



EMPLOYMENT TRIBUNALS

Claimant: Mr S Samuels

Respondent: The First Element Group Ltd

Heard at: Reading **On:** 3 July 2026

Before: Employment Judge Shastri-Hurst

Representation

Claimant: in person

Respondent: Mr Pal

RESERVED JUDGMENT

1. The claimant was, during the relevant period of May to October 2024, disabled by way of ADHD and Depression combined.

REASONS

Preamble:

The parties have my apologies for the delay in this decision being sent to them. The hearing came before a period of non-working days, during which I realised the need to seek their submissions on a particular case (set out in more detail below). For some unknown reasons, my first communication requesting any submissions was not sent in July, when it should have been. It was only on my return from non-working days in September that I was aware there may have been an issue with that communication, which led to the Tribunal's letter of 25 September 2026. I do not underestimate the effect delays of this nature have on the parties: I thank them for their patience.

Introduction

1. The claimant worked for the respondent from 1 January 2023 until his resignation which took effect on 30 November 2024. He held the role of Head of Software and Control Systems.
2. The claimant entered the ACAS early conciliation period on 27 December 2024: that period ended on 7 February 2025. The claim form was presented on 8 February 2025. The respondent duly submitted its ET3 with Grounds of Resistance on 20 April 2025, defending the claim.

3. The claim was the subject of a preliminary hearing on 24 February 2026 with Employment Judge Hawksworth – [56]. At that hearing, it was clarified that the claimant was pursuing claims of:
 - 3.1. Constructive discriminatory dismissal;
 - 3.2. Discrimination arising from disability;
 - 3.3. Failure to make reasonable adjustments;
 - 3.4. Unlawful deduction from wages; and,
 - 3.5. Breach of contract.
4. EJ Hawksworth listed this hearing today in order for disability status to be determined. The claimant relies upon the following two conditions for his disability claims:
 - 4.1. ADHD;
 - 4.2. Depression (Mixed Anxiety and Depressive Disorder).
5. The respondent disputes that the claimant met the definition of disability during the relevant period (the period of the alleged discrimination). Its position is as follows:
 - 5.1. ADHD – the effects are not substantial and adverse, and are not caused by ADHD;
 - 5.2. Depression (Mixed Anxiety and Depressive Disorder) – the effects are not long-term, substantial or adverse.
6. From the list of issues set out at pages 63 to 68 of the preliminary hearing bundle, the claimant's claim regarding disability discrimination covers a period of May to October 2024. That is therefore the relevant period for which I must consider whether the claimant fulfilled the definition of disability.
7. In terms of documents available to me for this hearing, I have a bundle of 286 pages (including the index): page X in the bundle will be referred to as [X]. Of particular note is the claimant's Disability Impact Statement ("DIS") which is found at [164]. I was also provided with a Skeleton Argument by Mr Pal, for which I am grateful.
8. Following the hearing, and in consideration of the relevant case-law on the issue of disability, I realised that I had not discussed the case of Stedman v Haven Leisure Ltd [2025] EAT 82 with the parties. Prior to finalising this Judgment, I wrote to the parties to ask for any submissions they wished to make on this case. I did not receive anything from the claimant: this is entirely understandable given that he is a litigant in person. I would not have expected him to reply, but wanted to give him the opportunity. I did receive submissions from Mr Pal, for which I am grateful, and which I have read and considered.

Preliminary matter

9. As a preliminary matter, the respondent raised concerns regarding the claimant's Disability Impact Statement ("DIS"), on the basis that it considered it had been produced with the assistance of Artificial Intelligence ("AI"). The respondent relies on the case of Godwin v Godwin [2026] EWHC 923 (Ch) (I have reminded myself of the specific paragraphs of relevance, at paragraphs 37 and 44 to 48).
10. In cross-examination, the claimant explained that he used AI to help with the structure of the document and to refine the wording slightly. He confirmed to me under affirmation that everything in his DIS was fact and from his own experiences.
11. It was suggested to the claimant in cross-examination that the majority of the words within his DIS were produced by AI. The claimant denied this, explaining that he has experience writing technical documents, and only used AI to tighten up things like grammar.
12. The respondent had, in previous correspondence, requested disclosure of previous drafts of the DIS and of the prompts used for the AI system in question: such documentation has not been provided. The claimant explained to me in cross-examination that he periodically deletes the backlog on his various AI systems he uses: given they are just editing tools (as he sees it), he does not consider it necessary to save any of the previous drafts or prompts.
13. Although I bear the warning in Godwin in mind, I do not consider that case and the index case to be comparable.
14. There are no particular phrases or words that cause me alarm in the claimant's DIS, or strike me as being purely AI generated.
15. The Tribunal is a different forum to the Court, and we are arguably bound by less strict rules of procedure, allowing an amount of flexibility when it comes to the formation and presentation of witness statements. I do not draw any adverse inference and do not treat the claimant's DIS with any less weight than had he produced it without any use of AI.

