



EMPLOYMENT TRIBUNALS

Claimant: AA

Respondent: BB (1)
CC (2)
DD (3)
EE (4)
FF (5)
GG (6)
HH (7)

Heard at: Bristol **On:** 12 & 13 December 2019

Before: Employment Judge Maxwell

Representation

Claimant: in person

Respondent: Miss K Anderson, Counsel

RESERVED JUDGMENT

1. The Claimant was a disabled person within section 6 of the Equality Act 2010 at material times (July 2018 to July 2019) by reason of the impairments of epilepsy and vitiligo.
2. The Claimant was not a disabled person by reason of cancer, dermatitis or organic psychosis.

REASONS

Parties

1. The Claimant works in a fast food restaurant.
2. References to “the Respondent” as set out below, should be taken as meaning all of the Respondents, save unless the context requires otherwise.

Claims

3. The Claimant brings claims of disability discrimination against the Respondents. The claims made are voluminous, repetitive and often difficult to follow. The bundle of pleadings runs to 700 pages. Her claims have been the subject of extensive case management at preliminary hearings on 25 July and 27 August 2019.
4. EJ Midgley ordered, by way of a table incorporated in his order of 27 August 2019, that various of the Claimant’s claims be determined at a first final hearing, before any decision is made on the remainder of her claims. This was an eminently sensible course of action, since it has the effect of making that part of her claims somewhat more manageable. The Claimant has resisted this approach, seeking to amend the table to add in additional claims.
5. For the avoidance of doubt, the claims proceeding to a first final hearing (subject to consideration of various preliminary issues) will be limited to those in the EJ Midgley’s table. This is in accordance with the interests of justice and the overriding objective.
6. The Claimant, who is not legally represented, found this two-day preliminary hearing a difficult and challenging experience, becoming tearful on several occasions. Her claims as limited to those in EJ Midgley’s table (if allowed to proceed) would result in a hearing measured in weeks rather than days, especially if there is a need for regular breaks during the hearing. Furthermore, in selecting claims which are more recent and where EJ Midgley was able to identify a PCP or act which the Claimant may point to and say was discriminatory, these claims may be amongst those which have greater prospects of success.
7. This approach is likely to put the parties on a more equal footing, since they they will both be able to focus on a, reasonably, clear and intelligible list of claims. The Claimant in particular will have an opportunity to engage with the process in a manner which adds to rather than detracts from the Tribunal obtaining a clear understanding of the matters she is complaining about. The Claimant may believe that she is better served by insisting on a Tribunal attempting to determine (at one hearing) each and every factual complaint in

her lengthy pleadings, but in reality this would make things more difficult for her, the Tribunal and the Respondent.

8. This course of action is also a proportionate one, since it is likely that a determination of the identified claims will reduce the need for a determination of the remainder. If the Claimant wins on some or all of the many claims in EJ Midgley's table, then a finding for her on the remainder will add little. If the Claimant were to lose on all of the claims in the table, then the findings made in that regard would better enable to a Tribunal to ascertain which of the remaining claims had a real prospect and required determination. This will also save expense and result in her claims being heard sooner rather than later.

Preliminary Issues

9. EJ Midgley on 27 August 2019 also ordered the following matters were to be determined as preliminary issues:
 - 9.1. Determining whether the claimant's conditions of dermatitis, vitiligo, astrocytoma brain cancer, epilepsy and organic psychosis amount to a disability for the purposes of s.6 and Sch 1 of the EQA 2010;
 - 9.2. Deciding whether any amendment of the claim should be granted and if so to what extent;
 - 9.3. Deciding whether any claim has little reasonable prospect of succeeding so that the Claimant should be ordered to pay a deposit to continue with the claim (Rule 39);
 - 9.4. In respect of any claim which proceeds, identifying the issues for determination at a final hearing;
 - 9.5. Making the case management orders which are necessary to prepare the matter for a final hearing.
10. Whilst this two-day hearing had been listed with a view to determining all of the preliminary issues, the volume of evidence produced by the Claimant coupled with the complex and detailed manner in which the case was argued (by both parties) led to the Tribunal considering the first issue only, whether she was a disabled person, and reserving the decision in that regard.

Additional Documents

11. At the beginning of Day-2 of this hearing, a message was passed by the clerk from the Claimant to the Tribunal, saying she had further documents she wished to rely upon. This was an inopportune moment, as the Claimant was part-way through being cross-examined on her evidence in relation to disability. Having canvassed the point briefly with the parties, I decided to wait until the the Claimant's evidence was finished, then hear argument and, if necessary, recall the Claimant.

12. The Respondent agreed I might look at the content of the new documents for the purpose of considering the application to admit them into evidence. The Claimant explained these were intended to show that the brain tumour she had removed in 2008 was cancerous, that being a contentious matter as between the parties and one on which she had been cross-examined during Day-1.
13. Having looked at the documents, they were of a similar nature to many the Claimant had produced previously and which were already in the supplemental bundle (257 pages) prepared for this hearing. They comprised public health guidance (such as from the NHS or Public Health England (“PHE”) websites) and scholarly articles. None of the documents was a medical report addressing the Claimant’s own health and whether or not she had cancer. They did not, therefore, appear to have high probative value with respect to the matters she had to prove. It was also correct to observe that the Claimant had known long before this hearing began that the Respondent disputed whether she had suffered from cancer, as in much of her evidence and representations she had expressed very clearly her distress and the injustice she perceived in being required to prove this. The Claimant could, therefore, have obtained this material at an earlier stage and put it in the bundle if she had wished to do so. Against that consideration, I have taken into account that the Claimant has suffered with her mental health (separately from whether in any respect that amounts to a disability within EqA section 6) and has found the Tribunal process a difficult and challenging one to engage with. I am, however, mindful of the need to seek to keep the parties on an equal footing and deal with matters in a proportionate way. The Respondent had taken a view not to respond to the evidence the Claimant produced previously by way of guidance and academic articles. In the event the Claimant wished to introduce more of the same, the Respondent would be entitled to reconsider its position, perhaps with a view to conducting a similar exercise (internet trawl) itself or obtaining some other more specific evidence in this regard. At the very least, Ms Anderson would need time to read it all carefully and take instructions from her client, which steps would make it less likely that I would be able to conclude evidence and submissions on the questions of disability at this hearing. I also had to consider proportionality. This hearing was listed to deal with 5 issues. In the event it was only possible to deal with one of those issues (and then only with a reserved decision). I indicated to the parties that I would be looking to list the matter again to consider the remaining issues. In circumstances where the additional documents did not appear to take the Claimant very much further, the interests of justice favoured not admitting the same.
14. When I explained to the Claimant that she must take care to provide all relevant documents before a hearing, in accordance with Tribunal orders and that she would not, generally, be able to add further documents during a hearing, she became distressed. It is, however, important that the Claimant understands and co-operates with the ‘ground rules’ established for Tribunal hearings (primarily in ET orders), especially in circumstances where she

wishes to pursue voluminous and complex claims that will require a lengthy final hearing.

