EMPLOYMENT TRIBUNALS

Claimant: SUKVINDER SINGH JOHAL

Respondent: MITIE SECURITY

PRELIMINARY HEARING

Heard at: Birmingham Employment Tribunal (by CVP video)

On: 27 May 2025

Before: Employment Judge McCluggage

Appearances

For the claimant: Mr Richard O'Keefe (counsel)
For the respondent: Ms Jolene Charalambous (counsel)

JUDGMENT

The Claimant was not "disabled" within the meaning of the Equality Act 2010 at material times.

REASONS

Introduction

1. This was a preliminary hearing to determine whether the Claimant was a disabled person within the meaning of section 6 of the Equality Act 2010. By a case management order dated 20 January 2025, Employment Judge Knowles ordered that this preliminary hearing determine whether the Claimant was a disabled person at the material time. The material times were between December 2023 and 19 March 2024.

2. The Claimant was employed by the Respondent as a Security Officer from 10 October 2012 until his dismissal on 19 March 2024. The claim concerns his dismissal and allegations of discrimination arising from disability and failure to make reasonable adjustments. The Claimant alleges that at the relevant time he was disabled by Post-Traumatic Stress Disorder (PTSD). The final hearing is listed for 24 to 27 November 2025 at Birmingham Employment Tribunal.

3. I heard oral evidence from the Claimant who gave evidence by confirming an Impact Statement dated 25 February 2025 and was then extensively cross-examined by the Respondent's counsel. I was provided with a 447-page bundle though much of the content comprised redacted medical records.

4. There were two features of this case that I should note at the outset as they were defining features of the case. Firstly, the Claimant's impairment said to constitute disability was Post-Traumatic Stress Disorder (PTSD), but neither party sought to refer to established diagnostic criteria or any other source as to what PTSD was, its typical symptoms, or diagnostic criteria. In a case where the Claimant's credibility was in issue as to his symptomatology, this would have been helpful. As I informed the parties, whilst I had some professional experience of PTSD in the litigation context, there had to be strict limits on the extent to which I could bring that to bear on the case as my background knowledge was not 'evidence' and I am not a psychiatrist.

5. Secondly, I noted features of the Claimant's Impact Statement that were concerning. It described detailed PTSD symptoms using technical language more commonly found in neuropsychological assessments than in typical witness statements from a lay person. During his evidence, it became apparent that the Claimant simply did not understand the technical terminology used in his own statement.

Facts

6. I found the following facts for the purpose of this Preliminary Hearing, though restrict this section largely to the documented matters within medical and occupational records. Insofar as they extend beyond facts strictly necessary for a finding on the issue of disability they should not impinge on the evidence or facts at Final Hearing.

7. The Claimant was employed by the Respondent as a Security Officer from 10 October 2012 until his dismissal on 19 March 2024. He had been employed by Securitas and transferred to the Respondent under TUPE.

The Historical Medical Position

8. On 30 May 2003, the Claimant visited his GP with a soft tissue swelling over the left orbit. This had resulted from an assault. The records also detail involvement in a road traffic accident in August 2004.

9. On 13 June 2005 the Claimant attended his GP following a needlestick injury at work in the context of his work as a bus driver. This was a significant incident. He had been

to hospital and taken Hepatitis A and HIV tests. The GP described him as being very anxious. The following day, he was prescribed Escitalopram 10mg for symptoms of anxiety. On 22 June 2005, anxiety and stress persisted and the medication was increased to 20mg with Zopiclone added.

10. The records showed that the Claimant was off work through July and August 2005. On 15 September 2005, improvement was noted and a final MED3 was issued for return to work. However, on 10 October 2005 the Claimant presented with morbid thoughts and night stress, and medication was restarted.

11. On 28 November 2005, Dr Naughton (a General Practitioner) diagnosed the Claimant with PTSD arising from the needlestick injury. This appears to be the first attempt to give a formal diagnosis of PTSD in the medical records. The basis on which he applied a diagnosis of PTSD is unclear, but there had been nightmares and recurring thoughts as part of the Claimant's recorded history by this time.

