went off sick on 25 June 2019.

23. On 10 July 2019, C1 had a further GP consultation. The notes record he reported ongoing work stress. He referred to his anxiety levels being increased due to ongoing correspondence with R and to feeling 'panicky'. He also reported that he was not sleeping and was losing hair and weight. On 12 July 2019, C1 had a further consultation when he reported issues of loss of libido. His GP observed in the notes that this could be related to the medications but also to stress and anxiety. C1 said he would self-refer for counselling. He was issued 28 x 100mg tablets of Sertraline and instructed to take these up to twice daily for agitation. The doctor also prescribed 60 x 25 mg Quetiapine tablets (an antipsychotic drug) "*for the paranoia / anxiety*".

24. On 30 August 2019, C1 had a further GP consultation at which his work situation was discussed. His GP's notes recorded that he "*seems a bit calmer*" but also that "*things at work have not really progressed at all so unable to think about him going back*". C1's prescription for 100mg Sertraline tablets was renewed and he was supplied with 56 tablets with the instruction to take one per day.

25. On 27 September 2019, C1 had another GP consultation when it is recorded that he reported that the Sertraline was helping but wondered if an increased dose would be more helpful. His GP referred to side effects in his notes including erectile dysfunction but also recorded "*this may also be due to underlying anxiety*". The GP's notes recorded that C1 remained

stressed and anxious. They also recorded: "*Advised that medication etc is not likely to be fully effective when ongoing stressors from work situation*." Following this consultation, C1 was prescribed a further 56 x 50 mg Sertraline tablets. His GP recorded he was happy to try increasing C1's prescription of Sertraline initially to 150mg and then to 200mg.

26. On 1 November 2019, during a telephone consultation, C1 asked his GP for his slickline to be extended and again asked about increasing his Sertraline dose. The GP agreed to increase his dose to 200mg and indicated that they would review it each time C1 gets a script. His GP notes recorded: "*work issues are moving very slowly except now on half pay which is causing a lot of extra stress*." With regard to medication, the doctor recorded, "*review when next line due have done til end November*". C1 was issued with 112 x 100 mg Sertraline tablets.

27. On 4 December 2019, C1 contacted his GP surgery by telephone to ask for more Sertraline. The doctor's notes recorded: "*ongoing stress at work mood a bit better*". She declined to prescribe more tablets at that time on the basis that C1 should have enough at home, having been prescribed two months' worth on the last occasion (on 1 November 2019). C1 agreed to check his stock of tablets.

2020

28. On 14 January 2020, C1 consulted his GP on a telephone appointment. The notes record C1 reported feeling a bit better. He asked for a 2-week line rather than 4 weeks.

29. On 14 February 2020, C1 had a telephone consultation with his GP at which the notes record they discussed that the work issues were ongoing. The note records "*Needs meds 3* [fit note] *and that he needs his meds until 01/03 and then will see what has happened by then*".

30. At some stage during his absence towards the end of 2019 or in early 2020 (not later than February 2020), C1 made certain complaints to Safecall, an external organization which R engages to provide a whistleblowing hotline. C1 says these amounted to qualifying disclosures for the purposes of the

whistleblowing legislation. These concerned practices in R's Building Services Department in which C1 and C2 worked.

31. On 27 March 2020, C1 had a telephone conversation with his GP. The note records that nothing much was happening about progressing the work issues because of the Covid 19 shutdown. It records that his GP agreed to extend C1's sick line. The doctor also prescribed more Sertraline (112 x 100mg tablets).

32. On 1 May 2020, C1 was prescribed 112 x 100 mg Sertraline tablets to be taken 2 per day.

33. On 11 June 2020, C1 experienced a panic attack. C1 was on his way to a face-to-face meeting with R. He experienced sweating, nausea, palpitations and a racing heart. He felt on edge and confused. He had never experienced an episode of the sort before.

34. On 12 June 2020, C1 called his GP about the panic attack. He was prescribed 14 x 2 mg diazepam tablets and instructed to take hourly, if required, for panic. This was not a daily medication; C1 was told it was to be taken only as required. C1 was not prescribed diazepam on any further occasions.

35. On 21 August 2020, C1 had telephone contact with his GP at which the notes record he reported that he had attended an OH assessment for R and advised he was not fit for work until the issues were sorted out. The GP notes record that he was told to continue taking his medication.

