EMPLOYMENT TRIBUNALS

Claimant: Mx J Williamson

Respondent: John Lewis PLC

JUDGMENT AT A PUBLIC PRELIMINARY HEARING

Heard at: **Birmingham (in public, by video** **On:** **5 October 2026**

Before: **Employment Judge V Jones**

Appearances

For the claimant: Mr D Hallström, counsel

For the respondent: Ms J Laxton, counsel

JUDGMENT

1. The claimant was a disabled person within the meaning of section 6 (1) and (2) of the Equality A ct 2010 during the period 7 January to 30 April 2025 by reason of the following impairments:

    a) sciatica/lower back pain;
    b) frozen shoulder/left shoulder injury;
    c) depression and anxiety/post traumatic stress disorder/seasonal adjustment disorder.

REASONS

Background

1. The respondent operates a national chain of retail department stores and the Waitrose supermarket chain. The claimant was employed as a supermarket assistant at the respondent's Waitrose store in Uttoxeter from 12 March 2016 until their employment was terminated with effect on 30 April 2025.

2. The claimant's ET1 claim form was presented on 9 September 2025 following a period of early conciliation which began on 14 May 2025 and ended on 25 June 2025. They bring claims for unfair dismissal and discrimination (pursuant to sections 15, 20 and 21 Equality Act 2010 ('EqA')) by reason of the protected characteristic of disability.

3. The claimant asserts that they are a disabled person as defined by section 6 EqA and that they have been subject to unlawful discrimination by the respondent over a period of time commencing on 7 January 2025, after the claimant commenced a period of sickness absence, and ending when they were dismissed on 30 April 2025.

4. The Respondent lodged a response and Grounds of Resistance on 27 September 2025 denying the claim in its entirety. No admissions were made as to whether the Claimant was disabled within the meaning of the Equality Act 2010 at the relevant time.

5. The claimant relied on six impairments which they said amounted to disabilities. In response to a case management order made by Legal Officer Parmar in February 2026, they provided medical evidence and a disability impact statement to the respondent. They also responded on a voluntary basis to the respondent's request for further information. However the respondent had insufficient time to consider this information before the case management hearing on 28 April 2026 (see below) because it was only received a few days before.

Case management hearing 28 April 2026

6. A case management hearing took place on 28 April 2026 before Employment Judge Walker where the issues in the claim were clarified and recorded in a case management order sent to the parties on 30 April 2026. At paragraph 4.1. of the list of issues (p112) EJ Walker set out the impairments relied on by the claimant as follows: sciatica (1); frozen shoulder (2); PTSD (3); seasonal affective disorder (4); anxiety (5) and depression (6).

7. The respondent was not in a position to concede that the claimant was a disabled person by reason of any of the impairments and could not confirm whether the claimant had provided all of the further information it had requested. EJ Walker ordered the respondent to write to the claimant by 9

May 2025 setting out any outstanding information which had not been provided and ordered the claimant to provide that information by 12 June. Thereafter, the respondent was ordered to advise the claimant whether disability was conceded in relation to all or any of the impairments. If not conceded, a public preliminary hearing would take place on 5 October 2026 to determine whether the Claimant was disabled at the relevant time by reason of one or more of the six impairments relied on ("the disability issue").

8. The claimant's further information was not provided until 14 and 15 September. In its amended ET3 response dated 28 September 2026 the respondent said it did not concede that any of the alleged impairments were disabilities for the purposes of s6 EqA and the matter should be determined at this public preliminary hearing.

This Hearing

Evidence

Bundle of documents

9. There was a 597 page bundle containing relevant materials (Hearing Bundle). In addition, the claimant provided a skeleton argument.

Witnesses

10. The Claimant gave evidence, relying on their disability impact statement (DIS) and supplemental disability impact statement (SDIS) (pp 429-444 and395-428 respectively) They were cross-examined.

Application to amend claim

11. As a preliminary matter the claimant applied to amend their claim to rely on the following further impairments: lower back pain; musculoskeletal issues and an extension of the "frozen shoulder" impairment to include "left shoulder injury".

12. The respondent objected to the application which was being made very late in the day. The final hearing is scheduled for 22-26 February 2027. The claimant had had ample opportunity to include these additional impairments before and was represented at the case management hearing in April 2026.

13. Having heard the parties' submissions I considered the balance of prejudice and hardship favoured granting the application in part, as follows:

    13.1 "lower back pain" and "Joint pain in knees and hips" would be added as separate impairments;
    13.2 The impairment "frozen shoulder" would be expanded to include "left shoulder injury"

13.3 The application in respect of "musculoskeletal issues" was refused.

14. I gave full reasons for my decision orally at the hearing.

15. The question for determination at this hearing is therefore whether the Claimant was disabled at the relevant time by reason of:

sciatica (impairment 1);
frozen shoulder/a shoulder injury (impairment 2 as amended);
PTSD (impairment 3);
Seasonal Affective Disorder (SAD) (impairment 4);
anxiety (impairment 5);
depression (impairment 6)
Lower back pain (impairment 7);
joint pain in knees and hips (impairment 8).

The Law

16. In order to bring a disability discrimination claim, the Claimant must satisfy the definition of "disability" as set out in section 6 of the Equality Act 2010.

Section 6

"(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".