12. There was ongoing treatment through 2005 and into 2006. He had returned to work in 2006 but then had further time off in January 2007. At that time Dr Naughton described him as having a 'depressive episode'. He was struggling and not sleeping. He was referred to psychiatry.

13. On 16 March 2007, Mrs Groom (a mental health nurse) carried out a mental health review and recorded "his presentation is more of an adjustment disorder with a prolonged depressive reaction…". A few days later on 20 March 2007, Dr Jaswal recorded a call from "Dr Chandran from Hallam Street" who said that the Claimant was showing signs of adjustment disorder. I am aware that Hallam Street Hospital is an NHS Psychiatric Hospital and therefore the Claimant had almost certainly been referred for a psychiatric appointment. Unfortunately, the medical records disclosed were only the computerised records. They did not include the GP's correspondence file which would have contained letters with the result of specialist appointments such as that with Dr Chandran. Given the lapse of time, it was unsurprising that the Claimant did not have detailed knowledge of events so far back. In June 2007, Dr Jaswal recorded that the Claimant was not coping at work and had one week off sick due to stress. At various times during this period the Claimant was prescribed with Venlafaxine, Diazepam and Zopiclone, which are well-known medications relevant to depression, anxiety and insomnia though the records do not say exactly the reason for prescription.

14. On 5 January 2009, Mrs Clarkson recorded a panic attack when the Claimant attended for a blood test, requesting different arrangements. I find that this was because the Claimant continued to find needles disturbing. He told me in oral evidence that he still suffered panic attacks when he went for a blood test. I was prepared to accept that, but did not find a blood test to be in the nature of a day to day activity.

15. The Claimant acknowledged in evidence that he had brought a personal injury claim in respect of the needlestick injury and had been referred for counselling privately at some point in relation to the treatment. The expert psychiatric reports and private

counselling records that might have illuminated the Claimant's progress and prognosis at this time were not disclosed. They may not have been available this many years later. There was reference on 09 August 2007 to a referral to a clinical psychologist, Dr Rowan in Wolverhampton. This was probably an NHS referral, but even then, the records were not made available. However, on 01 December 2008 there is a note that the Claimant was feeling 50% better since sessions with the psychologist.

16. There was then a significant gap in the medical records relating to mental health issues until July 2013, when following a fall, Dr Deole reported work stress, depression, irritability and short temper. In November 2013, Dr Singh recorded low mood, work stress and disturbed sleep, starting Citalopram 20mg. The Claimant had lost his driving licence with reference made to a neurology letter, though the circumstances were unclear. In December 2013, stress at work and home was noted, with Citalopram restarted despite the Claimant declining counselling.

17. I concluded that the evidence demonstrated a clear break in both the chronological sequence and the nature of symptoms, such that I was not satisfied the 2013 presentations were to be regarded as a continuation of the condition diagnosed following the 2005 needlestick injury.

18. In June 2016, Dr Deole attributed mood disturbance to obesity/diabetes, with the Claimant keen to improve lifestyle. Records indicate that the Claimant was prescribed Metformin 50mg three times daily, which I am aware is a first line treatment for type 2 diabetes, and Ramipril and Simvastin in relation to what may have been related cardio-vascular issues.

19. On 11 November 2019 the Claimant underwent a health review from the surgery's staff nurse which included a depression screening review that recorded 'no issues'. I heed that a screening review is no more than that and would not necessarily ask or alert as to any symptoms relevant to lingering post-traumatic stress symptoms.

20. In June 2023, an incident occurred involving a known offender at the Wolverhampton store where the Claimant worked. There was police involvement. Various work issues arose from this which I will not delve into for the purposes of the preliminary issue. The Claimant raised grievances against his line manager Gary Pugh, alleging that Mr Pugh had caused him stress and anxiety through his conduct and had lied to him. Some aspects of these grievances were upheld by the Respondent.

21. It was apparent that events from that time on precipitated further psychological symptoms leading the Claimant to return to the doctor. There had been a gap of some 7 years without mention of psychological issues in medical records until 1 November 2023, when Dr Munro recorded a consultation for stress and depression with a reported high impact on his life. Exacerbating factors were said to include "lying around doing nothing". He had had the problem before. The last treatment was 'meds from gp'. It was also recorded, "He does not know what might be causing the problem".