36. On 11 December 2020, C1 had a telephone appointment with his GP. The GP notes record that "*sick line ran out a while back. Is a whistleblower, stress and anxiety provoking*." The notes also record that C1 had stopped taking his Sertraline a few months previously as he was having difficulty getting an appointment and thought he would try without. However, they record that C1 wished to restart as he felt that medication had helped. The doctor agreed to put the Sertraline prescription on repeat but advised C1 to take 100mg only per day for the first couple of weeks before increasing to the original 200 mg dose. His GP prescribed one pack of 112 x 100 mg tablets to be taken twice a day.

2021

37. On 9 February 2021, C1 had a telephone appointment with his GP. The GP notes record that he advised that nothing was really progressing workwise and he had been told it was on hold "*until things back to normal*". (This was a reference to the Covid 19 restrictions). The note also records that C1 "*will need a sick line for some time still*" and that he was "*managing to keep busy / occupy himself at home, been reading more. Mood ok*".

38. On 20 April 2021, C1 had telephone contact with his GP. He asked for his sick line to be extended.

39. In the period between 11 December 2020 and 4 May 2021, C1 did not take Sertraline tablets continuously and consistently. His supply as provided on 11 December would only last 56 days if taken in accordance with the instruction to take two per day (i.e. until 5 February 2021). C1 attempted periods including some period between 11 December 2020 and 4 May 2021 to come off the Sertraline. He wished to identify whether some of the physical effects he was experiencing were side effects of the medication and to see if this would improve if he stopped taking it. He did not feel that any improvement during these periods was sustained, however. He found that he began to feel on edge in the periods without the medication and asked to be put back on it.

40. On the following dates, C1 was issued with a repeat prescription of Sertraline (each time in packs of 112 x 100mg tablets). On each of these occasions, there was no GP consultation and the medication was issued as a repeat prescription:

    (i) 4 May 2021 (2 packs);

    (ii) 21 June 2021 (1 x pack);

    (iii) 18 August 2021 (1 x pack).

41. On 20 August 2021, C1 had a telephone consultation with his GP. He asked for a further sick line which was overdue. The GP notes record that there was an ongoing enquiry at work which remained anxiety provoking. The notes record that C1 and his doctor discussed how realistic it was for

him to return to work in the same job. The notes record that his GP advised to continue on the medication meantime.

42. On 14 September 2021, C1 was issued with a repeat prescription of Sertraline (2 packs of 112 x 100mg tablets). This was issued without a contemporaneous GP appointment on repeat, the most recent consultation having taken place on 20 August 2021.

43. On 2 November 2021, C1 had a telephone appointment with his GP during which he reported feeling tired, low and lethargic.

44. On 10 November 2021, C1 was issued with a repeat prescription of Sertraline (3 packs x 112 x 100mg tablets). This was issued without a contemporaneous appointment, on repeat.

45. In the period between 10 November 2021 and 9 August 2022, C1 did not take Sertraline tablets continuously and consistently. His supply as provided on 10 November would only last 168 days if taken in accordance with the instruction to take two per day (i.e. until around 27 April 2022). During some period between 10 November 2021 and 9 August 2022, C1 had some further time off the Sertraline. He wished to identify whether some of the physical effects he was experiencing were side effects of the medication and to see if this would improve if he stopped taking it. He did not feel that any improvement during these periods was sustained in the longer term, however. He began to feel on edge without the medication and latterly asked to be put back on it in August 2022.

46. On 3 December 2021, C1 had a telephone appointment with his GP. The GP's notes record that they discussed the results of recent blood tests but also C1's work situation. The notes record " …*he is off work long term, keeping busy with exercise and reading* …"

2022

47. On 8 March 2022, C1 had a telephone appointment with his GP. The notes record that they discussed C1's work situation and the medication was extended.

48. On the following dates, C1 was issued with a prescription of Sertraline (each time, 112 x 100mg tablets). On each of these occasions, there was

no contemporaneous GP consultation at which his symptoms were discussed. The medication was issued as a repeat prescription:

(i) 9 August 2022;

(ii) 21 November 2022; and

(iii) 22 November 2022.

