EMPLOYMENT TRIBUNALS (SCOTLAND)

Case No: 8002718/2025

Held in Glasgow on 22 September 2026

Employment Judge L Murphy

Mr J Tiffoney	**Claimant** **Represented by:** **Mr G Bathgate - Solicitor**
Kaefer Limited	**Respondent** **Represented by:** **Mr A Hardman - Advocate** **Instructed by:** **Ms M Robson - Solicitor**

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

(1) The judgment of the Tribunal is that the claimant was a disabled person for the purposes of section 6 of the Equality Act 2010 (EA 2010) at the material times, namely between 27 May and 7 November 2025.

(2) Parties are ordered to write to the Tribunal within 14 days of the date this judgment is sent to them to update the Tribunal as to whether the claimant has raised a separate claim of unfair dismissal or imminently intends to do so. If proceedings have been raised, parties must advise of the case number and confirm whether their respective positions remain (as advised at the PH) that the unfair dismissal claim should be conjoined with the present proceedings.

REASONS

Introduction

1. The claimant brings complaints under sections 19 and 26 of the Equality Act 2010 ("EA"). He avers he was, at the material times, a disabled person for the purposes of EA and the respondent disputes this. A substantive

preliminary hearing (PH) took place on 22 September 2026 in the Glasgow Employment Tribunal. The purpose of the PH was for the Tribunal to decide whether the claimant (C) was a disabled person within the meaning of section 6 of EA during the material period.

2. C complains of harassment related to disability and of indirect disability discrimination. The conduct complained of as harassment is said to have taken place on 27 May 2025 and in the period thereafter until the submission of the claim on 7 November 2025. (The acts relied upon are set out at para 12(a) to (d) of EJ Neilson's PH Note of 10 March 2026). The alleged 'provisions, criteria or practices' (PCPs) for the purposes of the s.19 complaints are likewise said to have applied between 27 May 2025 and 5 November 2025 (para 6(a) to (c) of EJ Neilson's Note). The parties agreed that the material period during which disability status is to be assessed is between 27 May and 7 November 2025.

3. I heard evidence from the claimant. A relatively small number of documents from a larger joint inventory of productions running to 172 pages were referred to during the evidence. I am grateful to both Mr Bathgate and Mr Hardman for their assistance to the Tribunal with the case.

Findings in Fact

4. The following facts, and any further facts set out in the 'Discussion and Decision' section, are found to be proved on the balance of probabilities or were agreed by the parties. The facts found are those relevant and necessary to my determination of the issues. They are not intended to be a full chronology of events.

5. C was employed by R from 2008 with a break before later returning in 2013. His employment ended in March 2026. He was employed as a Thermal Insulation Engineer. C normally worked at Grangemouth but sometime had to travel to work at other sites.

6. C had symptoms involving his bowel movements from 2016. He was under investigation for two years at that time. His blood samples were normal in this period. In 2018 a colonoscopy was carried out. Following the colonoscopy, he was diagnosed with Inflammatory Bowel Disease Unclassified (IBDU) (proctitis). It is not established that C has been diagnosed with Ulcerative Colitis (UC) in 2018 or at all. C has not been diagnosed with Crohn's Disease. It is not established that there were any ongoing investigations into potential Crohn's Disease for which results were awaited or that a diagnosis of Crohn's Disease was expected or considered likely at the material times in 2025 by the medical professionals in the Gastroenterology Department at the Royal Alexandra Hospital (RAH) who were treating C for his bowel condition.

7. It is not established that the pain or fatigue C experiences in his joints (his knees and elbows) is related to his bowel condition which is the asserted disability in this case. It is not established that any symptoms affecting C's eyes are linked to his bowel condition.

8. On a weekly basis C experiences changes in his bowel movements. He fluctuates from being constipated for 3 or 4 days with discomfort passing stools to being looser and requiring to access the toilet frequently.