Findings of fact

16. I have set out facts relevant to the question of disability status below. I have seen documents regarding the claimant's medical position in 2025 (more specifically, post-the relevant period), however I have not referred to them below. This is because, in deciding whether a claimant is disabled or not, I must consider the position as it was known to be within the relevant period, and not be influenced by what has happened thereafter.
17. As set out above, the claimant worked for the respondent from 1 January 2023 to 30 November 2024. During that period, he was never performance managed, and there was never a suggestion that he was not performing as required within his role.
18. The claimant currently works by running several parallel work streams at

the same time. This means that when he cannot concentrate on one, he can move to another that is capable of retaining his interest and concentration for a period of time. Although the claimant has set up this system of parallel working to mitigate his symptoms, this does not get around the issue he has of not being able to direct his attention to tasks in order of priority. If he does manage to so direct his attention, his work pace is much slower and requires a great deal of effort to keep persevering with the task in hand. This is not simply him choosing to work on the projects that interest him at the time, as he explained in cross-examination:

“Sometimes there are things I really want to do and would enjoy doing and can’t get started. Sometimes there are things I don’t enjoy that I can’t draw my attention away from”.

19. The claimant explained that he tends to struggle with procedural and repetitive tasks: he finds it easier to focus on more complex matters.

Academic and professional achievement

20. The respondent makes the point that the claimant has qualified as a Master of Engineering in Artificial Intelligence and Cybernetics, and that in his various roles he has needed to undertake significant organisational and logistical roles – [110]. It was put to the claimant in cross-examination that his degree would have required him to engage in administrative tasks, attempting to undermine the claimant’s purported symptoms. The claimant explained that he did manage to do the requisite administrative tasks, but that this was with “great difficulty”: in fact, the claimant was required to repeat a year. The claimant also used to work through the nights, but got his exams “the wrong way round”.
21. The claimant ran his own business, Think Engineer, from 2017 to 2024. The company employed up to six individuals, two of whom were co-founders. The claimant explained that he ran the company in conjunction with his two co-founders. He did undertake some of the administrative tasks such as payroll and contacting the accountants, however he was late with payroll on several occasions and did not contact the accountant on time. The claimant felt he did not cope with those responsibilities as well as his co-founders.
22. One of the claimant’s co-founders left within the first year, following which the claimant struggled to cope with the workload. When the second co-founder left, the claimant faced further struggles: he could not keep on top of the accounts and fell behind on communications and on projects.

Finances

23. The claimant has been the subject of more than one County Court Judgment (“CCJ”) due to financial and administrative difficulties. He puts these down to his difficulty with financial management, which he says is another symptom of his ADHD. Although I do not have corroborative evidence of these CCJs I accept on balance that they do exist: I found the claimant to be a credible, straight-forward witness who conceded matters when appropriate.

24. The respondent argues that financial mismanagement is not necessarily connected to ADHD, and that I cannot be satisfied that, in this case, there is such a causal connection. Ultimately, I have to weigh up the evidence I have in front of me and determine what is more likely. I accept here that the claimant has a diagnosis of severe ADHD, and that his symptoms involving mismanagement of personal affairs are more likely than not connected to that condition.
25. I accept that there is no supportive evidence to corroborate the claimant's evidence; however I also consider that there is nothing to undermine that evidence. There is no positive assertion from the respondent that anything else was the cause of his financial mismanagement. I am satisfied, on the balance of probabilities, that the claimant has in the past mismanaged his finances, and that his ADHD is the reason.