22. Importantly, on 6 November 2023, Dr Mahon recorded that the Claimant had been feeling low since the start of August. I found that the following reference related to the Claimant drawing a subjective connection between the 2005 needlestick injury and its consequences into his present problems: “a few years ago had incident at work, had PTSD, had counselling, improved a little but work things have become stressful again and having financial troubles”. It was said that he was struggling to sleep, was not working and could not concentrate. This was in context of having been suspended from work with no pay.

23. On 20 November 2023, continued distress was recorded with a request for further counselling. The Claimant refused medication.

24. In early January 2024, the Respondent raised an allegation that between 26 December 2023 and 04 January 2024, the Claimant had been booking onto the company's electronic system whilst in the car park rather than when physically present in the store. These were the allegations that led to his dismissal.

25. An investigatory meeting was held on 10 January 2024. The Claimant explained that he would book on whilst in the car park because he was experiencing stress and anxiety, sometimes having panic attacks that could last 20 minutes to over an hour before he felt able to enter the store.

26. Following the investigation, the Respondent obtained an Occupational Health report dated 01 February 2024. This stated that the Claimant appeared to be suffering severe symptoms of anxiety and depression and was unfit to work. It recommended a stress risk assessment and noted that the Claimant's panic attacks and stress were likely to be considered a disability. The report described the symptoms as being attributable to "work related stress" and stated that his symptoms were as a result of an incident at work at Sainsbury's.

27. A welfare meeting was held on 02 February 2024 with Darren Stevens. The Claimant explained his condition and that panic attacks mainly occurred when thinking about going to work rather than when actually at work. A stress risk assessment was completed identifying only the need for regular breaks. This record is important as it indicated that the Claimant’s symptoms were more related to thinking about work than his activities at work.

28. On 05 February 2024, Dr Wright recorded issues at work since September 2023, noted a suicide attempt in November 2023, referred to panic attacks on going to any Sainsburys and recorded “PTSD from issues in the past”. There was some discussion during the hearing about the status of such a comment. I concluded that the GP was recording what the Claimant told him about a diagnosis in the past; Dr Wright then in a separate entry recorded “Post Traumatic Stress Disorder” but did not record any diagnostic criteria for the recorded diagnosis and I was not satisfied that he was exercising an independent clinical judgment on this issue.

29. Furthermore, I attach limited weight to the history given by the Claimant in the 05 February 2024 record. This is because, for reasons explained further below, I do not accept a suicide attempt in November 2023 and the reference to panic attacks on visiting any Sainsbury's store is inconsistent with the Claimant's history to Mr Stevens only days earlier.

30. A disciplinary hearing was scheduled for 8 February 2024 but was postponed due to the Claimant's sickness absence. Further attempts to arrange the hearing were made, with the Respondent offering various accommodations including attending via Teams, written submissions, or having questions provided in advance.

31. The Claimant was issued with various Med 3 sick notes. On 12 March 2024 the Claimant specifically requested that the GP record "PTSD". The Claimant was prescribed Sertraline, a SSRI antidepressant around this time.

32. The Respondent made its disciplinary decision without a hearing and on 19 March 2024 the Claimant was summarily dismissed for gross misconduct.

33. An appeal hearing in person was held on 3 April 2024. The appeal was unsuccessful.

Law

34. Section 6 and Schedule 1 of the Equality Act 2010 provide that a person has a disability if they have a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities. A substantial adverse effect is one that is more than minor or trivial, and a long-term effect is one that has lasted or is likely to last for at least 12 months or is likely to last for the rest of the life of the person.

35. The burden of proving disability lies on the Claimant. Four questions usually need to be answered: (1) does a person have a physical or mental impairment? (2) does that have an adverse effect on their ability to carry out normal day-to-day activities? (3) is that effect substantial? (4) is that effect long-term? These questions may overlap to a certain degree. It is good practice for a tribunal considering the issue of disability to consider each step considered separately and sequentially: *Goodwin v Patent Office* [1999] ICR 302 (EAT).