Events up to end June 2023

49. On 13 January 2023, C1 had a consultation with his GP. The notes record that he advised his sick line had run out in May though he had not realized this.

50. On the following dates, C1 was issued with a prescription of Sertraline (each time, 112 x 100mg tablets). On each of these occasions, there was no contemporaneous GP consultation at which his symptoms were discussed. The medication was issued as a repeat prescription:

(i) 6 February 2023;

(ii) 3 March 2023;

(iii) 14 April 2023;

(iv) 6 June 2023

51. On 14 April 2023, a duty doctor reviewed C1's notes and recorded "*Request to RA* [shorthand for "renew absence"] *and print Sertraline. Not reviewed since 2020 as far as I can see*." In fact, the notes record there had been reviews with the GP when symptoms were discussed and medication was extended at least on 20 August 2021 and 8 March 2022 since he restarted the Sertraline medication on 11 December 2020.

52. On 6 June 2023, C1 had a telephone appointment with his GP at which he asked for a sick note. The notes record a Sertraline review was undertaken and it was recorded he was to remain on this.

Observations on the evidence

53. Mr Bathgate submission invited the Tribunal to accept the evidence of C1 as being reliable and credible.

54. Ms Ross referred to remarkable similarities between the processes which were the subject of the claims of C1 and C2 as well as similar similarities between their respective consultations with their doctors. Additionally, she suggested there were remarkable similarities between their evidence to the PH.

55. Ms Ross said that C1 had exaggerated the effects of stress at best, and at worst had not been honest. She said there was little support in the medical records for the effects C1 described. She pointed out that C1 said that he was unable to read without difficulty but there were references in the medical records to him "keeping busy reading". In Ms Ross's submission, C1's explanation for the discrepancy was not credible. She also referred to evidence that he had difficulty travelling in the city centre and holding conversations and noted that nothing in the medical records recorded that there had been consultation with his doctor on these complaints. With regard to his sleeping problems, she observed that there were only three references over a four year period, and none since 2019. She said that he had described periodic panic attacks but that they were only referred to in the medical records in 2020.

56. Ms Ross said that C1's suggestion that his were normal symptoms which didn't need to be reported did not ring true. She suggested that if he had told his GP that he was finding it difficult to leave home that would have been recorded and his GP would have wanted to explore other treatment options and check in with him as opposed to simply extending fit notes.

57. Ms Ross also argued that neither C1 nor C2 was honest with their doctor about the cause of their stress at work. She observed that they only referred to whistleblowing allegations that they had raised and not to the conduct allegations they faced. In those circumstances, she argued it was difficult to see how his GP could give an informed view on C1's condition. She asked the tribunal to treat C1's evidence with caution.

58. There were indeed similarities in the timelines of consultations as well as an overlap of symptoms. I did not conclude that these similarites were such as to undermine the credibility of C1's account (or C2's). I was not persuaded that they evidenced some kind of collusion or complicity

between C1 and C2 about the decision to seek advice from their respective GPs or their reporting of symptoms to their respective medical professionals, if such was the suggestion. It did not seem to me to be inherently improbable that two individuals who are work colleagues might experience similar symptoms triggered initially by work stressors across similar timelines. There was no expert medical evidence before me to suggest that such an overlap in symptoms of the kind reported as between two patients was improbable or even uncommon such that their accounts should be treated with caution by dint of their similarites.

59. I was not persuaded that C1 had either exaggerated his symptoms or been dishonest with the Tribunal. The support put forward for this submission was primarily the perceived discrepancies with the GP notes or an absence of reference (or of repeated, periodic reference) in those notes to certain symptoms or effects.

60. I do not find that the GP notes are inconsistent or irreconcilable with C1's account. Firstly, I accept C1s proposition that the GP notes do not amount to a full and verbatim account of all that was discussed during any given 10 or 15 minute appointment. It is plain from the notes produced that they are a brief summary of the discussion reduced to a few lines, often just two or three. I accept, therefore, on the balance of probabilities, that there were occasions when not all symptoms which were discussed at consultations were specifically recorded or recorded in any depth.

61. I also accept C1's evidence that there were times when he did not seek an appointment for his symptoms, but that this did not mean they were not ongoing. There was evidence in the GP notes of frequent occasions when texts were sent to C1 as a patient to advise that due to staff shortages, the surgery was dealing only with medical emergencies. There was evidence that difficulties with obtaining an appointment prompted C1 on at least one occasion to try coming off his antidepressant medication (before it was prescribed on repeat).