Personal care

26. The claimant says that his personal hygiene suffers as a result of his ADHD: for example, he alleges that his dental hygiene is poor as he does not brush his teeth. The respondent criticises him for not producing dental records to support this assertion: such criticism may be more fairly levelled at the claimant if he were represented. However, I do not accept the underlying assertion from the respondent that the claimant is lying about or exaggerating his difficulty with dental hygiene.
27. The claimant also told me that he has difficulty getting himself to have a shower and wash. He explained that, even though he is aware of the need to take care of his personal hygiene, this "does not manifest in the action" in his words. I accept this evidence and refer back to my view of the claimant's evidence above at paragraph 21.

Communication

28. The claimant explained that he struggles with routine communications with friends. To give an example, he told me (and I accept) that someone he considers to be his best friend, he has not spoken to for years. The friend messaged him a few days before the hearing, but the claimant had not replied at the time of the hearing.

Viking festival

29. The claimant and his wife run a Viking festival; Valhalla Viking Festival. Although they founded this festival (and the associated limited company) together, the claimant gave up his directorship and role in the company in 2021. His wife now does the majority of the work.
30. The claimant helps when he can with the festival, but finds that he is at his best when the event is on and he is required to fix problems that arise; that sense of urgency is one that boosts his motivation.

ADHD

31. The claimant has a diagnosis of ADHD which the respondent accepts is a lifelong condition.
32. The main symptom that the claimant has highlighted in his DIS is the negative impact his ADHD has on his organisational/management skills.
33. The claimant has historically managed his own business, through which he employed a number of staff and won highly complex government grants.
34. The claimant and his wife organise the UK's largest annual Viking festival. The respondent says that this requires him to "co-ordinate the land hire, insurance and licences, trade concession stands, food and beverage suppliers, re-enactment, entertainment, obtaining sponsorship and so on" - [110].
35. The respondent's position is that any effect of the claimant's ADHD is not substantial and adverse, but just requires him to work in a different way to others, but obtaining the same result.

Symptoms

36. In the claimant's DIS, he sets out the following effects of his ADHD - [164]:

- 36.1. Significant difficulty sustaining attention;
- 36.2. Poor executive function;
- 36.3. Impulsivity;
- 36.4. Difficulty managing time; and,
- 36.5. Problems organising and completing tasks.

37. He then further expands upon these on [166], and lists the following symptoms:

- 37.1. Attention and task management;
- 37.2. Organisational and administrative tasks;
- 37.3. Sleep and fatigue;
- 37.4. Financial management;
- 37.5. Personal self-care;
- 37.6. Communication and social interaction.

Medical evidence

38. The claimant explains that the first mention of possible ADHD was on 21 August 2023 in a GP consultation - [220]. At that consultation, the claimant reported:

"recently wondered about the possibility of ADHD

Always left things to the last minute – now has small child which hinders his last minute rushes to complete projects/work".

39. He was then referred to Psychiatry UK LLP for an ADHD assessment (see [228]) which concluded that the claimant did indeed have ADHD, and that it was of "sufficient severity to justify specialist referral" – [165].

40. The claimant received the formal diagnosis of ADHD from Dr Jeanette Lewis, following the completion of a DIVA-5 (Diagnostic Interview for ADHD in Adults, 5th edition) on 7 May 2024. The DIVA-5 report is at [234].
41. The new diagnosis is noted in the claimant's GP records at [214] on 15 May 2024.

DIVA-5 Report

42. The report explains within its introductory pages the main requirements of a diagnosis of ADHD:

“that the onset of ADHD symptoms occurred during childhood and that this was followed by a lifelong persistence of the characteristic symptoms to the time of the current evaluation. The symptoms need to be associated with significant clinical or psychosocial impairments that affect the individual in two or more life situations”.

43. Within the assessment proper, the claimant has answered questions related to both adulthood and childhood under sections entitled as follows:

- 43.1. Symptoms of attention-deficit;
- 43.2. Symptoms of hyperactivity-impulsivity;
- 43.3. Impairment on account of the symptoms;

44. Following the claimant's answers to those sections, the outcome seen at [252] is that the claimant has ADHD (“combined presentation type”) and that, on a scale of mild to severe, it is severe.