17. Para. 12 of Schedule 1 of the Equality Act 2010 provides that when determining whether a person is disabled, the Tribunal "must take account of such guidance as it thinks is relevant". The "Equality Act 2010 Guidance: Guidance on matters to be taken into account in determining questions relating to the definition of disability" (May 2011) (Guidance) was issued by the Secretary of State pursuant to section 6(5) of the Equality Act 2010.

Physical or mental impairment

18. The words 'physical or mental impairment' should be given their ordinary meaning. The impairments do not have to be the result of an illness, nor does the cause have to be established with medical precision, provided that the tribunal is satisfied that it exists (paras A3-A8 of the Guidance).

19. In **Morgan v Staffordshire University** [2002] ICR 465, the EAT gave useful guidance for parties seeking to establish the existence of a mental impairment, including the following principles:

- Tribunal members cannot be expected to have anything more than rudimentary familiarity with psychiatric classification. Claimants should identify clearly and in good time exactly what their impairment is, and the Respondent should identify whether that impairment is an issue, and, if so, why. The parties will then be clear as to what must be proved and rebutted, in medical terms, at the hearing.

- Tribunals are unlikely to be satisfied of the existence of a mental impairment in the absence of suitable expert evidence. However, this does not mean that a full consultant psychiatrist's report is required in every case.

- There will be many cases… where the medical evidence will need to cover not merely a description of the mental illness but when, over what periods, and how it can be expected to have manifested itself in the course of the claimant's employment.

- The dangers of the tribunal forming a view on mental impairment from the way that the claimant gives evidence on the day cannot be overstated.

20. A four-stage approach to determining whether a person is disabled was approved by the Court of Appeal in Sullivan v Bury Street Capital Limited [2021] EWCA Civ 1694, where Singh LJ listed the questions as:

    20.1 Was there an impairment? (the 'impairment condition');

    20.2 What were its adverse effects on normal day-to-day activities? ('adverse effect condition');

    20.3 Were they more than minor or trivial? (the 'substantial condition');

    20.4 Was there a real possibility that they would continue for more than 12 months? (the 'long-term condition').

    Singh LJ emphasised that these are questions for the Tribunal; although it may be assisted by medical evidence, it is not bound by any opinion expressed.

21. There is no statutory definition of a physical impairment. In the case of College of Ripon and York St John v Hobbs [2002] IRLR 185, it was held that a person has a physical impairment if they have "something wrong with them physically".

22. There needs to be an adverse effect on normal day to day activities. It is settled law that "day to day activities" encompasses activities which are relevant to participation in professional life as well as participation in personal life, and that the Tribunal should focus on what the claimant cannot do, or can only do with difficulty, not what they can do (Para B9 of the Guidance).

23. Schedule 1, para 5 EqA 2010 provides that an impairment is to be treated as having a substantial adverse effect if measures are being taken to treat or correct it and, but for that, it would be likely to have that effect. 'Likely', in this context, means "could well happen" (SCA Packaging Limited v Boyle [2009] ICR 1056, HL).

24. This would also include coping or avoidance strategies or 'masking', for which account should be taken of how far a person can reasonably be expected to modify their behaviour (para B7 of the Guidance).

25. Under section 212(1) of the Equality Act (and para B1 of the Guidance), "substantial" means more than minor or trivial. The Tribunal should consider e.g. the time taken to carry out an activity, the way in which the activity is carried out, the cumulative effects of impairments, and the effects of environmental factors. The question of where there is a "substantial" adverse effect is a matter of fact for the Tribunal to determine.

27. Schedule 1, part 1, paragraph 2 of the Equality Act 2010 says the effect of an impairment is "long-term" if it has lasted for at least 12 months, is likely to last for at least 12 months or is likely to last for the rest of the life of the person affected.

28. Sch 1 para 2(2) provides that, if an impairment ceases to have a substantial adverse effect on a persons 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. The guidance adds that this applies even where the effects occur only sporadically or for short periods. "Likely" in this context means "could well happen".

29. Where a claimant is seeking to rely on a number of potential conditions and it is unclear which conditions might have led to the various symptoms, it is important that the Tribunal makes clear findings as to the nature of each impairment and which symptoms were attributable to each, although it is not necessary to identify a specific condition; what is more important is the *nature* of the impairment: Morgan Stanley International v Posavec EAT 0209/13.

Findings of fact

30. The Claimant provided medical evidence (pp445-597). Of note are the following entries:

Sciatica

30.1 The claimant had a formal diagnosis of sciatica on 30 July 2012 (p529)

30.2 The GP record of an appointment in July 2025 states that sciatica is "ongoing"

30.3 Dr Omar Elgharrably's clinical information summary dated 30 June 2026 (at pp 566-7) records that the claimant has a 29 year history of intermittent sciatica, which commenced during pregnancy.

Lower back pain

30.4 The claimant's medical record on 23 March 2015 records a complaint of lower back pain (p529).

30.5 An MRI on 23 September 2024 revealed shallow disc bulges in the lower 3 lumbar discs, moderate facet arthrosis and minimal anterolisthesis at L3/4 and other degenerative changes (p480);

30.7 The medical record of November 2024 records a complaint of lower back pain (p529)

30.8 The medical record of March 2025 records a complaint of "pain in thoracic spine" (p529)

Frozen shoulder/left shoulder injury

30.9 The GP record of 24 July 2023 records a complaint of shoulder pain (p532);

30.10 An ultrasound scan on 7 December 2023 revealed supraspinatus tendinopathy (tendinitis) (p466). The claimant received steroid injections for this on 12 December 2023 and 16 July 2024 (pp467,477)

30.11 The GP record of 6 January 2025 records a further complaint of shoulder joint pain (p532). The claimant was referred to a consultant.