62. Although the notes showed gaps in appointments when discussion of C1's stress / anxiety symptoms was recorded, during some such periods, C1 was being prescribed and taking Sertraline on a repeat prescription basis.

63. I accepted C1's his evidence that he resigned himself, for example, to poor and interrupted sleep without repeatedly reporting the symptom to the doctor and asking to try different treatments. I likewise accepted his evidence that he came to accept as 'normal' his reluctance to go out and about and engage in social interactions and tried self-management of this rather than repeatedly discussing it with his doctor. As he noted in his evidence, when things got too much and he had extreme symptoms in June 2020, he did discuss the panic attack with his doctor. I am not persuaded, on the evidence before me in this case, that C1's failure to raise repeatedly thereafter the effect on his socialisation with a doctor, means that such effects had ceased or substantially diminished, or that they never existed.

64. I do not make detailed findings on the evidence before me about what level of detail C1 gave to the various doctors he spoke to about his work situation. The evidence before me on the point was sparse. C1 was asked in cross examination about whether he discussed the disciplinary allegations and said he wasn't sure whether he discussed the detail of these or not. I do not find it necessary to make a finding in fact on this point because I am not persuaded it assists me in making a finding on the issues I require to decide.

65. Even assuming it were a fact that C1 was unforthcoming with his medical advisors about the disciplinary allegations he faced, I am not persuaded that this would weaken the credibility of his evidence to the Tribunal about the health effects he was experiencing. C1 was seeking medical advice from his doctor, not advice on his employment position. It is unsurprising that his account of the dispute would not be the main focus of the discussions with his medical advisors or that the medical advisors might be unlikely to prioritise narrating this background when writing up their notes. It is also unsurprising that C1's account of the work situation to a third party (his doctor) might differ from how R would frame it. There was no evidence before me to support a finding that C1 had been deliberately dishonest with his medical advisors such as to cast a meaningful concern over his credibility.

66. C1's fit notes submitted to R were not produced by either party. Ms Ross put to C1 that they all said work-related stress and did not refer to anxiety. C1 responded that he was not sure what the doctor responded. There is insufficient evidence on which to base any finding about what the fit notes prepared by C1's GP said with regard to the reason for his unfitness to work. I have made no such finding.

67. Overall, I found C1 gave his evidence in an honest and straightforward manner. I take full cognisance of Ms Ross's points with respect to some gaps between appointments and also gaps in the taking of the medication. I acknowledging the existence of some periods where limited or no support for C's account was available from the GP records. As set out above, I have accepted C1's explanation for this. It is also appropriate to acknowledge that there were many respects in which the contemporaneous written medical records were consistent with and did provide support for C1's account of his condition and symptoms.

Relevant Law

68. The burden of proof is on C to show, on the balance of probabilities, that he was disabled within the meaning of the EA 2010 at the material times.

69. Under s.6 EA 2010:

(1) A person (P) has a disability if –

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

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

70. In considering s.6(1) EA 2010, the Tribunal should ask itself four questions (**Goodwin v Patent Office** [1999] ICR 302):

i. Did the Claimant have an impairment (mental or physical) at the material time;
ii. Did the impairment affect his ability to carry out normal day-to-day tasks;

iii. Was the adverse effect substantial; and

iv. Was it long-term (i.e. had it lasted, or was it likely to last, at least 12 months).

71. Schedule 1 to Part 1 EA 2010 contains further provisions relevant to the assessment of whether a person is disabled. Further guidance is provided in the 'EA 2010 Guidance on matters to be taken into account in determining questions relating to the definition of disability' ("the Guidance") and in Appendix 1 to the Code of Practice on Employment published by the Equality and Human Rights Commission ('EHRC') ('the Code of Practice').

72. There is no definition of 'mental impairment' in the EA, 2010 but Appendix 1 to the Code of Practice states: 'The term "mental impairment" is intended to cover a wide range of impairments relating to mental functioning, including what are often known as learning disabilities'. Previously, the Disability Discrimination Act (DDA) stated that a mental illness would only amount to an impairment if it was an illness which was 'clinically well recognised'. However, that requirement was removed from December 2005 and the Employment Appeal Tribunal (EAT) has cautioned against Tribunals requiring too rigorous a clinical diagnosis (**Rayner v Turning Point and Ors** UKEAT0397 /10).