15. The Claimant pointed out that the Respondent had provided her with a copy of the decision of the EAT in **Lofty v Hamis** at this hearing. Decisions of the higher courts are binding on the Tribunal, they are not evidence in the case. Medical guidance and academic documents of the sort the Claimant sought to introduce are evidence. The Claimant had been ordered by EJ Midgley (para 2.1, order 27.08.19) to provide **all** her medical evidence by 16 October 2019.
16. The Claimant also complained that the Tribunal could and should have carried out its own research into cancer, using the various online resources available (as she has done). She reasoned that If the Tribunal could research the law (see discussion of **Lofty v Hamis** below) then it could also research medical evidence. I explained to the Claimant that the Tribunal was not permitted to act in this way, rather it had to make a determination based upon the evidence presented by the parties.

Amendment

17. At the hearing, Ms Anderson for the Respondent said the Claimant could not, for the purpose of showing she was a disabled person within EqA section 6, rely upon many of the impairments identified by EJ Midgley in his order as she had not pleaded them, namely:
 - 17.1. dermatitis;
 - 17.2. brain cancer (as a past disability, Miss Anderson accepted that it was sufficiently pleaded as a present disability);
 - 17.3. organic psychosis.
18. I reminded myself of the helpful guidance on the consideration of applications to amend provided by Mummery J in **Selkent Bus Co Ltd t/a Stagecoach Selkent v Moore [1996] UKEAT/151/96**.
19. In her first claim form presented on 10 January 2019, the Claimant included:
 - 19.1. at box 12.1 she said she was disabled”
 1. Epilepsy 2. Brain Tumour-Astrocytoma 3. Vitiligo - autoimmune disease. Epilepsy and autoimmune disease are linked, the presence of one disorder increases the risk for the other, so vitiligo have a major long-term effect on my normal day-to-day activities my weakened immune system overreacts to triggers ex.chemicals and can cause me seizures.
 - 19.2. the particulars attached to her claim included:

“Under the Equality Act 2010 I come to bring the claims of discrimination arising from disabilities (DOC.1) Brain Tumour and Epilepsy and vitiligo”;

“Around May/june 2018 I went to see the neurologist / epilepsy nurse because of possible return of seizures, the low B12/iron in my blood tests around also that time made me think my immune system was going down again...”;

“On the 23/12/2018 and 24/12/2018 I once again made question to remind the Respondent and their store manager [...] and manager [...] when they sent me to the dining area to clean without protective gloves that the chemicals had ingredients that can cause my dermatitis to get worse and also that could induce me seizures...”;

“...I highlight my disabilities and their triggers chemicals/high temperatures/stress (allergens) but the respondent did not cared about it and did not thought to highlight the ingredients in their chemicals to see if they could cause me injury -seizures/dermatitis/...before sending me to clean with chemicals without protective equipment and did not stop to put me under high temperatures.”

“Vitiligo for me is not just a skin condition but a disability because it is a long term condition and if gets worse can trigger my other disabilities.

Epilepsy and autoimmune disease (vitiligo - skin) are linked, with the presence of one disorder increasing the risk for the other and vice versa.”;

“Skin conditions can be a disability under the Equality Act 2010 if they have a major long-term effect on the suffers normal day-to-day activities.”

20. In her amended pleading (application to amend) presented on 10 July 2019 the Claimant included:

“The Claimant is a female disabled person pursuant to section 6 and 11 of the Equality Act 2010, because she was diagnosed with Astrocytoma-type of brain cancer in 2008 and started to impact her ability to carry out normal day to day activities when induced by her other disabilities: epilepsy, vitiligo autoimmune disease and an organic psychosis after lobectomy surgery.”

“...even then knowing that the Claimant had a skin disability and on top a dermatitis...”

“...the Claimant was denied heat protective gloves and put on purpose to work with her hands with a burn, dermatitis and vitiligo under 375q heat lights and that was causing huge pain and distress.”

“For months the Respondent allow managers to discriminate the claimant by putting her to work without protective equipment causing her even more medical conditions on top of her skin vitiligo and contact dermatitis she because of the failure of the respondent to follow HSE orders was diagnosed with Pompholyx Eczema in her hands”.

“...denied her protective gloves despite her hands being with vitiligo/dermatitis and so when in contact with chemicals it was painful.”

21. Whilst the Claimant in her first claim form did not say expressly that she was a disabled person by reason of dermatitis, she did refer to suffering from that condition and, separately, asserted that a person may be disabled by reference to a skin condition. Given she was not legally represented and reading her claim form in a fair, non-technical way, I am satisfied her references to dermatitis were sufficient to allow that this condition was part of

what she relied upon for being a disabled person. As such she does not require any permission to amend. If I am wrong and permission were necessary, then I would have granted it. The amendment required would be exceedingly modest (essentially a relabelling of existing facts) and the interests of justice call for it to be allowed: the Claimant already relied upon another skin condition as amounting to a disability (vitiligo); the Claimant expressly pleaded suffering with dermatitis; the complaints about not being provided with appropriate gloves are central to the Claimant's complaint; the Respondent was on notice of the need to deal with the complaint about gloves and damage or risk to the Claimant's skin.

22. As far as brain tumour is concerned, this has always and unambiguously been a part of the Claimant's case. No point is taken by the Respondent that this is insufficient for her to rely upon as an assertion of suffering with cancer at all. Rather, the point taken is that the Claimant asserts suffering with cancer currently rather than historically. This position of the Respondent appears to be a new development. The Claimant's original claim included an assertion that she suffered with an astrocytoma brain tumour. I fail to see how the Claimant's original pleaded case involved her adopting the position she was a disabled person by reason of cancer currently and not historically. A past diagnosis of cancer will suffice to satisfy EqA section 6, irrespective of whether that is present within the body at future times when complaints of discriminatory acts or omissions are made. I see nothing in the Claimant's pleading to disavow the application of section 6 on the basis of an earlier diagnosis. If an amendment were needed then I would have granted permission: again, the facts necessary were already pleaded and would come as no surprise to the Respondent. The Respondent was on notice that the Claimant relied upon cancer for being a disabled person.
23. The organic psychosis is a new matter, raised in the Claimant's amendment application for the first time. The assertion that she is disabled by reason of psychosis is a new fact. The Claimant requires permission to amend. I give her that permission as it is in the interests of justice to do so. To the extent that it is necessary to consider whether time should be extended, I am satisfied it would be just and equitable to do so. When asked in cross-examination why she had not mentioned it originally, the Claimant said she feared being mocked (her employment with the Respondent is continuing) as her contemporaneous complaints about vitiligo and dermatitis had been dismissed as "medical bullshit". I am satisfied the Claimant has given a genuine explanation for why she did not refer to psychosis previously. Those who suffer with their mental health are often fearful of the stigma which may result from disclosing the same and the Claimant's fear is an understandable one (I make no finding at this stage about the background, i.e. what managers or colleagues had said about her other medical conditions). The balance of hardship and injustice favours allowing her to amend: if the Claimant is a disabled person by reason of psychosis and that impairment is relevant to her existing claims, then she would be prejudiced by not being able to rely upon that; I do not at this stage give the Claimant permission to rely upon any