30.12 The claimant saw Mr Dan Morris, consultant orthopaedic surgeon, on 10 February 2025. His letter (p.500) sets out the background to the consultation as follows:

"(JW) has had two bouts of recent problems with the left shoulder the first of which was precipitated in July 2023 when she was having to reach more in their role as a checkout worker. This resulted in 4.5 months off work where she had two injections to the shoulder and physiotherapy, but then managed a phased return to work.

Over the recent Christmas period there was an increase in demand on her work and again the shoulder became more painful to the extent that she was wearing a sling at work. She has had no injections or physiotherapy input to the shoulder this time and has been referred through to discuss treatment.

"She currently has pain daily including some night symptoms. She describes it as being diffuse across the shoulder with some pain that also radiates down into the hand, particularly in the morning. She

describes the hand symptoms in a C6 nerve distribution and the pain in the shoulder mainly around the rotator interval. She has PTSD, depression and anxiety. She is medicated and receiving therapy for this….. She is currently off work because of her shoulder issues."

30.13 Mr Morris diagnosed adhesive capsulitis (frozen shoulder) (p500). He recorded the claimant was able to forward flex to 90 degrees, abduct to 70 degrees and externally rotate to 10 degrees (compared with 60 degrees on the contralateral side). A steroid injection was administered (p500) and the claimant was referred to physiotherapy with a review in 4 months time.

30. 14 At their review in July 2025, the claimant's forward flexion, abduction and external rotation were found to have improved significantly but they were still unable to raise their arm sufficiently high for personal care. They received a further steroid injection (p514). A further steroid injection was given in December 2025 (pp 537).

The records at 30.14 above postdate the period under consideration in this hearing.

Hip and Knee pain

30.15 There is an entry of "joint pain" with no further details on the GP record dated June 2014 (p532). On 8 April 2024 there is a record "patient has had a fall" with no further details.

Mental impairments

PTSD

30.16 The claimant completed a 6-session Grounding Emotions program with the Staffordshire NHS Complex Trauma Pathway between November and December 2023 (p464,467)

30.17 A letter from LeAndra Nephin (complex trauma therapist at NHS Staffordshire and Stoke on Trent Talking Therapies) dated 25 April 2025 (p507) records the end of a further period of therapy with the claimant and sets out the history of their involvement as follows:

"We met for an initial appointment on June 7, 2024. Following this we met for 10 sessions to work on your feelings of anxiety, depression, and traumatic stress….
"At the beginning of our sessions you identified anxiety, depression, and traumatic stress as your presenting problems. To address these difficulties we spent our sessions focusing on Narrative Exposure Therapy (NET), Trauma Focused Cognitive Behavioural Therapy (TF-CBT), Schema Focused CBT, Eye Movement Desensitisation and

Reprocessing (EMDR) Therapy, and mindfulness/stress management techniques…..

Psychometric Scores
We completed some questionnaires which showed the severity of your symptoms at initial contact as (moderate/severe) and upon discharge:
Depression questionnaire PHQ9 score: 9
Anxiety questionnaire GAD 7 score: 6

Recommendations
In our final session we discussed ways in which you could maintain this improvement and what steps you might take should your levels of stress return in the future.

….. however you do now have a range of new skills and grounding techniques which you can use to manage your feelings of traumatic stress, anxiety, and depression. I recommend that you put these into practice over the next few months as time is important for maintaining the improvement you have made….”

30.18 The claimant was prescribed an antidepressant medication (sertraline 50mg) on a repeat prescription basis from 12 September 2024 (p529)

Anxiety/depression

30.19 The claimant was diagnosed with mixed anxiety and depressive disorder in 2004 which is listed by their GP as a “significant” problem (p530).

30.20 They were prescribed sertraline from September 2024 (see above) Though there is no GP record to confirm it, they say they had been taking citalopram on a repeat prescription basis since 1998, but no longer have the relevant records which would confirm this.

30.21 As the disorder is classed as “significant” and as the claimant refers to long term use of citalopram in their OH adviser consultations from 2016 onwards, I accept their evidence that they were prescribed citalopram from 2004 if not earlier, though I noted from the OH reports that there was a period when they decided not to take it because they felt it did not help (p176).

30.22 The grounding emotions programme (see above) also dealt with the claimant’s anxiety and depression (p456). In addition the claimant attended 11 therapy sessions via NHS Talking Therapies from October 2023 to January 2024 specifically targeting depression and related anxiety (p545). At the end of these sessions the claimant was referred to self help and self care websites to help maintain their wellbeing.

Seasonal Affective Disorder

30.23 The letter dated 14 April 226 from Dr Sophie Brooks, the claimant's GP(p557) states they have suffered from SAD for a "prolonged period".

30.24 The claimant says they were advised by a mental health professional to use a light box to help manage the symptoms (p410). There were no medical records about this in the bundle.