73. With respect to the requirement for an impairment, paragraph A6 of the Guidance states: "*It may not always be possible, nor is it necessary, to categorise a condition as either a physical or a mental impairment. The underlying cause of the impairment may be hard to establish. There may be adverse effects which are both physical and mental in nature. Furthermore, effects of a mainly physical nature may stem from an underlying mental impairment, and vice versa*."

74. Stress is not itself a psychological injury or a mental illness, but it may lead to mental impairments such as depression or anxiety disorder or it may exacerbate other conditions which are physical or mental impairments. In **J v DLA Piper UK LLP** [2010] IRLR 936, the EAT observed that when

considering impairment in cases of alleged depression, Tribunals should be aware of the distinction between clinical depression and a reaction to adverse circumstances. The EAT held (at para 40):

> *The distinction between impairment and effect is built into the structure of the DDA. ..*
> *…the correct approach is as follows:*
> *(1) It remains good practice for a tribunal to state conclusions separately on the questions of impairment and of adverse effect (and, in the case of adverse effect, the questions of substantiality and long-term effect arising under it) as recommended in Goodwin.*
> *(2) However, in reaching those conclusions, the tribunal should not proceed by rigid consecutive stages. Specifically, in cases where they may be a dispute about the existence of an impairment it will make sense …to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adversely affected (on a long-term basis), and to consider the question of impairment in the light of those findings.*
> *3) These observations are not intended to … conflict with the terms of the guidance and existing case law...*

75. The EAT went on (at paras 41 to 45) to consider the distinction between the mental illness known as “clinical depression” and depression as a reaction to adverse circumstances. It acknowledged the value or validity of the distinction could be questioned at the level of deep theory, but noted it is routinely made by clinicians and should in principle be recognised for the purposes of the DDA. It held: “ … *it may be a difficult distinction to apply in a particular case; and the difficulty can be exacerbated by the looseness with which some medical professionals, and most lay people, use such terms as “depression” (“clinical” or otherwise), “anxiety” and “stress”. Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If … a tribunal starts by considering the adverse effect issue and finds that the claimant's ability … has been substantially impaired by symptoms characteristic of depression*

for 12 months or more, it would in most cases be likely to conclude that he … was indeed suffering "clinical depression" rather than simply a reaction to adverse circumstances. It is a common-sense observation that such reactions are not normally long-lived." [para 42]

76. The EAT maintained that the distinction between clinical depression and an adverse reaction to stress does not involve the restoration of the requirement previously imposed by para. 1(1) of Schedule 1 to the DDA that the claimant prove that he or she is suffering from a "clinically well-recognised illness". The impact of the repeal of para. 1(1) is in a case where it is evident from a claimant's symptoms that he or she is suffering from a mental impairment of some kind but where the nature of the impairment is hard to identify or classify (para 43).

77. In the later EAT case of ***Herry v Dudley Metropolitan Council*** *UKEAT0100/16/LA,* the EAT upheld an employment tribunal's decision that an employee was not disabled, even though he had to take a long time off work because of stress, where his condition had been a reaction to difficulties at work rather than a mental impairment. The EAT approved again the dicta of Underhill P in the **DLA Piper** case. His Honour, Judge D Richardson, added comments in relation to diagnoses of 'stress'. He began by cautioning that his comments did not underestimate the extent to which work-related issues can result in real mental impairment, especially for those who are susceptible to anxiety and depression (para 55). He went on to observe that unhappiness with a decision or a colleague, a tendency to nurse grievances or a refusal to compromise are not, of themselves, mental impairments: they may simply reflect a person's character or personality. Any medical evidence in support of a diagnosis of mental impairment should be considered by an employment tribunal with great care; so must any evidence of adverse effect over and above an unwillingness to return to work until an issue is resolved (at 56).

78. Although EA 2010 does not contain a list of normal day-to-day activities, the Guidance (at paragraph D3) provides that such activities are '*things people do on a regular or daily basis for example shopping, reading and*

writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities'.