36. Where there may be a dispute about the existence of an impairment, I note that in *J v DLA Piper UK LLP* [2010] ICR 242, at paragraph 40 Underhill J. stated:

> (1) It remains good practice in every case 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 there may be a dispute

> about the existence of an impairment it will make sense, for the reasons given in para.38 above, 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….

37. Following the repeal of the original paragraph 1(1) of Schedule 1 to the Equality Act 2010, there is no longer a requirement that a mental impairment must be a "clinically well-recognised illness". However, a distinction remains between, on the one hand, a mental illness or condition which constitutes an impairment within the meaning of the Act, and on the other hand, low mood and anxiety as a reaction to adverse circumstances which would not: *J v DLA Piper*, at paragraph 42. Such reactions to adverse circumstances are "not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problem at work) or… 'adverse life events'. As the EAT pointed out, the borderline between the two states of affairs is bound often to be very blurred in practice but must be recognised.

38. Consistent with the spirit of that analysis, in *J v. DLA Piper,* Eady J. in *Nissa v Waverly Education Foundation Limited* (2018) UKEAT/0135/18/DA was more concerned with the impairment and the symptoms rather than the diagnostic label: see paragraph 25.

39. I accepted that expert evidence is not necessarily needed and in many cases General Practitioner evidence would be sufficient for questions of disability arising from mental impairment under the Equality Act: see *J v DLA Piper*, at paragraph 52. However, in my view, a Tribunal must be more cautious where the alleged mental impairment is a more complex psychiatric condition such as PTSD. Unlike depression, PTSD has specific diagnostic criteria and may require specialist psychiatric assessment for reliable diagnosis. The weight to be given to a GP's note or to an occupational health advisor’s opinion will depend in my judgment on the particular circumstances.

40. Paragraph 2(1) of Schedule 1 to the Equality Act 2010 states that an impairment will have a long-term effect only if: (1) it has lasted at least 12 months; (2) the period for which it lasts is likely to be 12 months; or (3) it is likely to last for the rest of the life of the person affected.

41. If an impairment ceases to have a substantial adverse effect on a person's ability to carry out day-to-day activities, it is to be treated as having that effect if it is likely to recur (paragraph 2(2), Schedule 1, Equality Act 2010). The word 'likely' means whether something "could well happen" rather than it is more probable than not that it will happen: *SCA Packaging Ltd v Boyle* [2009] ICR 1056 HL. That is to be assessed at the time rather than with the benefit of hindsight.

42. Paragraph 6 of Schedule 1 provides that an impairment which would be likely to have a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities, but for the fact that measures are being taken to treat or correct it, is to be treated as having that effect. Such measures include medical treatment and

medication. In determining deduced effects, clear medical evidence may in some cases be needed not just the claimant's own testimony: *Woodrup v London Borough of Southwark* [2003] IRLR 111. However, the evidence need not be elaborate where the proposition is straightforward and unchallenged, for example concerning the effects of anti-depressants: *J v DLA Piper*, at paragraph 57. I did not in this case have any evidence as to deduced effect.

Analysis and Conclusions

43. As there are some complicated and conflicting aspects of the evidence in this case, I think it wise to apply the four-stage test established in *Goodwin v Patent Office*. This is a case where there is close linkage between impairment and day to day activities and so I give some cross-over consideration in the next section as recommended by *J v. DLA Piper*.

Does the Claimant have a mental impairment?