30.25 The claimant was prescribed an antidepressant medication (sertraline 50mg) on a repeat prescription basis from 12 September 2024 (p529)

Occupational health referrals

31. The bundle contains records of the claimant's occupational health referrals between October 2016 and February 2025. All meetings between the claimant and the occupational health advisers were conducted by telephone. The following entries are of note :

31.1 The report dated 10 October 2016 notes the claimant has an 18 year history of anxiety and depression, beginning with post natal depression and has taken citalopram for 18 years. Symptoms increase in the winter months (pp166-7);

31.2 The referral of 30 January 2020 (pp172-180) records that the claimant twisted their left hip at work two weeks previously. Pain had moved to their lower back and right hip. They were awaiting an X-ray result and physiotherapy and were taking strong painkillers. The respondent had put reasonable adjustments in place : a chair behind the kiosk, support when completing weekend newspapers and plan to breakdown time when doing product check on magazines. Under "past medical history" the OH adviser records "depression – ongoing issue" and "stopped taking anti-depressants – not helping". Reasonable adjustments were suggested for a few months then review, including: no repetitive heavy lifting; standing short periods only; pulling, pushing, reaching, bending for short periods; assistance/support with magazine boxes; may need short sit down break when experiencing acute hip pain; recovery time – hopefully pain levels will reduce over the next few months."

31.3 At a referral at the end of April 2021 (while the claimant was off sick following removal of a cyst from their neck 6 weeks earlier) the occupational health adviser recommended continuing with the previous adjustments (still on a temporary basis) and a phased return to work. The report records under "past medical history": "Depression – post natal 24 years ago, under GP, no medication taken" (pp181-7)

31.4 A referral was made to Neil Walker, OH adviser, in March 2022. The referring manager stated that JW suffered from SAD and had had adjusted working hours to accommodate this. He asked whether the claimant's shifts could now be moved back as the days were getting longer. Mr Walker replied:

"As indicated on the referral....(JW) suffers from seasonal affective disorder (SAD) as well as having a history of depression/anxiety which can impact on each other. (JW) …noticed an increase in their symptoms in the winter months especially later in the day, the main symptoms being low mood/lack of motivation". Mr Walker records that the claimant takes medications and utilises self help techniques. Their symptoms can vary in severity and frequency. Permanent reasonable adjustments were suggested as follows:

- a more planned, structured, schedule/rota to allow better work/life balance to allow more than two days off together;
- avoid working after 6.30pm to allow better management of symptoms (SAD, depressions and anxiety)

The report notes that JW is taking citalopram 20mg, has previously had counselling and is self-managing (p202). Mr Walker advised that further medical information was not required and the case would be closed (p200).

31.5 The referral in September/October 2022 (pp205-212) records that the claimant's depression/anxiety is stable at present: they are having CBT. There are some MSK issues (lower back pain-sciatica): can radiate down left leg; some pain in knees with prolonged standing (no definitive diagnosis). They are taking naproxen and citalopram 40mg.The claimant is taking positive steps to manage their limitations to reduce any negative impact on attendance and performance.

31.6 The response to the referral in November 2022 refers to "increased pain in left knee and hip but no diagnosis. Advised to see GP and referred for physio". The OH adviser said there was no plan to review.

31.7 The referral in May 2023 says the claimant has sciatica and is struggling with their back. They have recently had a short period of sickness absence. The OH adviser, Mr Walker, states it would be beneficial to have a wellness plan in place, JW needs to be able to change position on a regular basis and avoid prolonged static postures (both standing/sitting) dependent on the severity of symptoms on a particular day. Task rotation, exploring working on the welcome desk and having a suitable chair to rest are all recommended. JW is

managing their MSK symptoms and depression on a day to day basis. Asked to advise how their capability changes on a day when their sciatica is playing up, Mr Walker says It is difficult to differentiate as it depends on the severity of symptoms. JW has a good understanding of their limitations

31.8 The claimant was referred to OH again in July 2024 because their manager said their conditions must be reviewed frequently. The OH adviser advised that this was not the case: their conditions were permanent and the recommended adjustments were also permanent. The wellness Plan should ideally be reviewed and updated, however a clinical review was only necessary if there was a significant change in their conditions. The adviser considered the Equality Act was likely to support the claimant's conditions. Under the heading "Outcome/prognosis" the following advice was given:

"Ms Williamson has a number of chronic and complex conditions which are permanent, however they are aware of their limitations and has advised that they are able to implement some flexibility in their working role…."

31.9 Reviewing the claimant's history, the adviser said there had been previous referrals for sciatica, ongoing musculoskeletal issues, "all the mental health issues" and JW had recently been off with left shoulder issues and a new diagnosis of carpal tunnel in both wrists. They had been referred for further investigations for their joints. In relation to depression, citalopram 40mg was said to be not effective "but (JW) notices when she doesn't take it". They have had talking therapies. They also have PTSD. They have ongoing shoulder issues and it is a repetitive injury. They are supposed to work only two hours on the kiosk but this is not happening, which has led to a flare up. They mainly works on tills but it impacts their hip and back. They can cover self check-out but only for a short time (10-15 mins). They were supposed to be trained for the welcome desk but could not do that as there was no chair. They rotate from kiosk to tills and do other "little" tasks e.g. putting baskets away or swapping tills for a change of posture. They take over-the-counter medications and use muscular rubs. They do exercises and Tai chi.

31.10 The July 2024 report also contains the following paragraph:

"Also has OCD (sic) and one manager wanted her to work when it is dark. Can't do this, it affects her. Has a permanent restriction on late night working". I find this entry must refer to SAD as the adjustment regarding late night working was put in place in March 2022 because of

SAD, anxiety and depression. There is no mention of “OCD” anywhere else in the Occupational Health reports.