new acts or omissions (i.e. as set out in her amended pleading) and so the question of psychosis will only be relevant to the extent that it can be shown to be relevant to the factual matters the Respondent is already called upon to address; any prejudice to the Respondent is limited as to the extent it did not know (and / or could not reasonably have known) she was disabled by psychosis at material times, that consideration is likely to operate as an effective defence to her claims.

Facts

Background

24. The Claimant had produced medical records from the time when she was living in Portugal and more recently (from circa 2012) in the UK. She did not create a translation of the Portuguese documents in advance of this hearing, although in cross-examination she was asked what various reports contained and whether they included the word “cancer”.
25. The Claimant was born in 1981. She was diagnosed as suffering from epilepsy in 1996, which affected her at night and although she was not consciously aware of having seizures, they were observed by her family and also recognised by her in terms of where and in what state (e.g. enuresis or a bitten tongue) she awoke. During treatment and investigations for her epilepsy, a brain tumour was discovered. An operation was carried out in 2008 to remove this tumour.
26. The nature of this tumour and whether it was cancer (the Claimant’s case is it was) is a contentious point between the parties.

Tumour Removal

27. The Claimant does not say that her treating physicians told her at the time (i.e. in 2008) that her tumour was cancer, rather she says (and relies upon recent public health advice and scholarly articles in this regard) that all brain tumours are now classified as cancer and so that is what she had.
28. Furthermore, the Claimant understood her doctors to have advised in 2008 that the tumour was causing her epilepsy and this would cease on its removal. As the Claimant has experienced further episodes of epilepsy subsequent to the operation, she believes the tumour has not been entirely removed. On this basis she reasons, she continues to suffer with cancer. The Claimant also says she has cancer because it cannot be proved that no cancerous cell remains in her body.
29. The surgical procedure for the removal of this tumour had unforeseen consequences. She suffered psychosis following the operation and was admitted to hospital as an in-patient for this. In her impact statement, the Claimant says:

After the lobectomy to remove the astrocytoma I was faced with 'executive dysfunction' that affected my memory and caused me cognitive, emotional and behavioural difficulties this had a profound effect on many aspects of my day to day life.

30. The Claimant said that she experienced hallucinations, was prescribed anti-psychotic medication and sleeping pills. She was under the care of a psychologist for a year and was given coping strategies, which included avoiding stressful situations.

Portuguese Medical Records

31. The unforeseen consequences appear to have been the subject of complaints made by the Claimant (or on her behalf) to the Portuguese hospital where the surgery was carried out. The Claimant translated various documents as including correspondence passing between the hospital and relevant government departments, saying that the post-operative symptoms she experienced were a remote, unexpected outcome, for which she was receiving appropriate treatment.
32. The Claimant was referred to a medical report dated 28.11.09, which had a printed heading "DIAGNOSTICOS PRINCIPAIS" and a manuscript entry which began with the word "tumour". She explained the Portuguese word for cancer was "cancro" and this did not appear in the document. She also said this was unsurprising at the document related to her brain surgery and was not a pathology report.
33. The Claimant was referred to another document dated 28.11.19, which did appear to be a pathology report; this included a heading of "RELATORIO NEUROPATOLOGICO" and text below (again, not including "cancro"):

Nos fragmentos correspondente a amigdala, apeneas em um dos cortes histologicos e numa area restrita do tecido amigdalino, e possivel observar uma proliferacao neoplasica benigna de elementos astrocitarios de morfologia "pilocitica" e "fibrilhar", fortemente immunoreactivo para a GFAP, que corresponde a astrocitoma de de baixo grau (I/II)"

The Claimant responded "yes it says low grade". She then referred the Tribunal to a document in the bundle from the PHE website which provided:

Astrocytic tumours are the commonest type of cancer of the brain. They originate in a particular kind of glial cells, star-shaped brain cells in the cerebrum called astrocytes. This type of tumor does not usually spread outside the brain and spinal cord and it does not usually affect other organs. Astrocytomas can occur in most parts of the brain.

Astrocytic tumours include a range of histological types* and malignancy grades. The least aggressive WHO grade I tumours are Pilocytic Astrocytomas and Subependymal Giant Cell Astrocytomas. The WHO grade II tumours include Pilomyxoid Astrocytoma, Pleomorphic Xanthoastrocytoma, as well as the Diffuse Astrocytomas, which include the following subtypes Fibrillary, Gemistocytic and Protoplasmic. Anaplastic Astrocytomas are more aggressive and are WHO grade III.

The Claimant said that “pilocitica” and “fibrilhar” in her report were the Portuguese equivalents of pilocytic and fibrillary on the PHE website, her tumour being a WHO grade 1 or grade 2 on that basis.

34. The Claimant was asked about a letter of 10 December 2012, which she explained was a response to her complaint. The Claimant said “mais maligno” meant more malignant and she translated the material passage in the course of giving her oral evidence as:

“in good hour the patient had surgery because she was diagnosed with low grade tumour of the glial, which despite being low grade, it will probably grow and have biologic behaviour more malignant”

UK Medical Records

35. A medico legal report was prepared on 16 June 2014 by Dr Silva, Consultant Neurologist, in connection with an earlier personal injury claim. Dr Silva recited much of the Claimant’s medical history, including:

- 35.1. a report of 20 April 2013 by Dr Fuller, Consultant Neurologist

She had an MRI scan which then shoed[sic] a right temporal lesion which from one letter she brought with her was thought to be a dysembryonic neuropithelial tumour - a benign glial tumour. She then had an operation in 2009 and is not clear about the history. Three months later she developed auditory hallucinations and was in a psychiatric hospital. Since then she has continued to have auditory hallucinations.

She also seems to have some very fixed views that the surgeons had somehow used her in an experiment and perhaps inserted some sort of stimulator in her brain and she tells me she is starting a court case. [...]