79. 'Substantial' for this purpose means more than minor or trivial (s.212 EA 2010). The focus must be on what a person cannot do, or can only do with difficulty, not what they are able to do. An impairment may not directly prevent someone from carrying out normal day-to-day activities but may still have a substantial adverse effect on how the person carries out those activities.

80. For the purpose of determining whether an impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities, the effect of ongoing medical treatment on the impairment is ignored (paragraph 5(1) schedule 1 EA 2010).

81. By paragraph 2(1) of Schedule 1 to the EA 2010, the effect of an impairment will be long term if: (a) it has lasted for at least 12 months; or (b) is likely to last for at least 12 months, or is likely to last for the rest of a person's life. In considering whether the effects are likely to last for at least 12 months, the Tribunal must consider matters as at the date of the alleged discriminatory act, and must not take into account anything only known or occurring after that time (**All Answers Ltd v W** [2021] IRLR 612) (paragraph C4 of the Guidance). It should consider what the effects of the impairments were at the material time and whether there is information before it which shows, viewed at that time, that it could well happen that the effects would last for more than 12 months (**Nissa v Waverly Education Foundation Ltd** UKEAT/0135/18).

82. 'Likely' means "could well happen" and is not to be equated with 'more probable than not' (Guidance at paragraph C3 and **Boyle v SCA Packaging Ltd** [2009] ICR 1056, HL). By paragraph 2(3) of Schedule 1 to the EA 2010, the impairment is treated as continuing if its substantial adverse effect on normal day-to-day activities is likely to recur.

Submissions

83. Both Mr Bathgate and Ms Ross gave oral submissions**.** The entire content of both submissions has been carefully considered and taken into account in making the decisions in this Judgment. Failure to mention any part of these submissions in this Judgment does not reflect their lack of consideration by this Tribunal. The submissions are addressed in the decision section below, which sets out where the submissions were accepted, and, where they were not, why not. Both representatives referred to the 4 stage test in the **Goodwin v The Patent Office** and the 'Discussion and decision' section below follows this four stage structure. I have, however, varied the order in which I have considered the four limbs as suggested by the EAT in **J v DLA Piper UK LLP**. I have, therefore, considered the question of the existence of 'mental impairment' last, after consideration of the other three limbs.

Discussion and decision

Adverse effect on normal day to day activities?

84. Given the evidence of the effect on C1's sleep pattern, concentration, ability to read, comprehend and absorb information as well as on his ability to socially interact, Mr Bathgate said the evidence showed C1's ability to carry out normal day-to-day activities was indeed affected.

85. With respect to normal day-to-day activities, Ms Ross said there was little compelling evidence to support this conclusion for C1. She referred to the impact statement and medical records. She said C1 consulted his GP many times on a variety of issues and that she would expect it to have been mentioned if he suffered symptoms over a four year period. She accepted that the Tribunal must consider the effects of medical treatments and assess the effects as they would be without such treatment. She acknowledged that C1 was prescribed medication, but pointed out this was not consistently. She noted that there were considerable periods when he was not prescribed Sertraline. There was, she said, limited information about how he was impacted when he was not taking the medication. Nothing in the records suggested any adverse impacts. In these

circumstances she said it was difficult for the tribunal to conclude how his health would have been without the medication.

86. She also noted that C1 was prescribed medication over a lengthy period without any medical assessment as to the justification of the continued prescription of such medication. She commented that C1 went three years without the medication being reviewed by a doctor. Ms Ross suggested it may be superficially attractive to say that the prescription over an extended period must indicate the necessary effects of the condition, but she suggested that little weight should be attached to the extended a period of prescription. It was difficult for the Tribunal to tell if it was genuinely required or how C1 would have fared without it.

87. Likewise, Ms Ross suggested it might be deemed relevant that C1 had been signed off work for a considerable time but when the medical records were considered, she said that would not be a sound basis for a conclusion. In the same way that his doctor had been casual with regard to prescribing medication, so, she said, he had been equally casual in relation to the provision of fit notes. She noted that both claimants had been able to obtain backdated fit notes for months and months without any assessment even at the retrospective point at which they were requested.