9. Separately and in addition to these relatively low level symptoms, C has experienced more debilitating 'flare ups' from time to time since 2016 and continued to do so periodically up to (so far as relevant for these purposes) November 2025. These flare ups occurred at intervals of perhaps 12 weeks or so, though they are not predictable and the frequency can fluctuate. When the flare ups have occurred, C has experienced more severe symptoms. The exact triggers for the flare ups can vary or be unclear but they appear to be sometimes exacerbated by poor diet (spicy foods), alcohol (from which C consequently largely abstains), taking long flights and by stress. These flare ups have sometimes resulted in C experiencing severe pain and cramps which have left him doubled over on the bathroom floor. They have sometimes resulted in his requiring to open his bowels very frequently, perhaps 5 or 6 times per day and finding that his stools were very liquid with the presence also of mucus and occasionally blood. They have sometimes resulted in problematic constipation over several days with painful passing of stools.

10. Depending on his symptoms, when his recurrent flare ups have occurred, he has required to keep close to toilet facilities. C used incontinence pads daily when he was having a flare up of the sort that caused his bowels to loosen. On some rare occasions, he found the pads offered insufficient protection and that his fecal incontinence was such that he also had to change his underwear.

11. During a flare up, C found his symptoms made it difficult to travel or to work away at unfamiliar sites where he was less aware of where the nearest toilet facilities might be. When working away, C's colleagues would often go to the pub after work in the evenings but C refrained from going because he was afraid of having an accident and also because he did not drink or rarely drank alcohol because of his condition. C became very withdrawn socially during periods of flare ups as he was embarrassed by his condition or concerned about toilet access. He stopped going to his mother's house or his wife's house. Sometimes in a flare up, his symptoms meant it was difficult for him to make himself a meal.

12. During flare ups, C's commute to work at Grangemouth was extended by several minutes by the requirement for him to factor in a toilet stop at a supermarket *en route*.

13. In addition to prescribed medication, set out below, C tried to be careful with his diet and keep on top of exercising while avoiding alcohol to try to reduce his symptoms.

14. C was on sick leave from 2 August 2019 for 5 days. He recorded on his self-certification form that the reason for his absence was "UC [Ulcerative Colitis] Flare up / ongoing stomach issues." This was the only occasion on which C was off on sick leave and reported the reason to be connected to a bowel condition. C believed he had received a diagnosis of Ulcerative Colitis in 2018. C was having a flare up of the kind described above when he reported sick.

15. It is not established that C consulted his GP monthly in the period between May and November 2025. Nonetheless, C experienced flare up symptoms in that time, including in September 2025 which prompted him to contact the RAH team. At that time he was experiencing constipation and strain passing hard stools. He was also concerned about pain in his knees which was subsequently confirmed to be unrelated (see medical records section below).

16. On 11 August 2021, C had a blood test which tested among other things for ESR to measure inflammation and the result recorded was 'Abnormal – high'. The comment recorded on the medical record with the result was 'prepatellar bursitis' which relates to the knee and is not linked to C's bowel condition.

17. Between November 2022 and November 2024, C did not consult his GP with respect to his bowel condition in connection with any flare up. However, in that period, C was in contact with and under review by the Gastroenterology Department at RAH.

18. C was prescribed Salofalk oral granules and (from October 2024) Salofalk suppositories in connection with his condition. These were prescribed prior to and during the material times between May and November 2025. He found the medication eased his symptoms but did not completely block them. On one occasion in 2021 when he was working at a site in Newcastle and ran out of his medication, he experienced worsening symptoms. C travels to the United States once or twice a year. He has on occasion obtained prescriptions for these medications when in the US.

Medical records

19. On 11 January 2024, Nurse McCluskey, a Clinical Nurse Specialist in Gastroenterology at the RAH, wrote to C as follows: ".. *I understand that you have had recent blood and stool markers completed that appear to be within the normal range. I was sorry to hear that you are having ongoing symptoms despite this. From your electronic file I can see your GP appears to have given you some oral steroids. It is important you optimize your*

Masalazine treatment regime..This means that you should be taking on a daily basis your oral Salofalk 3gms once daily indefinitely. You can also ask your GP for some Mesalazine suppositories 1 gm once daily for a minimum of 4 weeks …"

20. On 29 January 2024, Nurse Broadhurst, a Clinical Nurse Specialist in Irritable Bowel Disease at the RAH, wrote to C's GP following an appointment with C on 18 January 2024. She recorded "*Jonathan recently made contact with the IBD Service having ongoing symptoms from his IBD. He is currently on dual Mesalazine and a course of Prednisolone steroids. His recent bloods were all within normal parameters, however, he continues to suffer with loose stools, passing mucus and reports abdominal pain. …I think it would be sensible to reassess via a sigmoidoscopy*".