45. The respondent asserts that the DIVA-5 is hearsay evidence, as it is based upon answers that the claimant gave to the medical specialist. It is therefore argued on behalf of the respondent that I have no independent expert medical evidence of the claimant's symptoms.

46. I accept that the DIVA-5 is based on the claimant's answers; however, it is clear to me that this is the way in which ADHD assessments are completed. It must be that a diagnosis comes from the history given by a patient, given (for example) that matters relating to childhood are taken into account. Such process and practice is clearly accepted by the medical profession as providing sufficient medical evidence to lead to a sound diagnosis. I will not go behind such process adopted by the medical profession. I do not agree that the DIVA-5 result and diagnosis is undermined by the fact it is based on the claimant's subjective answers. I do however consider the claimant's primary evidence from his DIS and consider the DVIA-5 to be a relevant piece of evidence, but not determinative.

Medication

47. Following his referral, the claimant received a prescription of Elvanse; this is medication specifically for adults with ADHD. I can see a reference to starting ADHD medication in the claimant's GP notes at [213]. The claimant has had a repeat prescription for a daily dose of 50mg since 31 January

2025. This was after a period of “trial and error” with a different drug, Equasym XL. The claimant explains that the main effect of Elvanse is to reduce his exhaustion – [169].

48. The claimant went through a period of medical titration via a private specialist ADHD clinic from May to October 2024, stepping up his dosage. He describes this as a difficult period - [167]:

“the claimant was functioning without fully effective treatment while simultaneously adjusting to the physiological effects of a new and potent medication”.

49. The claimant in his DIS highlights this period as demonstrating what the effects of his ADHD would be without medication, as during that period he was working his way up to the optimum dosage. The claimant explains that the effects of his ADHD during this period were as follows – [169]:

- 49.1. Fluctuating productivity and output;
- 49.2. Sleep disruption and associated cognitive effects;
- 49.3. Reduced and inconsistent communication; and,
- 49.4. Inconsistent time logging.

Coping strategies

50. The claimant has developed coping mechanisms to reduce the effects of his ADHD. Those mechanisms themselves, the claimant says, require “daily effort and commitment” - [168]. He says that:

“the level of maintenance required is itself evidence of the substantial adverse effect the condition has on his life”.

51. The claimant sets out the following coping mechanisms:

- 51.1. Meditation;
- 51.2. Exercise (sporadically);
- 51.3. Task management strategies, such as parallel work streams and flexible hours of working;

Depression (Mixed Anxiety and Depressive Disorder)

Medical evidence

52. The claimant considers that he has suffered depression for as long as he can remember. He received a diagnosis of depressive disorder on 10 February 2020 (see [256]), following which he started treatment: he started Step 2 (Guided Self-Help) and then moved to Step 3 (High Intensity CBT) on 29 June 2020.

53. The claimant has undertaken periods of Talking Therapies. The claimant's first period of Talking Therapies ran from 19 February 2020 to 28 October 2020 - [222-226]. At the end of that period, the claimant had a PHQ9 score of 16 (moderate/severe) and a GAD7 score of 13 (moderate). Talking Therapies also recorded his Work and Social Adjustment Scale (WSAS)

score, which is marked out of 40: across the 8 months, he had scored a range between 13 and 20, other than the last score of 28. A score of 28 represents significant to severe functional impairment (the lower the score, the more severe the impairment).