Talking to [AA] today I wondered whether she had some features of an organic psychosis. I wondered whether this could constitute a post ictal phenomena with subclinical seizures at night and think it would be reasonable to do a 48 hour EEG.

- 35.2. a report of 9 October 2013 by Dr Weir

I am not hearing from her symptoms to make me worry that she has active epilepsy at the moment and this is why I do not thing[sic] an EEG will be helpful.

She has now received from Portugal a copy of neuropathology report from the time of her surgery in 2009. There is discussion of a low grade astrocytoma (grade V) in the specimen removed from the right hippocampus. She explained to me that she had been on Valproate 800bd and Topiramate and stopped these a few months after surgery.

- 35.3. a report of 12 November 2013 by Dr Aurangzeb:

We went through her clinic letters from that time, which were written in Portuguese but [AA] kindly translated them for me. She was diagnosed with secondary generalised seizures, had 4-5 seizures a year and was started on Valprionate 800mg twice a day in 1997. She also tells me she had a video EEG at that time for five days and they recorded a seizure during it. In 2008, due to

ongoing seizure activity, she was started on Topamax 50mg nocte. She changed her doctor at that time, who requested an MRI with contrast for the first time. It was reported as having possible DNET in the right amygdala. She subsequently underwent surgery in Portugal in 2009. The biopsy report (written in Portuguese but translated by [AA]) suggested an astrocytoma benign type VII, which was immunoreactive to GFAP.

She tells me that she developed complications as a result of the surgery and she is currently pursuing legal action against the neurosurgeon. She also developed extensive vitiligo around the same time. She was also seen by an endocrinologist in Portugal but no significant cause was found.

Her anticonvulsant medication was stopped in 2009 following her surgery. She lives alone and is unsure whether she is still having nocturnal seizures. She has noticed sleep walking 2-3 times. Sometimes when she is lying in her bed, not yet asleep, she has a generalised body jerk with no associated loss of consciousness. She gets these jerks about five times per week. She denies having early morning myoclonic jerks or myoclonus during the day. As far as she can tell, she has never experienced metallic taste in the mouth, abnormal smell, déjà vu or blank spells. No one has commented that she has any vacant spells or that she drifts off in conversation. Ever since the anticonvulsant was stopped, she has never woken up having injured herself, bitten her tongue or urinary incontinence.

[...]

We had a long discussion today. As she lives alone, she is worried she may still be having nocturnal seizures without her being aware of them. This issue is quite difficult to address but I will arrange a sleep deprived EEG to see if there are any active epileptiform discharges. She has read about SUDEP in a book recently and is quite worried about it.

[...]

She is worried about the clips in her skull, which are made from titanium (B-Brain with reference FF091/D). She has done extensive search on the internet and has downloaded papers where titanium has been found to be carcinogenic and that local corrosion could cause damage to the glial cells and result in systemic features. She is worried that the titanium is harmful for her and may have contributed to the vitiligo.

36. A letter of 20 October 2014 from Dr Martin, Consultant Neurologist, refers to the Claimant having raised a concern with her GP about the presence of nanotechnology in her body and wish for a scan to be conducted. Dr Martin indicates that there was no scan available to test for this and agreed (presumably with the referring GP) that this was a “mental health problem”.
37. A letter of 28 April 2017 from the dermatology department of Gloucestershire Hospitals NHS Foundation Trust provided:

I saw this very nice lady today who wanted an explanation for her vitiligo. She has lots of research articles that she looked at and was very interested in the fact that acetylcholine can destroy melanocytes. This is pertinent to her as she has had electrical stimulation for her epilepsy which can stimulate acetylcholine.

Acetylcholine as well as many other chemicals may be involved in the pathogenesis of vitiligo but what she was asking in terms of trying to find out if this is the cause in her is not able to be done. [...]

Unfortunately I appreciate this was an unsatisfactory consultation for this lady but she was not interested in any treatment for her vitiligo.

38. A letter of 18 December 2017 from Dr Martin of the Gloucestershire Hospitals NHS Foundation Trust provided:

She lives alone and so there are no current descriptions of the seizure episodes. She was seen in A & E on the morning of 20th November having been incontinent of urine overnight and with some headache and a feeling that she did not feel quite right.

Her blood showed a mild elevation in white count at 12.1 and a significant elevation in CK to 902 both of which are seizure markers. A prolactin was not sent on this occasion but a previous prolactin which I presume was taken post-seizure on 8th May 2013 showed a marked elevation of 1500 subsequently this fell back into the normal range. There is, therefore, good biochemical and haematological evidence for these being seizures (I think in Oxford there was a question about whether they were non epileptic from what she told me today).

She is read widely in epilepsy, she is concerned about a risk of sudden death in epilepsy and I explained that the risk is estimated to be one in a thousand treated patient years and that the risk dramatically drops with seizure control. I think she should be started again on an anticonvulsant.

39. The Claimant declined the anticonvulsant medication prescribed by her GP shortly after the letter from Dr Martin, being fearful of the potential side effects and preferring what she would describe as “alternative” or “natural” remedies.
40. The GP entry for 3 April 2018 included that she had not yet taken the prescribed medication and “she doesn’t necessarily think she is still having seizures”.
41. A letter from the Epilepsy Specialist Nurse on 27 June 2018 included:

[AA] continued to not want to take any medication and is worried about the risk of side effects which we explored fully in clinic today. [...]

She woke with evidence of urinary incontinence in another part of the room. She had a tongue bite, she remembers a little about being disorientated and again wanting to know if this was possibly a sleep problem. I have suggested to [AA] that the symptoms point to this being a probable seizure and again we would recommend medication; any medication we tried would be at a low dose and introduced slowly to reduce the risk of does related side effects. Again [AA] isn’t keen on medication and I respect her decision, whilst at the same time making her aware of the risk of SUDEP (sudden unexpected death in epilepsy). She is well read in the subject of SUDEP and medication.

42. The note 29 October 2018 made by the Claimant’s GP practice nurse record a diagnosis of “contact dermatitis” and includes:

having problems with a sore rash on hands itching burning; is not as bad at home but seems to flare up at work; does not use scetyed [sic] products and avoids direct sunlight as had vitiligo. has to use hand sanitisers and work under hot grills at work (Works in [...]) has asked for PPI but manager has refused without evidence from GP.

[...] asking for note to employers.

43. An undated letter from the Claimant's GP (presumably written in response to her request on 29 October 2018) provided:

This patient has given me permission to write to you as their employer with respect to contact dermatitis that is affecting her hands and which has become problematic for her. She has also been known to suffer from vitiligo since 2007. She feels that there is an occupational component to her condition as her current work environment seems to flare her skin problems, possibly as a result of exposure to heat and chemicals within the workplace. She has therefore asked for a letter form to confirm that she has been in discussing this problem with us. Given the skin problems flare after her work it would seem likely that they are related in some way.