44. The Claimant's case is predicated upon a diagnosis of PTSD. For context, PTSD under DSM 5[1] diagnostic criteria requires: (A) exposure to actual or threatened death, serious injury, or sexual violence, (B) presence of intrusion symptoms associated with the traumatic event, (C) persistent avoidance of stimuli associated with the traumatic event, (D) negative alterations in cognitions and mood, (E) marked alterations in arousal and reactivity, (F) duration of disturbance for more than one month, (G) clinically significant distress or impairment, and (H) the disturbance is not attributable to substance use or another medical condition. That is a very basic summary of PTSD drawn from public record. The UK National Institute for Health and Care Excellence (NICE) invites medical professions to consider PTSD in people reporting the following symptoms, which is interesting to compare with the language in the Claimant's Impact Statement:[2]

    1. Re-experiencing a traumatic event, either through 'flashbacks' or in the form of dreams/nightmares — this is the most characteristic PTSD symptom
    2. Negative self-perception (including feeling diminished, defeated, or worthless).
    3. Interpersonal difficulties or problems in relationships.
    4. Emotional dysregulation.
    5. Dissociation — where a person feels disconnected from themself and/or the world around them.
    6. Emotional numbing — where the person lacks the ability to experience feelings, feels detached from other people, gives up activities that they have previously enjoyed, communicates less with other people, has amnesia associated with significant parts of the event, or has persistent negative beliefs or expectations about themselves.

[1] DSM-5 is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by the American Psychiatric Association. It is a standard classification system used by psychiatrists to diagnose mental health conditions. ICD11 is an alternative classification published by the World Health Organisation. Its criteria might be regarded as more restrictive, but that debate is irrelevant here.

[2] Diagnosis | Diagnosis | Post-traumatic stress disorder | CKS | NICE

7. Negative alterations in mood and thinking.
8. Hyperarousal (including hypervigilance, anger, and irritability). May also manifest as self-destructive or reckless behaviour, exaggerated startle responses, insomnia, and difficulty concentrating.
9. Avoidance of situations that trigger memories of the event. The person may avoid talking or thinking about the event by becoming absorbed in work or hobbies.

45. Whilst I accept that the Claimant suffered mental health difficulties following the needlestick injury in 2005, including a diagnosis of PTSD by Dr Naughton in November 2005, there was insufficient evidence that this condition persisted into the material period of December 2023 to March 2024. The medical chronology demonstrates a clear break in continuity. Following improvement noted in 2008/2009, later symptoms in 2013 and 2016 appeared related to the Claimant's life stresses at that time, not the traumatic effects of the 2005 incident.

46. Most significantly, I found the Claimant's Impact Statement to be fundamentally unreliable. It employed sophisticated clinical terminology the Claimant demonstrably did not understand during cross-examination. When asked about "dissociation" and "executive functioning", he was unable to provide coherent explanations.

47. The statement contained assertions about day-to-day activities plainly inconsistent with the evidence. The Claimant claimed he "avoided shops entirely due to severe anxiety" but had still been working as a security officer in retail. I was particularly concerned about the sub-paragraph on "work/study-related tasks" in which he described dysfunction in “professional/academic” settings irrelevant to his actual work as a security guard, using clinical terminology inconsistent with his own language, such as "cognitive impairment" and "emotional dysregulation".

48. The Claimant's counsel argued that it was common for solicitors to assist litigants with statements. I accept this, and do not criticise the fact of such assistance *per se*. However, there remains a distinction between appropriate support and the production of a statement which no longer reliably reflects the witness's own words or understanding. The Civil Procedure Rules emphasise the importance of using a witness's own language (CPR PD32), and while Employment Tribunals do not expressly apply that standard in the Tribunal Procedure Rules, in my experience the same principle is widely followed. In this case, the Impact Statement adopted a level of clinical precision and an unusually formulaic, multi-clause structure that lacked credibility and gave me cause to wonder how it was created.

49. At points, the statement read as a textbook symptom inventory, articulated in terms of maximum severity. Its language and structure bore little resemblance to how the Claimant described his difficulties in oral evidence or how they were recorded in the General Practitioner records.

50. I did not accept the Claimant's evidence regarding an alleged suicide attempt in November 2023. His account was unconvincing and inconsistent with Dr Mahon's

contemporaneous record of 20 November 2023, which recorded "no suicidal thoughts/self-harm".

51. Overall, I cannot accept the Claimant's evidence about his symptoms and their effect on activities unless corroborated by contemporaneous records.

52. I do accept that from approximately September 2023 onwards, the Claimant was experiencing symptoms of anxiety and low mood. This is supported by Dr Munro's record of 1 November 2023 noting stress and depression lasting "a couple of months".