88. The material period when disability discrimination is alleged is between the start of July 2022 and the end of June 2023. I begin by considering whether C1 experienced adverse effects on his ability to carry out normal day-to-day activities in July 2022 at the beginning of the alleged period of discrimination. I have made findings in fact that from April 2019 until June 2023, C1 experienced effects on his sleep pattern and concentration which in turn had an adverse effect on his ability to read and to cook, as well as to engage in social interactions and to spend time out of the house in the city of Edinburgh. I accept that these effects applied in July 2022 and indeed in the period from July 2022 to June 2023. I am satisfied that activities such as sleeping, cooking reading, being out and about and engaging in social activities and new social interactions are ‘normal day-to-day activities’ for the purposes of the legislation.

89. The 'Observations on the Evidence' section sets out the reasons why I have rejected R's submission that the absence in the medical notes of more frequent references to the symptoms undermines his account. I have explained in that section that I accepted C1's evidence and why I did not find the challenges to his credibility compelling. I have found as I have in relation to the effects on C1 on the basis of his evidence to the Tribunal about those effects which I accepted. His extended absence from work and the lengthy prescriptions of anti-depressant are consistent with his evidence but these did not provide the sole or the main basis for my findings.

90. With respect to the submission that C1 was not on Sertraline for considerable periods, I have accepted his reasons for doing so and made findings in fact about these. I have not found that C1's decision to come off the Sertraline at times was because all of his symptoms and effects on activities had alleviated or fully resolved at those times. I am not persuaded that the fact of C1's unmedicated periods undermine the factual findings I have made about the effects he experienced both within and outwith those periods.

91. I conclude that as at July 2022 and indeed throughout the period from then until June 2023, C1 experienced adverse effects on his ability to carry out normal day-to-day activities.

Effects 'substantial'?

92. Mr Bathgate pointed out that the meaning of 'substantial' is merely more than trivial and he asserted that it was clear from the evidence that the effects were more than trivial; he said they had a significant impact. He pointed out that in assessing whether the effects were substantial, the impact of any medications should be ignored. Mr Bathgate argued that if C1 periodically came off the medication, he would suffer heightening of his symptoms.

93. With regard to whether the effects were substantial, Ms Ross said there was insufficient evidence to conclude that they were so. She said there was little corroboration from the medical records and that medication was prescribed and fit notes issued without assessment. Both claimants'

medical records indicated periods when no medications were prescribed at all.

94. I have found that there were effects on day-to-day activities throughout the material period (July 2022 to June 2023). I am satisfied that these were substantial. They were neither trivial nor minor. In some cases they stopped C1 engaging in normal day to day activities like socialising altogether. In other cases, they reduced his capacity to carry out such activities or made them more difficult (for example, activities like reading or cooking).

95. Ms Ross's submissions about a lack of corrobboration from the medical evidence have been discussed in the Observations on the Evidence section. Put shortly, I accepted C1's evidence about how significant the effects were for him on the balance of probabilities.

Effects 'Long term'?

96. As to the requirement that the effects be long term, Mr Bathgate said that the evidence supported a conclusion that C1 had suffered since 2019 and that he continues to do so today. He noted that he was receiving prescribed medications.

97. With regard to whether the effects were long term it, Ms Ross noted that C1 had been absent for more than 12 months and that there had been a willingness of his GP to write fit notes. Nevertheless, it was not possible for the tribunal to decide during what period C1 had in fact been unfit for work. According to Ms Ross, there is insufficient reliable evidence evidence from which the Tribunal could conclude the necessary substantial adverse impact on normal day-to-day activities or that it was long term.

98. Ms Ross said the relevant time frame for the claims was from July 2022 onwards. She observed that C1 did not consult the GP regarding stress between March 2022 and January 2023. She said that there was no period of 12 months prior to July 2022 from the evidence which supported sustained adverse effects.

99. The material period of the claim is July 2022 to June 2023. I have found as a matter of fact that, by the beginning of that period, the effects had persisted for more than 12 months. At that time, I have found as a fact that they had lasted for around 3 years. The effects were, therefore, long term for the purposes of the EA.

100. Ms Ross's submissions focused on a lack of reliable evidence. By this, she referred to the written GP records. As before, I accepted C1's evidence about how the period over which he experienced the effects he described on his normal day to day activities. I am not persuaded that, simply because C1 did not have a doctor's appointment to discuss his symptoms between March 2022 and January 2023, it means that he did not experience adverse effects on his activities during this period. For the majority of that 10 month period, C1 was treated with Sertraline.