31.11 The OH report of Pamela Strydom dated 13 November 2024 states that JW has underlying health conditions affecting performance and attendance and they are permanent (p253). Relapses are said to be “likely to occur”. Miss Strydom referred the respondent back to previous occupational health reports as “*it is the same conditions that trigger the referrals each time.”* She considers all of the claimant’s conditions are likely to be supported by the Equality Act and recommends they be supported with reasonable adjustments. She said she had not arranged to review the claimant and a re-referral should only be made if JW’s condition changed significantly: “a*nother referral without any change in (JW) will be rejected as inappropriate.”*

31.12 Ms Strydom records that the claimant has recently had an MRI scan which showed arthritis and narrowing of nerve canals in their spine and has been referred for further investigation. They have difficulties working in the kiosk because it involves using their left shoulder a lot, impacting the underlying shoulder injury. Repetitive stretching does the same. They can work in the kiosk if able to sit down intermittently. Static standing is difficult. Even with some movement, being on their feet exacerbates their spinal condition. Walking around (as suggested by the claimant’s manger) is not ideal as it involves standing upright. The manager’s suggestion of 45 minutes is not a reasonable amount of time to stand: the claimant is likely to manage 15 minutes.

31.13 The referral of 19 February 2025 (pp258) (at which time the claimant had been off work for 6 weeks) states that they have three long term medical conditions: MH conditions; musculosketal condition affecting their back; and a left shoulder injury. Though acknowledging that it is not ultimately a medical decision, In the opinion of the OH adviser (Kate Naylor) these three conditions are likely to fall within the remit of the Equality Act.

31.14 Ms Naylor’s report records that on 7 Jan 25 the claimant went off sick because of shoulder pain after an increase in the volume and pace of work. They had begun to feel pain three days earlier but had continued to work on, by which time their left arm was in a sling. They had a fit note to 4 March 2025 though Ms Naylor considered it more likely they would be off until mid-end March. When they were fit to return, the following reasonable adjustments were recommended:

Limit standing to 10-20 minutes
Limit bending to low levels

Allow claimant to sit down regularly
Limit kiosk work to 2 hours or 1 hour if busy
SCO work –limit to 10/20 minutes depending on back pain
Checkouts - continue to alternate between duties and have access to a chair
Reductions - limit to 1 hour
Training in cash office would be helpful
Have more frequent breaks during shifts: an extra 15 minute break plus unplanned breaks for mental health
No late shifts
Maximum of 3 consecutive shifts
Absences for mental health, back or shoulder pain should fall under the respondent's long term conditions/sickness policy
A phased return to work

31.15 At pp 265-267 the OH provided the following information about the three conditions she had identified as long term:

(i) lower back pain/sciatica

The claimant has intermittent back pain triggered by prolonged standing, heavy lifting, stress. It is settled at the moment. An MRI scan Dec 24 identified bulging discs and claimant was referred to physio. In March 2025 they were referred to a consultant. Suffers pain only when stressed or cannot manage an activity. Referred for physio, continuing two weekly. Takes paracetomol and Brufen for pain, rotating.

(ii) Mental health

Has suffered for 27 years since their son was born. Has been on anti-depressants for many years. More recently has suffered with PTSD and is having EMDR for PTSD sessions 1-2 times per month. There is a SAD element for which they use a light box. Has fixed rota, earlier shifts - can predict shifts, plan treatment, gives structure and routine. Suffers with anxiety in the mornings. Has panic attacks – none since their medication was changed from citalopram 40 mg to Sertraline 50mg in 2024 to help with PTSD. Their anxiety is "not great as worried about her job" Was tearful when speaking about their mental health. Manages their mental health with crafts, journals crystals, aromatherapy etc.

(iii) Left shoulder pain

Severe pain which causes the claimant to cry sometimes. Pain level has improved since injection but still has restricted movement. Pain score is 4-5/10 at present. When lifts to put deodorant on pain is "severe 10/10". Has been diagnosed with a condition which limits

movement of the shoulder and causes high levels of stiffness and pain. Manages tasks at home with right hand. Has rearranged their kitchen so they can reach items without raising left arm. Difficulties dressing, can just about wash themselves, washing under arm very limited. Lifting their fork to their mouth is painful. Driving- has automatic car. Shoulder specialist did not give any indication of recovery time.

Claimant's evidence

32. The claimant relied on their Impact Statement (DIS) and Supplemental Impact Statement (SDIS) at pp 429-444 and 395-428 respectively. I make the following findings from their evidence:

Sciatica and lower back pain

32.1 Symptoms vary in severity but include pain in their left hip thigh and leg, tingling and altered sensation, numbness in their left foot, weakness in their left leg, stiffness after remaining in one position, reduced mobility during flare ups and discomfort when standing walking or sitting for prolonged periods (p397). They use pain relief to manage the symptoms, tramadol from 2012-2016 and then naproxen until advised to discontinue because of contra-indications with their blood pressure medication. Since then, including during the period January-April 2025, they have used paracetomol and aspirin regularly.

32.2 The DIS sets out the effect on day to day activities at p430. The impairments made it challenging for the claimant to sit stand or move for extended periods. They often have to sit down after 10-20 minutes of standing unaided (less on bad days) due to the intense join pain. This makes it increasingly difficult to carry out daily tasks. The pain can severely affect movement and mobility. Their car has a higher seating position with heated seats and automatic transmission. On bad days they have to lift their left leg into the car by hand because the pain can be excruciating. Basic tasks such a getting out of bed, dressing their lower body, preparing meals, maintaining personal care or moving around independently can be either extremely difficult or unmanageable. They use furniture around the house for support when moving around, use a stool in the kitchen while washing up or cooking, cook microwave meals to minimise time spent standing. The effort expended on daily tasks saps their energy and motivation. At work they were unable to stand or sit for extended periods (more than 10-20 minutes, shorter if their sciatica was bad). They were sometimes able to use an orthopaedic chair at one of the tills which was more supportive.