54. The claimant stopped attending Talking Therapies because the therapy did not work for him.
55. The claimant has been prescribed Sertraline periodically: his first prescription was dated 8 July 2020, starting on 50mg - [278]. He told me that he stepped this up to 150mg by October 2020. His GP notes show something slightly different: he went up to 75mg daily in September 2020, went up to 100mg in April 2021 then back down to 50mg in December 2021 - [277-278]. He continued to take a prescription of 150mg until December 2021, when he had a break.
56. On 1 May 2024, the claimant was diagnosed with Mixed Anxiety and Depressive Disorder – see [218/256]. The claimant attended his GP and reported the following symptoms - [218]:
- 56.1. Struggling with mood and anxiety;
 - 56.2. Low energy and lack of concentration;
 - 56.3. Feeling tired all the time;
 - 56.4. Procrastinating a lot;
 - 56.5. Intermittent racing heart;
 - 56.6. Struggling with tasks at work and at home; and,
 - 56.7. Struggling with sleep.
57. At that point, the claimant retook the PHQ9 and GAD7 tests and got the scores of 19/27 (moderate/severe) and 19/21 (severe) respectively – GP records [216], report [232-233]. The claimant explained to me that the reason he went to see his GP at this point was that he was feeling overwhelmed and could not cope; he said matters had been building for a long time.
58. At this stage, the respondent raised a credibility point in relation to 1 May 2024 during the claimant's cross-examination, which I shall deal with now. In the claimant's PHQ9 test of 1 May 2024, in answer to the question regarding self harm, the claimant answered "several days", giving him a score of 1. On the same day, in his GP appointment, the claimant denied suicidal thoughts or thoughts of self-harm.
59. When asked about this apparent discrepancy, the claimant explained that he found it difficult to admit to thoughts of self-harm when face to face with his GP, but could fill in the questionnaire without the same difficulty/awkwardness. I accept this explanation for the apparent inconsistency. If the claimant was lying in his PHQ9 test, he would have done so knowingly and deliberately to give a worse impression of his mental health. If this was his intent, it makes no sense for him then to not match that intent and lie to the GP as well. I find the more likely explanation to be the one offered by the claimant.
60. The claimant was prescribed Sertraline afresh for the period May to August

2024, at a dose of 50mg daily - [257].

61. The claimant undertook a second period of Talking Therapies which commenced on 24 October 2025 (Stage 3 Counselling for Depression) and was continuing at the point of writing his DIS.
62. In terms of other coping mechanisms, the claimant undertakes meditation and exercise for both his depression and ADHD.
63. The symptoms described above are experienced by the claimant, even with medication and other treatment. He accepts that there is some mitigation of the effects of his depression, but the symptoms are by no means reduced significantly or eradicated.

Symptoms

64. The claimant also lists the following symptoms in his DIS – [171] and [175]:

- 64.1. Persistent low mood;
- 64.2. Fatigue;
- 64.3. Difficulties with motivation and concentration;
- 64.4. Withdrawal from social and professional life;
- 64.5. Emotional dysregulation;
- 64.6. Suicidal ideation;
- 64.7. Sleep difficulty;
- 64.8. Fatigue and low motivation/energy;
- 64.9. Difficulty with self-care (dental hygiene, hair care, personal washing) and household tasks.

65. The claimant explains that he masks in order to get by professionally, but sets out that this comes at a “significant personal cost” - [172]. He manufactures urgency regarding work tasks so as to try to get himself to engage with them. This has led to internal stress.

66. The respondent asserts that the claimant’s depression is reactionary, and has occurred in two discrete periods which follow adverse life events. I do not agree with this. I understand that the claimant had two periods of seeing Talking Therapies, however his evidence has been consistent in his oral evidence when compared to his DIS. I accept the claimant’s evidence that, just because he has not been treated consistently/constantly, this does not mean that he has not continued to experience symptoms of depression. I accept that the reason he stopped Talking Therapies the first time was that he did not see the benefit: that is supported by his PHQ9 and GAD7 results for the end of that first period.

Composite effect

67. The claimant contends, and I accept, that his ADHD and depression interact and compound each other. He explains in his DIS at [164] that it is difficult to separate out the effects that come from the two conditions.
68. The claimant explains in his DIS at [167] that:

“the effects of ADHD are compounded by his depression, which reduces motivation, increases fatigue, and makes task initiation even harder”.

Legal framework

The Equality Act 2010

69. The definition of disability is found in s6 of the Equality Act 2010 (“EqA”):

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. The meaning of “long-term” is set out in paragraph 2 of Schedule 1 to the EqA:

2(1) 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.

(2) 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.

71. In relation to medication, Schedule 1 sets out:

5. Effect of medical treatment

An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if –
Measures are being taken to treat or correct it, and
But for that, it would be likely to have that effect.

“Measures” includes, in particular, medical treatment and the use of a prosthesis or other aid.

72. The meaning of the word “substantial” is set out at s212 EqA, and is defined as “more than minor or trivial”.

The 2011 Guidance

73. In 2011, a guidance note was issued entitled “Guidance on matters to be taken into account in determining questions relating to the definition of disability”.