44. The 12 November 2018 GP record includes "ongoing problem with contact dermatitis".

45. The 23 November 2018 GP record noted:

History: Has dermatitis in hands – likely following chemical exposures of work. See prev notes.

Came in to ask if this will become chronic if you continue to use the chemical. Advised if chemicals at work I'll because then she will likely continue to experience flare-ups, otherwise if you stopped using of the chemicals she should expect things to settle down with appropriate treatment providing there are no other triggerst o her dermatitis

Examination: Mild dermatitis currently, very well controlled

Plan: Advice re: emollient and steroids for flares

46. The 13 December 2018 GP record included:

History: dermatitis on hands comes and goes with cream – mild, advice.

47. An out of hours doctors report of 4 February 2019 noted that the Claimant reported having woken with urinary incontinence, a bitten tongue and felt she had been sleep walking. The Claimant gave a drug history of "natural remedies" and said that she felt she had been sleep walking during seizures the previous year.

48. The GP record of 15 February 2019 noted the Claimant believed she had suffered a fit and identified checks to be carried out. She was advised to have B12 injections but preferred to take this orally. She also requested a letter from her GP for her employer.

49. On 26 March 2019, the GP record included:

Problem: Depressed mood (XE0re)

History: struggling w low mood months, struggling to cope, crying all the time and sometimes feels faint. Not on any antiepileptics, declined them. Nocturnal seizures, doesn't think inc. frequency but unsure. Under lots of stress at work, says discrimination against her, seeking legal advice. Struggling to distract herself from everything, no close friends/family/partner. Wakes lots overnight.[...]

Plan: feels needs some medication for her mood trial citalopram, 10 mg OD for 7d inc to 20 mg OD if tolerated, discussed possible side effects, Declined counselling.

50. The GP record of 26 April 2019 noted the Claimant attended with low mood linked to the dispute with her employer and legal proceedings. Citalopram was to continue. The record included "not sure if had seizure 9th April".
51. The GP record of 4 June 2019 noted the Claimant attended with depressed mood and was given a Med3 "so option is there for time off work due to stress". The Med 3 was for the period to 17 June 2018 and cited "depression exacerbated by work stress". Further Med3s were issued on 17 June and 25 July 2018..
52. A GP record of 27 August 2019 noted the Claimant reported "sporadic" nocturnal seizures. She wished to reduce citalopram down to 10mg and wondered whether she had more nocturnal seizures on a higher dose. She requested an amendment to the letter written for her employer in February of that year, so as to specify "astrocytome".
53. A GP record of 30 August 2019 records the citalopram was reduced as the Claimant felt it was making her seizures worse. She again asked for the letter to her employer to be amended "to say amygdala was area affected by surgery and this can alter emotions, and also saying she's had psychosis". The amended letter provided:

Sleep related epilepsy from aged 17

Right temporal lobectomy from (removal of part of brain, in her case the amygdala which plays a role in emotional regulation) following a diagnosis of a glioma (astrocytoma Grade 1-2) in right temporal lobe 2009.

Following surgery she had an episode of psychotic symptoms and was in a psychiatric hospital for at least a week.

This is in addition to the vitiligo that has been previously described.

54. The GP record of 10 October 2019 included

wants re-referral to peilepsy[sic] nurse as has 4 seizures in 4 months which is more than previously [...]

Law

Disabled Person

55. Section 6 of the **Equality Act 2010** (“EqA”) provides so far as material:

(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.

56. The definition at section 6 is supplemented by Schedule 1 to EqA, which so far as material provides:

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.

[...]

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.

(3) Sub-paragraph (1) does not apply—

(a) in relation to the impairment of a person's sight, to the extent that the impairment is, in the person's case, correctable by spectacles or contact lenses or in such other ways as may be prescribed

Impairment

57. In relation to “impairment” the question for the Employment Tribunal is a functional one, what the Claimant cannot do practically. It is unnecessary to consider the cause of such limitation; see **MOD v Hay [2008] IRLR 928 EAT**.

58. In determining whether a person satisfies the definition of disability the Employment Tribunal must focus on what the person cannot do or can only do with difficulty, as opposed to what they can; see **Leonard v Southern Derbyshire Chamber of Commerce [2001] IRLR 19 EAT**.

Mental Impairment

59. Guidance on the correct approach to identifying a mental impairment was provided by the EAT in **J v DLA Piper [2010] IRLR 936**, per Underhill P:

40. Accordingly in our view the correct approach is as follows:

(1) It remains good practice in every case for a tribunal to state conclusions separately on the questions of impairment and of adverse effect (and, in the case of adverse effect, the questions of substantiality and long-term effect arising under it) as recommended in **Goodwin v Patent Office [1999] ICR 302**.

(2) However, in reaching those conclusions the tribunal should not proceed by rigid consecutive stages. Specifically, in cases where there may be a dispute about the existence of an impairment it will make sense, for the reasons given in para 38 above, to start by making findings about whether the claimant's ability to carry out normal day-to-day activities is adversely affected (on a long-term basis), and to consider the question of impairment in the light of those findings.[...]

41. The facts of the present case make it necessary to make two general points about depression as an impairment. [...]

42. The first point concerns the legitimacy in principle of the kind of distinction [...] between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to them as symptoms of low mood and anxiety. The first state of affairs is a mental illness—or, if you prefer, a mental condition—which is conveniently referred to as “clinical depression” and is unquestionably an impairment within the

meaning of the Act. The second is not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problems at work) or— if the jargon may be forgiven—“adverse life events”. We dare say that the value or validity of that distinction could be questioned at the level of deep theory; and even if it is accepted in principle the borderline between the two states of affairs is bound often to be very blurred in practice. But we are equally clear that it reflects a distinction which is routinely made by clinicians [...] and which should in principle be recognised for the purposes of the Act. We accept that it may be a difficult distinction to apply in a particular case; and the difficulty can be exacerbated by the looseness with which some medical professionals, and most lay people, use such terms as “depression” (“clinical” or otherwise), “anxiety” and “stress”. Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If, as we recommend at para 40(2) above, a tribunal starts by considering the adverse effect issue and finds that the claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for 12 months or more, it would in most cases be likely to conclude that he or she was indeed suffering “clinical depression” rather than simply a reaction to adverse circumstances: it is a common sense observation that such reactions are not normally long-lived.