32.3 The claimant says in their SDIS that they use practical aids and adaptations including a rollator (para 12 p398) However in cross examination they said this has only been used since November 2025 and they accepted this was later than the relevant period for their disability claim. Their symptoms have worsened since they left work but were “bad” before. At work they would either sit on an adjustable chair or on the steps of a “table top”. They said it was hard to separate out the symptoms of sciatica and lower back pain because they occurred at the same time.

Frozen shoulder/left shoulder injury

32.4 The claimant describes their symptoms at p425-428. The condition was present throughout the period January to April 2025. They experienced pain when reaching forwards, sideways or behind their back, when raising their arm above shoulder height, during repetitive arm movements and when carrying objects. They have a reduced range of movement and strength, stiffness, weakness, disturbed sleep and difficulty undertaking activities requiring sustained use of their left arm. Symptom fluctuate but can significantly restrict movement and function when aggravated. Treatment has included painkillers, steroid injections, physiotherapy and exercises.

32.5 At the relevant time, this condition affected the claimant’s ability to reach, fasten clothing such as bras, wash, brush or style their hair, put on or remove certain items of clothing, lift objects with their left arm, carry shopping or heavy items, undertake household tasks requiring reaching lifting or repetitive arm movements, get lids off jars, sleep comfortably, drive comfortably for longer periods. They had adapted by reorganising their home, e.g. moving times to lower positions so they do not have to stretch, wearing loose fitting clothes that are easier to take on or off. Completing everyday tasks could result in increased discomfort and fatigue.

32.6 At work the condition affected their ability to do repetitive checkout work, scan lift or move items repeatedly throughout a shift, work on the kiosk involving repetitive reaching and arm movements, do tasks requiring sustained use of their left arm, carry out manual talks comfortably, work prolonged shifts without pain and stiffness, maintain the same pace of work when symptoms were aggravated. They had to modify how they carried out tasks including serving one-handed on the till during Christmas 2024.

Mental impairments

PTSD

32.7. The Claimant has experienced recurring nightmares and night terrors since 1997. their symptoms were retriggered and aggravated by a workplace incident in June 2023, detailed in their impact statement (p405). They received trauma counselling and eye movement desensitisation and reprocessing (EMDR) treatment between June 2024 and March 2025 via the NHS Complex Trauma Pathway. They also completed a 6-session Grounding Emotions program in late 2023 (p465). They take antidepressant medication (Sertraline 150mg);

32.8 The Claimant's PTSD causes severe sleep disruption, insomnia, hyper vigilance, fatigue, concentration loss, emotional distress and overwhelm, and emotional disregulation. These affect their ability to carry out everyday tasks because of fatigue, and their ability to engage with distressing subjects. They feel unsafe in everyday situations, have difficulty tolerating crowds or people standing close to them and are startled by unexpected noise. They repeatedly check locks, door and windows, avoid particular TV programmes, and panic if they perceive someone as following them when walking or driving. Their ability to cope is reduced further during periods of stress.

32.9 The claimant's ability to maintain concentration, manage fatigue and cope with stress at work was also affected. They have difficulty regulating their emotions when symptoms are heightened. However work sometimes helped by distracting them and allowing them to focus on something different.

Anxiety

32.10 The Claimant has suffered anxiety for a long time, and was diagnosed with "*mixed anxiety and depressive disorder*" in August 2004. They take antidepressant medication with anxiolytic effects (Sertraline 150mg), having previously taken citalopram, as well as medication for insomnia.

The adverse effects of their anxiety on normal day-to-day activities are set out in the impact statement at p414. They include difficulty sleeping, concentrating, managing multiple tasks or moving forward with tasks until they felt they have been completed correctly. They have difficulty relaxing, engaging fully in activities, coping with uncertainty and unexpected change. They use avoidance behaviours in situations they anticipate will cause distress, have difficulty making decisions and seek reassurance from others before completing a task. Physical symptoms include palpitations, headaches, tremors, digestive discord, racing thoughts and occasional panic attacks. Symptoms occur most days. The claimant accepted in cross-examination that their anxiety was increased when reacting to stressful events but it was always present at an underlying level.

32.11 The claimant has undertaken CBT, NHS counselling (including during the period relevant to this claim) and received support from MIND, the

mental health charity. While treatment helps manage the symptoms it does not remove them entirely.

Depression

32.12 The Claimant has a long-standing history of depression, recorded by their GP in 1998 (p532). The severity of symptoms fluctuates and can be aggravated by chronic pain, disturbed sleep and stress. The condition causes a persistent low mood, reduced motivation and energy, fatigue, emotional exhaustion, tearfulness, intrusive thoughts, feelings of hopelessness, reduced self esteem and social withdrawal. Symptoms are worsened by stress, physical pain, fatigue, and poor sleep. This restricts their ability to care for themselves, maintain focus, and manage household tasks (419). It affects their ability to engage in hobbies, interests and social activities and maintain energy levels throughout the day. Sometimes they need to withdraw from activity or spend significant periods of time in bed to recover.