74. Regarding “substantial” adverse effect, Section B provides as follows:

B1. The requirement that an adverse effect on normal day-to-day activities should be a substantial one reflects the general understanding of disability as a limitation going beyond the normal differences in ability which may exist among people.

75. In terms of coping mechanisms and modifications to one's behaviour, paragraph B7 provides:

B7. Account should be taken of how far a person can **reasonably** 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. In some instances, a coping or avoidance strategy might alter the effects of the impairment to the extent that they are no longer substantial and the person would no longer meet the definition of disability. In other instances, even with the coping or avoidance strategy, there is still an adverse effect on the carrying out of normal day-to-day activities.

When considering modification of behaviour, it would be reasonable to expect a person who has chronic back pain to avoid extreme activities such as skiing. It would not be reasonable to expect the person to give up, or modify, more normally activities that might exacerbate the symptoms; such as shopping, or using public transport.

76. In terms of the case in which there is more than one impairment, paragraph B6 sets out as follows:

B6. A person may have more than one impairment, any one of which alone would not have a substantial effect. In such a case, account should be taken of whether the impairments together have a substantial effect overall on the person's ability to carry out normal day-to-day activities. For example, a minor impairment which affects physical co-ordination and an irreversible but minor injury to a leg which affects mobility, when taken together, might have a substantial effect on the person's ability to carry out certain normal day-to-day activities. ...

77. In terms of the "long-term" element of the test, paragraph C4 sets out as follows:

C4. In assessing the likelihood of an effect lasting for 12 months, account should be taken of the circumstances at the time the alleged discrimination took place. Anything which occurs after that time will not be relevant in assessing this likelihood. Account should also be taken of both the typical length of such an effect on an individual, and any relevant factors specific to this individual (for example, general state of health or age).

78. The Guidance sets out the following in relation to the term "normal day-to-day activities":

D3. In general, day-to-day activities are things people do on a regular or daily basis, and examples include 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. Normal day-to-day activities can include general work-related activities, and study and education-related activities, such as interacting with colleagues, following instructions, using a computer, driving, carrying out interviews, preparing written documents, and keeping to a timetable or a shift pattern.

79. Regarding "adverse effects on the ability to carry out day-to-day activities", at paragraph D19 of the Guidance, it states the following:

D19. A person's impairment may adversely affect the ability to carry out normal day-to-day activities that involve aspects such as remembering to do things, organising their thoughts, planning a course of action and carrying it out, taking in new knowledge, and understanding spoken or written information. This includes considering whether the person has cognitive difficulties or learns to do things significantly more slowly than a person who does not have an impairment.

Case-law

80. The legislative test can be broken down into a 4-stage test as set out by the Employment Appeal Tribunal ("EAT") in Goodwin v Patent Office 1999 ICR 302:

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 in one of the respects set out in paragraph 4(1) of Schedule 1 to the Act, 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 effect
Is the adverse effect (upon the applicant's ability) long-term?

81. The burden of proof in proving disability status is on the claimant – Kapadia v London Borough of Lambeth [2000] IRLR 699.

82. In terms of the relevance of medical evidence, such evidence is not necessary in order to prove a disability. However, it is instructive and important in order for a Tribunal to draw safe inferences on whether the essential conditions of s6(1) are satisfied – Royal Bank of Scotland Plc v Morris [2012] CLY 1122, EAT, *per* Underhill J at paragraph 61.

83. In consideration of whether any adverse effects are substantial, the focus must be on what the claimant cannot do, as opposed to concentrating on what he can do – Aderemi v London and South Eastern Railways Ltd UKEAT/0316/12, paragraph 15.

84. Regarding the question of whether any adverse effects are likely to last 12 months or more, it is established that "likely" is to be interpreted as meaning "could well happen" – SCA Packaging Ltd v Boyle [2009] IRLR 746. Furthermore, when looking at whether effects are likely to last 12 months or more, the Tribunal is not entitled to take into account events that occur following the relevant period – All Answers Ltd v Mr W [2021] IRLR 612.