21. On 30 April 2024, Nurse Brynes, a Clinical Nurse Specialist in Irritable Bowel Disease at the RAH, wrote to C's GP following C's attendance at an appointment there on that date. She recorded that C was booked to attend following recent contact to discuss worsening symptoms. She recorded he had a background history of IBD (unclassified) and that his current medication was Salofalk 1.5 granules x 2 daily. She said, *"Jonathan reports that he has been experiencing nocturnal rising in terms of dyspepsia which I believe he is currently prescribed Omeprazole for. He states he experiences upper abdominal cramping … He opens his bowels once every 2 days, passing soft stools. He denies any blood. However, he states there is mucus present. …in terms of his bowels, I explained to him that I would update his biomarkers, including a couple of stool tests, to rule out infections and ..to check inflammatory markers. I note he had a sigmoidoscopy carried out in February of this year, which showed macroscopically a normal study. However, pathology is awaited"*.

22. On 30 August 2024, Nurse Brynes wrote to C's GP following an appointment with him at the RAH on that date. In the Clinical Comments section, she recorded *"He has a background history of Inflammatory Bowel Disease Unclassified (proctitis) which was diagnosed in 2018 and his current IBD medication is oral Salofalk 1.5g x 2 daily…He denies any family history of colorectal cancer. Going on the current guidance he would be due his initial 8 year post diagnosis full surveillance colonoscopy in 2026…In terms of his bowels at present he states in the past few weeks he has noticed an increase in faecal urgency and a new onset of loose stools. He denies any blood or mucus."* The letter goes on to record that the Nurse would arrange for C to attend the medical day bed in the hospital unit to update his biomarkers including a stool sample to rule out infective causes.

23. On 15 October 2024, Nurse Brynes wrote to C following his having handed in a stool sample and attended for blood tests. She said, "*I wanted to*

update you as the results have now been made available to me and show that your blood tests have all been reported within normal limits. Your stool test has tested negative for infection and your faecal calprotectin has also been reported within normal limits. This is reassuring. I would advise that you can add in a rectal therapy in the form of a suppository to your current regime which may help calm your symptoms you had described of urgency and looser stools."

24. On 20 Nov 2024, C's GP completed a form about C's IBD for an insurance company. It recorded that his IBD was diagnosed on 16 May 2018. Dr Gray did not tick the boxes to indicate a diagnosis of Crohn's disease or of Ulcerative Colitis. Instead, she recorded a diagnosis of 'Inflammatory Bowel Disease (unclassified) – distal proctitis.' She recorded that C last reported a flare in January 2024 and recorded in that connection that, *"anal steroid for 1 week worked really well. I would describe his proctitis as being very well controlled."* She also recorded that C 'attends Gastroenterology regularly for routine reviews' and that there were 'no current planned investigations'. She recorded that there had only been one health record entry in the last 24 months which was on 19 September 2024 which concerned an unrelated complaint.

25. On 19 June 2025, C was assessed by R's OH Advisor, Juliet Borg, via telephone call. The advisor didn't have access to C's medical records but prepared a report based upon the history narrated to her by C. She recorded: "*Mr Tiffoney was diagnosed with Ulcerative Colitis in 2018 following two years of symptoms and investigations to determine the underlying cause. These symptoms included abdominal pain the presence of blood and mucus in his stool, mouth ulcers, and fatigue. He is currently under the care of a specialist gastroenterology team, which has suggested that his symptoms are more consistent with the diagnosis of Crohn's disease. However, this diagnosis has not yet been confirmed pending further diagnostic procedures...*
He is currently prescribed Salofalk granules, containing mesalazine, to be taken twice daily as well as mesalamine suppositories twice daily. To accommodate his bowel movements, he does not take these medications at fixed times but adjusts their administration... additionally, he utilises daily incontinence support due to his symptoms. During acute flare ups, he requires stronger pain management and corticosteroids to reduce inflammation…"