32.13 The claimant takes antidepressant medication - sertraline 150 mg and previously citalopram 40mg. They have undertaken counselling and other therapeutic interventions including attending 11 therapy sessions via NHS Talking Therapies from November to December 2023 specifically targeting depression and related anxiety (p467) and a further course of therapy targeting anxiety depression and traumatic stress between Jun 2024 and April 2025. Through treatment they have learned strategies to manage their symptoms but they do not remove them entirely.

Seasonal affective disorder

32.14 The Claimant experienced symptoms consistent with SAD for a number of years but in 2012 the symptoms became more noticeable after moving to their current home: mood and energy levels were affected by periods of reduced daylight and dull weather. They discussed these symptoms with a mental health professional and were advised to try using a light box. They did so on a trial basis and then bought their own. While symptoms are more noticeable during autumn and winter they can also occur in spring or summer if there are extended periods with limited sunlight. The condition was present during the relevant time (which began in the winter period in January 2025) and remain ongoing.

32.15 Symptoms and effects include low mood, reduced energy levels increased fatigue reduced motivation, increased need for sleep, difficulty being active in the mornings, reduced concentration social withdrawal, increased appetite and a worsening of underling depression symptoms. The claimant has received related mental health treatment, including antidepressant medication and counselling.

Conclusions

33 It is not disputed that, in order to bring their disability discrimination claims, the Claimant must satisfy the definition of disability under section 6 of the Equality Act 2010.

34. As set out above, following the relevant case law, there are four parts to this definition that a Tribunal should consider. The burden of proof for satisfying the test is on the Claimant.

35. Mr Hallström correctly pointed out, medical evidence is not necessary to prove the elements of section 6 of the Equality Act 2010. However, it will be of considerable evidential importance.

Physical Impairments

Sciatica and lower back pain

Physical Impairment

36. I find that the Claimant's sciatica and lower back pain were both impairments at the relevant time. The case law says a physical impairment is where there is something wrong with someone physically. I am satisfied from the medical evidence, the occupational health reports from the relevant time and the Claimant's evidence, that the claimant's sciatica and lower back pain were physical impairments applying the above test.

Adverse and substantial effect

37. I have taken the next two parts of the test together – namely, what were the impairments' adverse effects on normal day-to-day activities and were they more than minor or trivial? Here, I find there is sufficient evidence before the tribunal to demonstrate that these impairments each had adverse effects on the claimant's normal day to day activities at the relevant time which, taken together, were more than minor or trivial. I note that reasonable adjustments were made by the respondent to limit the time the claimant spent standing or sitting to no more than 20 minutes, to provide a chair and to allow them to rotate and change position. Those adjustments were stated to be permanent in July 2024 and subsequent referrals in November 2024 and February 2025 confirmed them. I accept the claimant's evidence as to the adjustments they had to make to their normal day to day activities to accommodate the effects of these impairments, and the medication they used at the relevant time. I find the adverse effects on day to day activities were substantial. I am therefore satisfied that these parts of the test in section 6 of the Equality Act 2010 are met.

38. The nature of the claimant's evidence was such that they themselves were unable to separate out the effects of the sciatica from the effects of the lower back pain. In their words they "go on at the same time". The medical evidence and Occupational Health reports do not assist me to reliably separate out the effects. While I am satisfied each impairment had an adverse effect, I am unable to conclude that each, independently, satisfied the test of "substantial" adverse effect. However, as stated above, I am satisfied that they did so cumulatively.

Long term

39. It was clear from the evidence that the effects of both sciatica and lower back pain had subsisted for more than 12 months at the relevant time. There was evidence that the sciatica had been ongoing for 29 years and the lower back pain is recorded in the OH reports dating back to February 2022 when adjustments were first made. They continued until the claimant went off sick in January 2025.

40. I therefore find that the claimant was at the relevant time disabled person applying the definition in s6 EqA by reason of sciatica/lower back pain.

Frozen shoulder/left shoulder pain

Impairment

41. I am satisfied from the medical evidence, the occupational health reports and the Claimant's evidence, that the claimant's frozen shoulder/left shoulder pain was a physical impairment applying the section 6 test.

Adverse and substantial effect

42. The claimant's evidence, which is supported by the occupational health and medical reports, was that their shoulder injury caused of significant adverse effects on their normal day to day activities including at work, causing adjustments to be recommended to accommodate their shoulder pain and restricted movement. This impairment resulted in the claimant taking four and a half months off work in 2003 and a further significant period commencing in January 2025. At the relevant time they had received steroid injections, were taking strong pain relief and having physiotherapy.

43. I am satisfied the effect on normal day to day activities was substantial applying the test in section 6 and the Guidance.

Long term

44. The claimant first experienced shoulder pain following an injury at work in July 2023 and received treatment by way of steroid injection and physiotherapy at that time. They had an extended period of absence from work. In July 2024

they had a further steroid injection and the OH adviser said the claimant's ongoing shoulder issues were a repetitive injury. In January 2025 they were referred by their GP to a consultant for further advice on treatment. The consultant's report refers to "to bouts of recent problems with the left shoulder". A frozen shoulder was diagnosed. Further steroid treatment and physiotherapy followed. The OH adviser in February 2025 referred to shoulder pain as a "long term" injury. The ongoing effects of the impairment are well documented in the OH and medical reports.

45. I am satisfied on the evidence that the substantial adverse effects of the claimant's left shoulder pain/frozen shoulder had subsisted for more than 12 months by the start of the relevant period and therefore satisfied the "long term" definition in section 6 EqA. They were thus a disabled person by reason of left shoulder pain/frozen shoulder during the period relevant to their claims.