85. In Paterson v Commissioner of Police and the Metropolis [2007] ICR 1522, the EAT set out its understanding of the comparison exercise to be done for the purposes of this part of the test of disability:

"68...In our judgment, the only proper basis, as the Guidance makes clear, is to compare the effect on the individual of the disability, and this involves considering

how he in fact carries out the activity compared with how he would do if not suffering the impairment. If that difference is more than the kind of difference one might expect taking a cross-section of the population, then the effects are substantial”.

“...when assessing the effect, the comparison is not with the population at large...what is required is to compare the difference between the way in which the individual in fact carries out the activity in question and how he would carry it out if not impaired”. – REF.

86. So, the Tribunal's attention must be on the impact of the impairment on the individual, rather than comparing how the individual is disadvantaged in relation to the general population.

87. The EAT in the case of Herry v Dudley Metropolitan Council 2017 ICR 601 was concerned with the question as to whether conditions described as “depression” will amount to impairments – *per* HHJ Richardson at paragraph 54 onwards:

“54. Underhill P said:

“42. The first point concerns the legitimacy in principle of the kind of distinction made by the tribunal, as summarised at para 33(3) above, between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to them as symptoms of low mood and anxiety. The first state of affairs is a mental illness - or, if you prefer, a mental condition which is conveniently referred to as “clinical depression” and is unquestionably an impairment within the meaning of the Act. The second is not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problems at work) or - if the jargon may be forgiven - “adverse life events”. We dare say that the value or validity of that distinction could be questioned at the level of deep theory; and even if it is accepted in principle the borderline between the two states of affairs is bound often to be very blurred in practice. But we are equally clear that it reflects a distinction which is routinely made by clinicians - it is implicit or explicit in the evidence of each of Dr Brener, Dr MacLeod and Dr Gill in this case - and which should in principle be recognised for the purposes of the Act. We accept that 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, as we recommend at para 40(2) above, a tribunal starts by considering the adverse effect issue and finds that the claimant's ability to carry out normal day-to-day activities 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 or she 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.”

55. This passage has, we believe, stood the test of time and proved of great assistance to Employment Tribunals. We would add one comment to it, directed in particular to diagnoses of “stress”. 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.

56. Although reactions to adverse circumstances are indeed not normally long-lived, 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. A doctor may be more likely to refer to the presentation of such an entrenched position as stress than as anxiety or depression. 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. Any medical evidence in support of a diagnosis of mental impairment must of course 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 to the employee's satisfaction; but in the end the question whether there is a mental impairment is one for the Employment Tribunal to assess."

88. Furthermore, in cases involving ADHD as the impairment, the EAT in Stedman v Haven Leisure Ltd [2025] EAT 82 provided some guidance as to the relevance of a diagnosis of ADHD (and autism):

"The significance of a diagnosis

57. Although I have dismissed ground 1 of the appeal, I need to say something about Professor Fox's diagnoses of autism and ADHD. In responding to this ground of appeal, at [15] of her skeleton argument, Ms Balmelli submitted that the Tribunal was right to consider the claimant's diagnoses as being relevant only to the question of whether the claimant has a 'mental impairment' and not to the question of substantial adverse effect. I am not convinced that is what the Tribunal in this case did, but if it did that would have been the wrong approach.

58. The parties are in agreement that, just because someone has a diagnosis of autism or ADHD, it does not mean that they are disabled within the meaning of section 6 of the EA 2010. I agree. Ms Balmelli is also right that autism and ADHD manifest in different ways in different people. However, it would in my judgment be wrong for a Tribunal to proceed on the basis that the fact of diagnosis was irrelevant to the question of 'substantial adverse effect'.

59. While I do not expect all judges to be familiar with the international diagnostic criteria for autism and ADHD, all judges should be familiar with the Equal Treatment Benchbook, and also with the principle that a diagnosis (in broad terms) reflects a clinical judgment that someone is significantly different from the norm as regards the area of functioning covered by the diagnosis. The Disability glossary to the Equal Treatment Benchbook provides a lot of information about autism, including explaining that "To have a diagnosis of autism a person will have difficulties with social communication and integration, and will often demonstrate restricted, repetitive patterns of behaviour, interests or activities." Equivalent information is included in relation to ADHD.