26. On 8 September 2025, Nurse Brynes wrote to C's GP following an appointment he attended at the Gastroenterology Clinic in the Royal Alexandra Hospital (RAH). Her letter included the following text:

> *"He has a background history of IBDU* [Irritable Bowel Disease Unclassified] *(originally a proctitis) and his current IBD medications*

are Salofalk 1.5 oral granules x 2 daily and Salofalk 1g suppositories PRN.

Jonathan reports that he feels his current flare may be due to a change in his work shift pattern …

He reports heartburn and constipation type symptoms often going 3 to 4 days between bowel motions, passing hard / solid stools which he states he can strain to pass on occasion.

His main issue today was mainly of his joints, specifically his knees. He states his knees are ;extremely' painful at present. I explained that sometimes this can be an extra manifestation of his IBD, however, I will post out a stool kit to check his inflammatory markers. I explained to him, if this is reported within normal limits, then it would appear that his joint issues are not related.

During the consultation it transpired that he purchases his Salofalk granules from America. The difficulty with this is that he is not having his near patient blood monitoring, given it is not prescribed by yourself.

I would be grateful if you would issue a couple of prescriptions in the community for:

1. Salofalk 3g oral granules …

2. Salofalk 1 g suppositories …

…"

27. On 7 October 2025, Nurse Brynes wrote to C's GP regarding the stool sample he had recently supplied. She noted that *"The faecal calprotectin has been reported within normal limits showing no evidence of ongoing inflammation. It appears the joint pains you have reported are not related onto your inflammatory bowel disease given the normal faecal calprotectin."*

Observations on the evidence

28. Mr Bathgate invited the Tribunal to accept the evidence of C as reliable and credible. Mr Hardman said that C had exaggerated his symptoms. He pointed out that the medical evidence did not coincide with C's own evidence on the effects of his condition.

29. There was a curious absence of GP records of consultations between C and his GP Dr Gray on the subject of his bowel condition despite C's insistence he had indeed had monthly consultations with Dr Gray by telephone between 27 May and 7 November 2025. C was asked why such medical notes were not to be found in the bundle and his response was to

the effect: ‘I don’t know; they should be’. The documentation shows that the GP was asked to release all medical records. I am not persuaded that C was exaggerating or deliberately misleading the Tribunal in the recollection he gave. However, in the absence of supporting documentation, I do not find it proved on balance that C consulted his GP with such frequency during the period between May and November 2025.

30. Nevertheless, there were records from the RAH, a hospital team to which C was able to self-refer without going through his GP. These records confirmed C had been diagnosed with IBDU and that he was prescribed medication in connection with that diagnosis. Though the records did not include the results of the 2018 colonoscopy and the subsequent correspondence from RAH did not specifically refer to it, I accept on the balance of probabilities that such a colonoscopy took place. C was adamant that it did so and it is reasonable to infer that some investigations led to the diagnosis. In one letter of 30 August 2024, the IBD Nurse mentions that based on the current guidance he would be due his initial 8 year post diagnosis colonoscopy with mapping biopsies in 2026. I accept that the results of a colonoscopy in 2018 led to the IBDU diagnosis.

31. C maintained he was diagnosed with UC at that time in 2018. Again, I do not find that C had any intention of misleading the Tribunal or exaggerating his situaiton on this matter. I accept that C himself believed that such a diagnosis had been made. However, having regard to the medical records and particularly those of the RAH which was principally involved in C’s care and treatment for his bowel condition, it is not established that C was in fact diagnosed with UC in 2018 or at all. I accept that this potential condition was discussed with C and that investigations were undertaken in this regard but it is not found that such a diagnosis was ultimately made. It seems inherently unlikley that, if such a diagnosis had been made, it would not have been recorded in the letters of the IBD Nurses at the RAH who specifically refer instead to a diagnosis of IBDU. The only record where a health professional refers to UC is the OH report prepared for the respondent. However, as C accepted, that report was based on his own account of his health history.