Substantial Adverse Effect

60. “Substantial” is defined at EqA section 212(1) as “more than minor or trivial”. In this context a substantial adverse effect means a limitation going beyond the normal differences in ability which may exist amongst people; see the Guidance paragraphs B1. Relevant factors may include:
- 60.1. the time taken to carry out an activity (B2);
 - 60.2. the way an activity is carried out (B3);
 - 60.3. cumulative effect of multiple impairments (B4-B6);
 - 60.4. effect of reasonably modifying behaviour (B7-B10);
 - 60.5. effect of environment (B11);
 - 60.6. disregarding the effect of treatment (B12-B17);
 - 60.7. whether there is a progressive condition (B18-B23);
 - 60.8. severe disfigurement.

Normal Day-to-Day Activities

61. Normal day to day activities can include work activities where they are found across a range of employment situations; see **Chief Constable of Dumfries & Galloway v Adams [2009] IRLR 613 EAT**.

Material Time

62. The question of disability must be determined as at the date of the alleged discriminatory act, as opposed to the date of hearing; see **Cruickshank v VAW Motorcast [2002] IRLR 24 EAT** and **Richmond Adult Community College v McDougall [2008] IRLR 227 CA**.
63. In this context the word “likely” means could well happen; see **SCA Packaging v Boyle [2009] IRLR 746 HL**.
64. The task for an employment tribunal is, therefore, to ask on each date when the Claimant alleges an act of discrimination:
 - 64.1. whether a sufficient impairment had lasted for at least 12 months;
 - 64.2. whether a currently sufficient impairment could have been said at that point to be likely to last for at least 12 months or to recur.

Past Disabilities

65. Pursuant to EqA section 6(4), a person who was a disabled person in the past, prior to the matters complained of, is treated a disabled person for these purposes.

Cancer

66. Just before the lunch break on Day-2, Ms Anderson for the Respondent indicated that she wished to hand up an authority, namely the decision of the EAT in **Lofty v Hamis**. I indicated that I had already seen that. This brief exchange caused the Claimant to become immediately concerned. The Claimant appeared to believe there had been some impropriety, presumably private communication by the Respondent with the Tribunal. I explained to the Claimant that this was not the case, I had looked in a legal textbook after the hearing concluded on Day-1, namely the IDS Handbook, and found the case of **Lofty** referred to in the commentary there.
67. The decision of the EAT in **Lofty v Hamis UKEAT/0177/17/JOJ** addressed the manner in which an Employment Tribunal had approached evidence about whether the claimant in that case had cancer; per HHJ Eady QC:

14. The Claimant’s solicitors then sent further instructions to her GP, noting his description of lentigo maligna as a pre-cancerous condition and the section of the BAD leaflet dealing with the meaning of in situ cancer. They posed the following question: “does this mean that Mrs Lofty’s condition can be described as cancer?”.

15. The Claimant’s GP responded in a further report, dated 13 October 2016 as follows:

“Mrs Lofty had cancer, the British association of dermatologists describes lentigo maligna as the earliest stages of melanoma, this is a cancer in situ but has the potential of becoming rapidly invasive and for this reason Mrs

Lofty required surgery. Some doctors may call a cancer in situ or non-invasive, pre-cancer. Lentigo maligna can become malignant melanoma which is rapidly invasive.”

[...]

46. The Respondent says that the ET was entitled in these circumstances to conclude that this was insufficient to discharge the burden of proof. That said, the evidence before the ET went further than the simple statement of her condition being “pre-cancerous”; it included evidence of the Claimant’s surgery and an explanation for her condition that suggested it was indeed to be understood as cancer. For the Claimant, it is said that was sufficient: she had been diagnosed as having cancerous cells in her skin - cancer in situ - it would be contrary to the apparent intention of Parliament to require a complainant to adduce medical evidence dealing with these issues at any greater level of technical expertise. Parliament had decided not to go down the route of distinguishing between different types of cancer and it would be wrong, as a matter of principle, not to extend the protection to those who the employer feared might develop one of the conditions deemed to amount to disabilities under Schedule 1 paragraph 6.

47. I largely agree with the Claimant on these points. When determining whether a condition satisfies the deeming provision of paragraph 6, there is no justification for the introduction of distinctions between different cancers or for an ET to disregard cancerous conditions because they have not reached a particular stage. I equally agree that it is undesirable that ETs’ determinations under Schedule 1 paragraph 6 should necessarily be required to be based on high-level medical expert evidence as to what is, or is not, cancer (not least as it is not impossible to conceive that this might be a matter of some specialist academic debate). Equally, however, Schedule 1 paragraph 6 does require that a complainant have one of the specified conditions; it is not sufficient that they might develop a relevant condition in the future and I am not persuaded that a purposive construction requires such a broad approach to be adopted.

48. In the present case, the evidence before the ET was that the Claimant had an in situ melanoma. That meant there were cancer cells in the top layer of her skin. It may be that a diagnosis of pre-cancerous cells might mean something different depending upon where the cells are to be found, but, in terms of skin cancer, the evidence before the ET was that this meant the Claimant had an in situ cancer. The evidence adduced by the Claimant to this effect took the form of her original diagnosis, as explained to her by her treating Consultant, together with the further clarification provided by her GP for the purposes of the ET hearing, along with the information leaflet from the BAD.

Conclusion

Approach to Evidence

68. During the course of this hearing or more than one occasion, the Tribunal sought to explain to the Claimant the difference between, on the one hand, public health guidance and academic material of a general nature relating to medical conditions, and on the other hand, notes and reports which involved a doctor giving an opinion or advice about her illnesses in particular. I did not have the impression the Claimant failed to grasp this distinction, rather that she was resistant to accepting it because the conclusions she wished the Tribunal to reach relied to a great extent on the general material. More than

once during the hearing, the Claimant mischaracterised discussions which had taken place in this regard by saying the Tribunal was telling her she “cannot trust” the NHS or PHE. I repeat here what I told the Claimant at the time, I am certainly not saying she cannot trust the guidance offered by the NHS or PHE, there is however a difference between general material saying, for example, that cancer may cause epilepsy and a medical report about her where a doctor gives an opinion on what has caused her epilepsy in particular.

69. The function of the Tribunal is not to carry out an independent investigation into the Claimant’s health, with a view to obtaining a full understanding of all her medical conditions, in order then to ascertain whether any of them individually or cumulatively amount to a disability. Rather, the onus is upon the Claimant to put before the Tribunal medical evidence and her own witness evidence as to the adverse effect upon her day to day activities, in order to show that she falls within EqA section 6. The opportunity for the Claimant to do this, indeed the obligation so to do, was provided by EJ Midgley’s orders at paragraph 2.1. Whereas the order called upon the Claimant in her impact statement to describe the adverse effect on her day to day activities, she did this to a limited extent only.
70. In her closing submissions, the Claimant referred to several new matters, with respect to the impact of her impairments on her day to day activities. These were matters she had not included in her written impact statement, or spoken of when answering questions in cross-examination, or when asked by the Tribunal. Ms Anderson for the Respondent, understandably, objected. I explained to the Claimant that I could not take this new information into account. She was able to comment upon the evidence already before the Tribunal, but could not tell me for the first time, for example, about activities she was unable to undertake because of her epilepsy.