60. Where a Tribunal has before it evidence of a clinical diagnosis of autism or ADHD, accordingly, then (unless there is some reason to doubt the reliability of that clinical judgment), the Tribunal must take that diagnosis into account not just

as evidence that someone has a condition or impairment, but as evidence as to the impact of that impairment. The diagnosis means they have been judged by a clinician to have significant (i.e. clinically 'more than minor or trivial') difficulties with the areas of functioning covered by the diagnosis.

61. It does not, of course, follow that the Tribunal must accept the clinician's view as answering the disability question under the Act. The Tribunal still needs to consider what it was that led the clinician to make the diagnosis in the claimant's case, and to make findings about the claimant's ability to carry out day-to-day activities. If the claimant is not a reliable narrator, that may undermine any clinical opinion that is based on the claimant's account. However, as regards something like social interaction and communication, if a clinician has judged a claimant's difficulties in that respect to be significant enough to merit a diagnosis of autism, a Tribunal will need to engage with that view in its reasons when dealing with the question of 'substantial adverse effect'.

Conclusions

89. Firstly, I am satisfied that the claimant has an impairment of both ADHD and Depression (Mixed Anxiety and Depressive Disorder).

90. I turn to the question of adverse effect on the claimant's ability to carry out normal day-to-day activities, and whether those effects are substantial.

91. The respondent, despite reminding me that the relevant test is what a claimant cannot do, has instead focused on what he can do. I have found that the claimant cannot prioritise by choice, and so struggles to complete work or feels the stress of running close to a deadline. I accept he has problems maintaining personal hygiene and has difficulty with financial mismanagement and organisational and administrative matters. Furthermore, I have found that those effects are because of the claimant's ADHD.

92. I do at this stage take into account the claimant's diagnosis, and the factors necessary for a diagnosis, as cited at paragraph 40 above. As I have set out above, I do not accept the respondent's criticism of the report, and consider it relevant to the issue of substantial adverse effect.

93. The diagnosis and the contents of the DIVA report support and compound the claimant's own evidence about the effect of his ADHD on his daily life. I am satisfied and conclude that his ADHD has a more than minor and trivial adverse effect on him.

94. I conclude that those symptoms are primarily linked to the claimant's ADHD, albeit I accept that they are exacerbated by his depression. The claimant has a diagnosis of severe ADHD. He has explained to me in his oral and written evidence that his view is that the symptoms he experiences are caused by his ADHD and exacerbated by his depression. There is no good evidence to undermine that evidence from the claimant. As I have set out above, I consider the claimant to be a credible witness, and accept his evidence on this point. I conclude that it is more likely than not that those symptoms are primarily linked to his ADHD.

95. However, I am permitted to consider the combined effect of two

impairments, and to decide whether, together, they have the requisite effect. I consider the effect of the claimant's symptoms, whether caused by ADHD alone or ADHD as exacerbated by depression, are substantial and adverse.

96. The respondent accepts that the claimant's ADHD is long term, and I conclude that it is thus.

97. In terms of the claimant's depression, I do not accept the respondent's case that this is a reactive condition that has spiked twice in the claimant's recent history. I have accepted the claimant's explanation for the gap in his Talking Therapies treatment. The medical evidence shows a prolonged period during which the claimant was being treated for depression, from 2020 to 2024.

98. I am satisfied that the substantial adverse effects caused by ADHD alone, or ADHD exacerbated by depression, were long-term. Therefore,

99. I conclude that the claimant is disabled by way of his ADHD as exacerbated by his depression.

Approved by:

Employment Judge Shastri-Hurst

Date: 6 October 2026

SENT TO THE PARTIES ON

10 October 2026

FOR THE TRIBUNAL OFFICE

Notes

All judgments (apart from judgments under Rule 51) and any written reasons for the judgments are published, in full, online at <https://www.gov.uk/employment-tribunal-decisions> shortly after a copy has been sent to the claimants and respondents.

If a Tribunal hearing has been recorded, you may request a transcript of the recording. Unless there are exceptional circumstances, you will have to pay for it. If a transcript is produced it will not include any oral judgment or reasons given at the hearing. The transcript will not be checked, approved or verified by a judge. There is more information in the joint Presidential Practice Direction on the Recording and Transcription of Hearings and accompanying Guidance, which can be found here:

www.judiciary.uk/guidance-and-resources/employment-rules-and-legislation-practice-directions/