32. C has also indicated he has been investigated for possible Crohn’s disease but that the investigations of his throat for ulcers did not establish this condition because he was in remission at the time. I accept C has undergone investigations including investigations which would help the medical team to identify potential Crohn’s disease. I accepted that he has discussed this possible diagnosis with specialists. However, as C himself accepts, no diagnosis of this disease has been made and it is not established on the evidence before me that such a diagnosis was likely or imminent during the material period in 2025. I carefully considered the medical records. The only medical commentary in relation to possible Crohn’s comes from R’s OH Adviser who says *“He is currently under the*

care of a specialist gastroenterology team, which has suggested that his symptoms are more consistent with a diagnosis of Crohn's disease. However, this diagnosis has not been confirmed…". This, again is based on C's account to the OH Adviser. It seems inherently unlikely that, if such a diagnosis was under active investigation / considered likely to be established by future tests or procedures at that time, it would not be mentioned in the letters of the IBD Nurses at the RAH.

33. C's evidence was that he regarded fatigue he experienced in his joints as being linked to flare ups in his bowel condition. However, I find this is not established on the balance of probability, having regard to the conclusions Nurse Brynes reported on 7 October 2025 that the matters did not appear related after tests were anlysed. C's pleaded case is clearly concerned with his bowel condition (referred to in the ET1 as Ulcertative Colitis). I do not set too much store by the labelling of the bowel condition which is said to be the physical impairment. However, even reading the claim generously, there is no hint in the pleadings that C also relies on another condition affecting his joints which are not mentioned at all in his pleadings. I confine my decision to whether C's bowel condition amounted to a disability at the material times.

34. Likewise, C mentioned that his optician told him his condition would 'go for [his] eyes'. However, there was no medical evidence from the optician or otherwise as to how the condition may affect C's eyes and C gave no further evidence on the matter. I therefore did not find a link with C's eyes to be established on the evidence before me.

35. Though it is right to say that the medical records might certainly lend more support to C's account of his flare ups, I do not ultimately find that they are irreconcilable with C's account of his symptoms. I noted that a number of sample tests performed at the RAH returned results described as being within normal limits or normal parameters. Though this evidence does not give particular support to C's account, it is also fair to observe that none of the correspondence from the specialists at the RAH suggested that the implication of the results was that C's diagnosis of IBDU was incorrect or that the symptoms he described to them were exaggerated. None of the correspondence suggested that in light of the 'normal' results, C did not require to continue his medication regime. On the contrary, he was recommended to do so.

36. I take full cognisance of Mr Hardman's observations with respect to a dearth of documentation containing notes of consultations and of documentation confirming prescriptions. I acknowledging the limited nature of the support for C's account available from the produced medical records. However, I found C gave his evidence in an honest and straightforward manner and I accepted his account of the periodic flare ups

he spoke to as well as of the severity of the effects upon him when these occurred.

Relevant Law

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

38. Section 6 of EA defines disability for the purposes of the Act:

> *6. **Disability***
>
> *(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.*
>
> *(2) A reference to a disabled person is a reference to a person who has a disability.*
>
> *(3) In relation to the protected characteristic of disability—*
> *(a) a reference to a person who has a particular protected characteristic is a reference to a person who has a particular disability;*
> *(b) a reference to persons who share a protected characteristic is a reference to persons who have the same disability.*
>
> *(4) This Act (except Part 12 and section 190) applies in relation to a person who has had a disability as it applies in relation to a person who has the disability; accordingly (except in that Part and that section)—*
> *(a) a reference (however expressed) to a person who has a disability includes a reference to a person who has had the disability, and*
> *(b) a reference (however expressed) to a person who does not have a disability includes a reference to a person who has not had the disability.*
>
> *(5) A Minister of the Crown may issue guidance about matters to be taken into account in deciding any question for the purposes of subsection (1).*
>
> *(6) Schedule 1 (disability: supplementary provision) has effect.*

39. Section 212(1) provides that “substantial” means more than minor or trivial.

40. Schedule 1, Part 1 to the EA includes the following provisions:

> ***Long-term effects***
>
> *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.