53. Following *J v DLA Piper*, I must distinguish between a mental condition constituting an impairment and "low mood and anxiety as a reaction to adverse circumstances". That is not easy here. The adverse circumstances multiplied from difficulties in summer 2023 through to serious disciplinary allegations in January 2024. The evidence suggests the Claimant's symptoms were primarily reactive to workplace stressors. However, I find that by November 2023 the symptoms had developed into an 'impairment' involving anxiety and depression. The contemporaneous records describe 'panic attacks, low mood, insomnia, tearfulness'. I conclude this goes beyond a mere understandable reaction to workplace stress.

54. I discussed with the parties whether the Claimant could succeed on a labelling of a general anxiety/depression impairment rather than PTSD. The Respondent argued that the Claimant was bound by his PTSD claim. I reject that submission. It would be inconsistent with *J v DLA Piper* and ignores the difficulties of psychiatric diagnosis. The Claimant understandably linked his current problems to past difficulties, but in my view a clash of diagnostic labels should not determine disability findings. The tribunal's focus should be on adverse effects where there are difficulties in identifying or determining impairment.

Did the impairment have an adverse effect on normal day-to-day activities?

55. The Occupational Health report of 1 February 2024 was given limited attention by the parties, but it is in my judgment an important contemporaneous assessment. Ms Parkin, who is titled an "Occupational Health Advisor" (with no suggestion that she has any medical qualifications) concluded that the Claimant was experiencing "severe symptoms of Anxiety and Depression" based on "nationally recognised questionnaires" and that he was "unfit for work in any capacity". She noted symptoms including panic attacks, worrying thoughts, inability to concentrate, lack of motivation and severe low mood.

56. While paying little regard to the Impact Statement, I do place some reliance on this document, albeit in relation to a generalised anxiety and depressive impairment, not 'PTSD'.

57. The difficulty in relying further upon this assessment is that the document speaks to psychological symptoms generally, but not the effect of those symptoms on day-to-day activities.

58. "Substantial" means more than minor or trivial. Even accepting the Occupational Health assessment at face value, the symptoms are set out in the abstract and are not analysed in terms of daily activities.

59. The Claimant's ability to function in other contexts such as security for VIP families at Villa Park, suggests that any adverse effects, whilst distressing, did not reach the threshold of being substantial in their impact on the Claimant's normal day-to-day activities. If I cannot rely upon the Impact Statement or the Claimant's oral evidence as he sought to stand by the Impact Statement, and the Occupational Health Report is insufficiently detailed, then I would have to resort to inference on day-to-day activities. That would be unsatisfactory.

Was any adverse effect long-term?

60. Even if I am wrong on the effect of the impairment on day-to-day activities, the evidence was insufficient for a conclusion that any adverse effect was long-term.

61. As found above, I do not find that the 2023/2024 problems form part of a chronic condition from 2005. The Claimant's symptoms commenced around August/September 2023, became significant by November 2023, and continued through the material period to March 2024. This represents approximately 6 to 7 months.

62. While I would accept the descriptive assessment of an "Occupational Health Advisor", I do not accept an unqualified person's psychiatric prognosis. There is no proper evidence to determine that, as at March 2024, the Claimant's symptoms away from the stressful work context might well (seeking to apply the lower *Boyle v. SCA Packaging* standard of probability) persist to October/November 2024. Had a GP given a view in the disclosed medical records, that would have carried weight, but there is no such evidence.

Conclusion on Disability

63. For the reasons set out above, I find that the Claimant was not a disabled person during the material period. Whilst I am prepared to find that the Claimant suffered from an impairment of a depressive/anxiety condition which could give rise to distressing symptoms, I am unable to find that it had substantial and long-term adverse effects on his ability to carry out normal day-to-day activities as required by the statutory language.

64. The matter will therefore proceed to final hearing on the remaining claims on 24 to 27 November 2025, where the Tribunal will consider the claims of unfair dismissal and notice pay.

65. The parties asked me to make any consequential revisions to the directions timetable and I have prepared a separate order to that effect.

Employment Judge McCluggage

25/06/2025