Astrocytoma Brain Cancer

71. The Claimant had an astrocytoma brain tumour in 2008, which was surgically removed. This was classified at the time as being benign and low grade. On the evidence before me, I am unable to make a finding on the balance of probabilities that this tumour was cancer. Nowhere in the medical evidence relating to the Claimant specifically (reports, letters, GP notes) is it said that her tumour was cancerous.
72. The Claimant has sought to prove she had cancer by relying upon material she has obtained from the internet, public health guidance and academic articles. She say this material establishes that all astrocytomas are now regarded a being cancer. The Claimant may be correct in her analysis. Her medical records do, however, requires interpretation to arrive at this conclusion. The oral evidence the Claimant has given me on this point is argument and opinion, which would need to come from a person with appropriate expertise and qualifications in order to be accepted. Whilst the Claimant undoubtedly spends a great deal of her time researching her

various medical conditions or concerns and may have acquired considerable knowledge in that regard, this cannot substitute for the evidence or opinion of an appropriately qualified professional. It is not the case that “high level” expert evidence is necessary. Had her GP or any treating physician stated her tumour was cancer, that is likely to have been sufficient. The Claimant agreed, however, that nowhere in the medical records relating to her (be those in Portuguese or English) does any doctor say she had “cancer”.

73. For the sake of completeness I should add that the Claimant did not seek to argue in the alternative she was a person disabled by reason of having a non-cancerous tumour in 2008. As such, I cannot say that by reason of this tumour in 2008, she was then a disabled person.
74. Whilst I anticipate that my conclusion on the question of cancer in 2008 will be a great disappointment to the Claimant, I doubt that such a finding would have assisted her in these disability claims in any event. The complaints in these proceedings do not begin until some 10 years later. The Claimant is not likely to have established a relevant PCP in 2018 which put her at a disadvantage by reason of having had a cancerous tumour in 2008, or that because of something arising from the same she was unfavourably treated. In order to succeed here, the Claimant will need to relate her treatment in 2018 to some impairment she was suffering from at that time.
75. As highlighted in the amendment application, the thrust of the Claimant’s argument was not that she was a disabled person at the material time because of a historic cancer diagnosis, rather she maintained she was suffering with cancer in 2018 and this is the continuing cause of her other impairments, including epilepsy and vitiligo. This is a point I can deal with briefly. Whilst I do not doubt the sincerity of the Claimant’s belief in this regard, there is no medical evidence relating to her which supports such a conclusion. Extensive medical records have been disclosed by the Claimant. Nowhere is there any evidence of a medical practitioner making a cancer diagnosis in the period subsequent to the removal of her tumour. I note also that on more than one occasion the Claimant has gone to a medical practitioner with theories as to the cause of her impairments which they did not support.
76. The Claimant says her cancer induced her other illnesses including epilepsy and vitiligo (which she characterises as an autoimmune disorder). She has produced public health guidance and scholarly articles to say that cancer can cause immunity disorders, vitiligo can be caused by immunity problems and cancer can cause epilepsy. Whilst the Claimant has produced documents which say that cancer may cause epilepsy or vitiligo, she has nothing from a medical practitioner to say that her conditions have that cause.
77. When asked during the hearing whether the doctors may not believe what she does about the cause of her ongoing medical conditions, the Claimant responded that she was “not a mind reader”. With respect, the Claimant does not need to read minds to understand that her beliefs are not shared by her

treating physicians, rather she need only read their reports, letters and notes, in which she will not find an opinion that her current illness is caused by ongoing cancer.

Epilepsy

78. The Claimant has suffered with epilepsy over many years. The nature and frequency of her seizures has varied. Because the seizures are nocturnal, the Claimant is not conscious of them as they are taking place, rather she becomes aware of their occurrence the following morning, by reason of a bitten tongue, enuresis or waking out of her bed.
79. There appear to have been lengthy periods during which she has suffered no seizures at all, or at least not been aware of doing so. At other times these attacks have been more frequent. The Claimant did not give very helpful evidence on the frequency of her seizures. Her focus was very much on why she suffered with epilepsy, which she attributed to her brain tumour, (which she would say was cancerous). She relied upon the fact of ongoing problems with epilepsy as evidence of ongoing cancer. Accordingly, the Claimant's approach and her evidence was much concerned with cause (which is of relatively little importance for EqA section 6) and far less concerned with practical effect (which is much more important for EqA section 6). Some evidence of frequency did, however, emerge from her medical records and in the course of cross-examination.
80. The material period begins circa July 2018 and, subject to the outcome of the amendment applications, may run until circa July 2019.
81. The Claimant is likely to have had a seizure prior to attending at A&E on 20 November 2017. She was referred to Dr Martin who prescribed anti-convulsant medication, which she declined to take. In April 2018 the Claimant did not think she was having seizures. In June 2018, however, the Claimant attended the epilepsy nurse having symptoms of a recent seizure and discussing treatment options. The next occurrence of epilepsy appears to have been February 2019, when she reported the aftermath. A further possible seizure was discussed in with doctors in April 2019. In August 2019 the Claimant reported sporadic seizures. In October of 2019, she reported 4 seizures in 4 months as being more than previously.
82. The adverse effect which results from the Claimant's epilepsy is not, however, limited to the symptoms experienced in the morning after she has a seizure, but also includes the shadow this casts over her in the periods in between.
83. The Claimant's reaction to her epilepsy and beliefs about that are strong, fixed and somewhat conflicted. She is very worried about the risk of SUDEP, despite reassurance in this regard from the professionals treating her. She has been advised that the best safeguard with respect to the risk of death is to control her seizures by taking anti-convulsant medication. The Claimant is,

however, unwilling to take the prescribed medication because she is very fearful of the possible side effects in this regard. The Claimant is prone to conducting extensive online research, formulating conclusions (which she shares with her treating physicians) and then relying on her own view, in some instances, over and above expert professional advice. The Claimant's fear of SUDEP is exacerbated by her research and has reinforced her in the view that she must avoid triggers. This includes that she does not drink coffee and she does not drink alcohol. The Claimant strives to avoid any exposure of her body to chemicals (such as cosmetics and ordinary cleaning products). The Claimant also said she avoids taking drugs and from the medical records it is apparent this has extended her refusing to take strongly recommended prescribed medication.