(3) For the purposes of sub-paragraph (2), the likelihood of an effect recurring is to be disregarded in such circumstances as may be prescribed.

(4) Regulations may prescribe circumstances in which, despite sub-paragraph (1), an effect is to be treated as being, or as not being, long-term.

….

Effect of medical treatment

5(1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if—
(a) measures are being taken to treat or correct it, and
(b) but for that, it would be likely to have that effect.

(2) "Measures" includes, in particular, medical treatment and the use of a prosthesis or other aid.

…

41. Statutory guidance was issued pursuant to section 6(5) on matters to be taken into account in determining questions relating to the definition of disability in May 2011. It does not of itself impose any legal obligations and nor is it an authoritative statement of the law. However, Schedule 1, Paragraph 12 to the EA requires the Tribunal, when determining for any purpose of the Act whether a person is a disabled person, to take into account any aspect of this guidance which appears to it to be relevant.

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

i. Did the Claimant have an impairment (mental or physical) at the material time;

ii. Did the impairment affect his ability to carry out normal day-to-day tasks;

iii. Was the adverse effect substantial; and

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

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

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

45. Although EA does not contain a list of normal day-to-day activities, the Guidance (at paragraph D3) provides that such activities are '*things people do on a regular or daily basis for example shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities*'.

46. The focus must be on what a person cannot do, or can only do with difficulty, not what they are able to do. An impairment may not directly prevent someone from carrying out normal day-to-day activities but may still have a substantial adverse effect on how the person carries out those activities.

47. The statutory guidance contains an appendix which includes an "illustrative and non-exhaustive list of factors which, if they are experienced by a person, it would be reasonable to regard as having a substantial adverse effect on normal day-to-day activities." That list includes the following text:

> *In the following examples, the effect described should be thought of as if it were the **only** effect of the impairment:*
>
> *….*
>
> - *difficulty carrying out activities associated with toileting, or caused by frequent minor incontinence*
>
> *….*

- *difficulty using transport; for example, because of physical restrictions, pain or fatigue, a frequent need for a lavatory or as a result of a mental impairment or learning disability*

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

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

50. However, 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 (s.2(2), Sch 1). 'Likely' means "could well happen" and is not to be equated with 'more probable than not' (Guidance at paragraph C3 and **Boyle v SCA Packaging Ltd** [2009] ICR 1056, HL). Therefore, a condition which produces sporadic substantial adverse effects such as flare ups may amount to a disability at times when the employee is in remission and not experiencing the substantial adverse effects so long as it could well happen that the substantial adverse effects will recur.

51. With regard to recurrence, although in many instances the fact that a substantial adverse effect recurred episodically might strongly suggest that a further episode was something that 'could well happen', that would not always be the case. Where, the substantial adverse effect was judged by a Tribunal to have been triggered by a particular event that was itself unlikely to continue or to recur, the Court of Appeal has found that it was open to the tribunal to find that it was not likely to recur (**Sullivan v Bury Street Capital Limited** [2022] IRLR 159.)

52. In **McDougall v Richmond Adult Community College** [2008] IRLR 227, the Court of Appeal had to consider the phrase 'likely to recur' in para 2(2) of Sch 1 to the 1995 Act. Reversing the decision of the EAT, the CA held that the question whether an employer had committed an act of disability discrimination had to be judged on the basis of the evidence available at the time of the act alleged to constitute discrimination and that, therefore,

in determining whether the adverse effect of a person's impairment was 'likely to recur', the ET should not have regard to subsequent events. As Pill LJ put it, at para [23], the exercise involves 'a prediction on the available evidence'. It can, however, be relevant to consider events prior to the alleged discriminatory acts in assessing the likelihood of recurrence as judged at a later period (**Sullivan** at para 95).