Mental Impairment?

101. With regard to the question of whether C1 had a mental impairment, Mr Bathgate said the focus is on the effect the impairment has on the employee's normal day-to-day activities and not so much on whether a label can be attached to the condition. He anticipated that R would seek to distinguish between whether it was work-related stress or anxiety. In Mr Bathgate's submission, it matters little which description is applied to the condition; it is clear from the medical records that it is a mental impairment.

102. Miss Ross said that the only medical diagnosis was work-related stress. She suggested when cross examining C1 that there was no mention of anxiety. Ms Ross argued that C1 has not discharged the burden of showing he was a disabled person at the material time. She said that the relevant time period for the complaint of discrimination was from July 2022 onwards.

103. The first limb of the test, she said, required an impairment, physical or mental. Ms Ross said that C1 did not have an impairment but a stress reaction to events or adverse circumstances at work and the result of R's processes. This did not amount to a mental impairment and C1 did not, therefore, surmount the first hurdle in **Goodwin**. Ms Ross relied upon **Herry v Dudley Metropolitan Council** and **J v DLA Piper.**

104. In support of her submission that C1 was suffering an adverse reaction to circumstances, she observed that he went off on sick leave after being told that he was facing allegations of misconduct and after raising grievances. She said that the only diagnosis made was of work-related stress. She also said that throughout the medical records there was consistent reference to ongoing issues at work and that C1 accepted that this was the main reason for his absence.

105. There is no dispute that C1 went off sick after being told he faced disciplinary allegations. C1 accepted and agreed that he experienced a reaction to stressful circumstances at work. It is not accurate, however, that the only medical diagnosis was work-related stress. In the GP records there is reference to 'anxiety', an 'anxiety/ depression plan' as well as to a GAD score (General Anxiety Disorder score), to 'low mood' and to 'paranoia'.

106. The effect of **J v DLA Piper** and **Herry** is not that an individual who experiences symptoms and adverse effects triggered by work-related issues or indeed exacerbated by these on a continuing basis, cannot have a mental impairment for the purposes of section 6(1)(a). In fairness, I'm sure that was not Ms Ross's proposition. It was recognised that there is no mutual exclusivity by Judge D Richardson in **Herry** when he carefully prefaced his observations on 'stress' with the words, "*In adding this comment, we do not underestimate the extent to which work-related issues can result in real mental impairment for many individuals, especially those who are susceptible to anxiety and depression*" (para 55).

107. In paragraph 56 he went on to speak of a class of case where the reaction "perceived as adverse can become entrenched". He talked about a person not giving way or compromising over an issue at work and refusing to return to work yet in other respects suffering no or little apparent adverse effect on normal day to day activities. The EAT went on to observe that a doctor may be more likely to refer to the presentation of such an entrenched position as stress rather than anxiety or depression. The EAT gave examples of a tendency to nurse grievances or a refusal to compromise and noted these are not of themselves mental impairments.

Ms Ross referred me to this paragraph in **Herry** in support of her submissions.

108. The examples given of the class of case to which Judge Richardson referred in paragraph 56 did not resonate with the facts I have found in the present case. The hearing was a discrete PH on disability status and very little evidence was led about the wider substantive issues between the parties.There was no evidence before me at the PH on which to base a finding in fact that C1 was refusing to give way or compromise or refusing to return to work or that he had a tendency to nurse grievances. No such findings could properly be inferred from the material before me at the PH and I make no findings in either direction about whether C1 was or was not a person who possessed any of the characteristics which Judge D Richardson described in paragraph 56 of **Herry**.

109. I am satisfied based on the substantial nature of the adverse effects on C1's ability to carry out day to day activities and on the longevity of these effects that he was suffering from a mental impairment of some kind. C1 does not require to prove a 'clinically well recognised illness' and it is not necessary for C1 (or for me) to identify precisely and classify the impairment.

Conclusion

110. I conclude that C1 was a disabled person within the meaning of s.6 of EA at the material times, namely between the beginning of July 2022 and the end of June 2023.

Employment Judge: **L Murphy**
Date of Judgment: **17 April 2024**
Entered in register: **19 April 2024**
and copied to parties