Joint pain in knees and hips

46. The medical evidence in relation to this alleged impairment is limited. There is an entry in the claimant's medical records dated 2005 saying "knee pain" but nothing else. The claimant has from time to time raised with OH advisers that they had been suffering from knee pain, but it was unclear what this was related to and the advisers referred the claimant to their GP for investigation . The OH report from 28 November 2022 (p218) records "pain/discomfort in left knee and hip with prolonged standing". The OH adviser referred the claimant for physiotherapy and suggested they discuss the issue with their GP but there is no evidence that they did so, or the outcome. The issue was not raised by the claimant in the subsequent OH referral. The only other evidence of knee pain was at p556 but this related to February 2026, long after the relevant period for this claim.

47. I found the limited evidence available was insufficient for me to find that the claimant's knee pain was an impairment which had a substantial and long term adverse effect on the claimant's normal day to day activities.

48. With regard to hip pain this appeared to stem from the claimant suffering an injury to their left hip at work in January 2020. They were awaiting physiotherapy and an X ray result. Their manger had put reasonable adjustments in place. On 26 February 2020 they had commenced physiotherapy and were taking strong painkillers. Temporary adjustments were recommended including a short sit down break when experiencing acute hip pain. There is a brief mention in the July 2024 report of the claimant's work on tills impacting their hip and back, but no further mention of this issue in Pam Stryden's report in November 2024 or the subsequent report in February 2025. Nor are there any recent medical records about it. The claimant has not dealt specifically with hip pain in their DIS or SDIS. On the

evidence I am unable to find the claimant's hip pain was an impairment at the relevant period or that it had a substantial adverse effect on their day to day activities.

Mental impairments

PTSD

49. The letter of 14 April 2026 from the claimant's GP at p557 states they have a documented history of multiple chronic health conditions including "Post-Traumatic Stress Disorder (PTSD) Complex PTSD (cPTSD)". Though this letter postdates the claimant's employment, it states the condition has been present for a prolonged period, has persisted for more than 12 months despite ongoing treatment and is long term in nature.

50. The claimant has completed two programmes of therapy through the NHS Complex Trauma Pathway, the first from November to December 2023 and the second from June 2024 to April 2025.

51. Dr Brookes letter at p557 says the claimant has a documented history of PTSD and it is a long term condition.

Depression and Anxiety

52. Depression was identified in the GP records as a significant problem in October 1998 and January 2001 and mixed anxiety and depressive disorder was identified in August 2004. The Claimant's GP records depression and generalised anxiety as separate conditions which have existed for a prolonged period and are long term conditions (p.557) I accept the claimant's evidence that they have been prescribed antidepressant medication for over 20 years and have been referred for counselling on many occasions. There was evidence in the occupational health reports that they ceased taking medication for a period because it did not help. But the OH reports show they had resumed citalopram by March 2022 (p200) and the dose had been increased from 20mg to 40 mg by October 2022 (p212). That continued until September 2024 when their GP moved them onto Sertriline 50mg, an antidepressant medication with anxiolytic effects. Their GAD scores have varied but at times revealed high levels of self-reported anxiety. The claimant agreed in cross examination that their anxiety increased in response to stressful events, including the stress of events at work (for example a fit for work meeting) and their tribunal claim. But I am satisfied that there was an underlying condition which subsisted throughout the relevant period for this claim.

Seasonal Affective Disorder (SAD)

53. The claimant was diagnosed with SAD by their GP in 2012. I accept their evidence that a medical practitioner recommended they use a light box and they have done so ever since, first on a trial basis and then purchasing their own. The medication they take for depression and anxiety also helps with this condition. Again, at p557 their GP says the claimant has had SAD for a prolonged period and that the condition is long term in nature. While this letter postdates the events relevant to this complaint, the GP refers to a documented history of SAD.

54. I am satisfied that each of the above mental health conditions meets the definition of a mental impairment for the purpose of section 6 EqA.

Substantial averse effect

55. The descriptions in the DIS/SDIS of the effects of the above conditions on the claimant's day to day activities overlap to a significant extent. In oral evidence they said the conditions were co-morbid and it was hard for them to say "I'm low because of depression or because of SAD, or whatever". I note their GP does not distinguish between the conditions when listing the effects.

56. The OH reports also group three of the conditions together. From March 2022 a set of permanent adjustments was recommended to address "depression/ anxiety and SAD". These recommendations were repeated in later reports without distinguishing between the conditions.

57. The claimant was taking anti-depressant/anti-anxiety medication, having complex trauma therapy, using a light box and employing a number of coping strategies at the relevant time. I accept their evidence that these all helped but did not remove the effects entirely. In any event I have to consider what would be the effect of the impairments without medication, counselling and other coping strategies. I am satisfied from the claimant's evidence supported by the occupational health reports and medical evidence that the cumulative effects of these four impairments on the claimant's ability to carry out normal day to day activities were substantial i.e. more than minor or trivial, at the relevant time.

Long term

58. I am also satisfied on the evidence that the adverse effects of the mental health impairments satisfy the "long term" condition in section 6. All had lasted for over 12 months at the relevant time.

59. The claimant was thus a disabled person by reason of depression and anxiety/ post traumatic stress disorder/seasonal adjustment disorder at all times during the period relevant to their claims.

Approved by Employment Judge V Jones

On 31 October 2026