Submissions

53. Both Mr Bathgate and Mr Hardman gave oral submissions**.** The entire content of both submissions has been carefully considered and taken into account in making the decisions in this Judgment. Failure to mention any part of these submissions in this Judgment does not reflect their lack of consideration by this Tribunal. The submissions are addressed in the decision section below, which sets out where the submissions were accepted, and, where they were not, why not.

54. There was no dispute as to the relevant legal framework between the representatives. I have summarised their positions in relation to each limb of the test in the discussion and decision section below.

Discussion and decision

Did C have a physical impairment?

55. Mr Bathgate noted it was not necessary to attach a label to a physical impairment and said it matters not whether C had UC or IBDU or Crohn's disease. Regardless, he said, the evidence supported a physical impairment. Mr Hardman did not dispute that C had shown a physical impairment.

56. I find that, at the material times, C had a physical impairment, namely Inflammatory Bowel Disease (Unclassified).

Did it have a substantial adverse effect on C's ability to carry out day to day activities?

57. Mr Bathgate referred me to the statutory guidance and the appendix examples of factors which it would be reasonable to regard as having a substantial adverse effect. He referred to the items I have set out at paragraph **47**. He said that given the frequency and the extent of the loss of control, C's day to day activities were adversely affected.

58. Mr Hardman's position was that C had not established a substantial adverse effect during the period in question (i.e. from 27 May to 7 November 2025).

59. It is relevant to consider whether, in the period before May to November 2025, C's flare ups, when they occurred, had a substantial adverse effect on his ability to carry out normal day to day activities. I consider this period because even if, as Mr Hardman would have it, any adverse effects had ceased by 27 May 2025, it is relevant to assess whether Schedule 1, Part 1, Section 2(2) is engaged.

60. I readily conclude that, in the 7 or more years before the 27 May 2025, when C experienced one of his episodic 'flare ups', it had a substantial adverse effect on his ability to carry out normal day to day activities. The affected activities included travel, working, socialising and sleeping. The effect on these which I have set out in the findings in fact was more than trivial. In fairness, it was not clear that Mr Hardman disputes this. He said that the records show a condition which flares up and, when it does, it requires treatment. Though he didn't explicitly accept that when a flare up occurs it has a substantial adverse effect, he did not make submissions to challenge this.

61. Even if I found C had not had a flare up in the period from 27 May to 7 November 2025, the impairment should be treated as continuing to have the adverse effect if it was likely to recur. Mr Hardman said that whether the effects were likely to recur or not at that time was not demonstrated by a medical report or anything else in the records. I was not persuaded by this submission. I have found there was a previous long established pattern of episodic flare ups. At the material time in 2025, C was prescribed medication by medical professionals to help manage his symptoms. At the material time, no medical specialist had suggested that medication was unnecessary or that his IBDU diagnosis should be reconsidered. Given the diagnosis of C's physical impairment and the long maintained pattern of recurrent effects, I am satisfied on balance that, at the material times in 2025, those substantial adverse effects were 'likely to recur'. Throughout that time, it could well have happened that they would do so. Having so found, it matters not whether they actually recurred between May and November 2025 for present purposes because his impairment is to be treated as continuing to have that effect throughout the period pursuant to Section 2(2) of Schedule 1, Part 1.

62. As it happens in any event, I have found that C did have a flare up in that period (in September 2025) with constipation symptoms for which he sought medical support on 8 September 2025.

63. I am satisfied that throughout the material period, C's IBDU either had a substantial adverse effect on his ability to carry out day to day activities on the dates a flare up happened or, in any event, is to be treated as having done so because the effects were, throughout that time, likely to recur.

Were the effects long term?

64. Mr Hardman did not dispute that the effects were long term. The substantial adverse effects had recurred periodically over a period of several years before 27 May 2025 and they were 'likely to recur' through the ensuing period with which we are concerned, ending 7 November 2025.

Conclusion

65. All four of the questions posed by **Goodwin** having been answered in the affirmative, I find that C was a disabled person for the purposes of section 6 of the EA during the material period from 27 May to 7 November 2025.

Date sent to parties **20 October 2026**