84. The Claimant is very fearful of SUDEP, having discussed this with many of the professionals treating her. This fear is an ongoing feature of her living with epilepsy. The Claimant's avoidance of potential triggers with respect to epilepsy has resulted in the adoption of a restricted, spartan lifestyle, which is an important part of the impact this impairment has on her. These lifestyle consequences, together with post-seizures symptoms and attendances upon her doctors for investigation and exploration of treatment options, create an impact on her day to day activities which is more than minor or trivial. This impairment is long-standing in nature, well in excess of 12 months and documented in her medical records before the material period began. I find the Claimant was a disabled person at material times by reason of the impairment of epilepsy.

Vitiligo

85. The Claimant has suffered with vitiligo over many years. In addition to the medical records documenting this condition, she provided photos showing the marked loss of skin pigmentation (and protection).
86. The main impact of this condition is again in the restrictions it has imposed on the Claimant's lifestyle. In the course of cross examination Ms Anderson suggested to the Claimant that the step she took of not wearing makeup had not been recommended by the professionals treating her. The Claimant responded that she knew to avoid triggers without such advice (which I took to mean it was the result of her own reading and knowledge of vitiligo). The steps the Claimant took in this regard did not seem to be unreasonable or surprising. No specific cause for the Claimant's vitiligo has been found by the doctors. She has decided, amongst other things, not to put any chemicals, including cosmetic products, onto her skin.
87. The Claimant keeps her skin covered and attempts to avoid sunlight. Despite living by the beach, she keeps out of the sun. She does not go on holiday to sunny places. In the course of cross-examination, the Claimant was asked how she travelled to the Civil Justice Centre for this hearing, the purpose of which question appeared to be to establish that she was exposed to sunlight and this issue was, therefore, only a minor one. The Claimant said she kept

herself covered. The Respondent's point on this had little force, especially on an overcast day in December. The Claimant did not go so far as to say she could not leave the house.

88. There was some overlap here with the triggers perceived by the Claimant for her epilepsy, as she also referred in connection with her vitiligo to avoiding, coffee, alcohol and drugs (she declined the exploration of treatment options for vitiligo in October 2014 when a definite cause could not be identified).
89. The Claimant is concerned about and avoids exposure to chemicals, including cleaning products. Whilst this is a workplace issue, it is also relevant to her life at home. In cross examination she was asked about the substances she avoids (she referred to corrosives and bleach) and the steps she takes to avoid exposure (wearing thick gloves). Whilst it was, not unfairly, suggested that these are common concerns, the level at which the Claimant is fearful in this regard is very considerable. She believes there is a real and immediate risk with respect to her health and life, in a way that most other people do not. Her strength of feeling in this regard is reflected in the workplace dispute with the Respondent, with respect to using chemical products, wearing protective gloves and exposure to heat from the grills (whilst I make no findings about the rights and wrongs of such matters at this stage, the fact of her raising her fears repeatedly and forcefully is not in dispute).
90. Once again the Claimant's fear that her health in this regard may be aggravated is an ongoing feature of the vitiligo and her avoidance strategy has led to a restricted lifestyle and workplace conflict. In my judgment, this impact is more than minor or trivial. This impairment is long-standing in nature, well in excess of 12 months and documented in her medical records before the material period began. I find the Claimant was a disabled person at material times by reason of the impairment of vitiligo.

Organic Psychosis

91. The Claimant suffered with psychosis in 2008, following the surgical procedure. She appears to have spent a week in hospital as an in-patient and had psychological follow-up for about a year. Whilst the impairment during the short period of hospitalisation will undoubtedly have been substantial, I have little information about the Claimant's symptoms outside of that time and cannot be satisfied on substantiality then. Again, the Claimant's focus was on the fact of her psychosis and cause, about which she spoke at length, rather than the practical effect on her, about which she said very little. Whilst the Claimant suffered with psychosis in 2008 and 2009, I cannot conclude she was then a disabled person within EqA section 6 by reason of that impairment.
92. The only reference to a later diagnosis of psychosis in the medical evidence is Dr Fuller's report of 20 April 2013, in circumstances where she had been discussing her belief that surgeons had experimented on her and "inserted

some sort of stimulator in her brain". Dr Fuller referred to continuing auditory hallucinations but otherwise gave no description of any symptoms (save perhaps the Claimant's belief about the stimulator). I could not with that bare information conclude there was a substantial adverse effect on day to day activities.

93. There is no evidence of any later diagnosis of psychosis. The Claimant made reference to auditory hallucinations and noise but said nothing beyond that of their nature, duration or frequency.
94. No positive opinion has been given by a doctor that the removal of the Claimant's tumour caused any ongoing problems for her, whether with respect to "organic psychosis", "executive function", "emotional regulation" or otherwise. The letter from her GP of 30 August 2019, written as a result of her several and highly specific requests, is expressed passively. The doctor does not say, positively, that the Claimant has suffered with problems in regulating her emotions, or indeed describe those problems or any other ongoing consequences of her surgical procedure.
95. Whilst the Claimant's impact statement says she has executive dysfunction, memory, cognitive function, emotional and behavioural problems, she does not go on to explain any symptoms or practical consequences in that regard.
96. Furthermore and importantly, if the Claimant had suffered with "profound" effects (per her impact statement), then I would have expected to see this reflected her medical records. Beyond that which is set out above, there is nothing in this regard. None of the GP notes records a consultation in connection with psychosis, or executive dysfunction, or emotional regulation, or any discussion of symptoms or treatment for the same.
97. I cannot on the evidence before me find that at times material to her claims the Claimant was a disabled person by reason of organic psychosis.

Dermatitis

98. The Claimant was found to be suffering with mild dermatitis in the period from October to December 2018. This responded to treatment with emollient cream. The Claimant was advised to avoid exposure to workplace chemicals. Her doctors did not believe this was a chronic problem, rather it was expected to go when her exposure to irritants ceased.
99. Dermatitis did not have a substantial adverse effect on the Claimant's day to day activities. The impact of this impairment was not long term, it had not lasted 12 months and there was no reason to suppose that it would.

Other Impairments

100. The Claimant has also said that her immunity is low and she is vulnerable to infection. Asked about the consequences of this, she spoke of respiratory tract infections. Her account of these ailments in terms of nature and

frequency was unremarkable. In any event, I do not find, as the Claimant contends, that this is a consequence of her ongoing cancer. She does not rely upon low immunity as a free-standing impairment for the purpose of establishing she is a disabled person.

101. Since the workplace dispute became entrenched the Claimant has begun to suffer with depression. She has been prescribed anti-depressant medication, which she says have caused her to be confused, suffer blurred vision, body aches and apathy. The Claimant refers to this as an example of the injury done to her by the Respondent, she does not rely upon depression for being a disabled person within the Act.

Cumulatively

102. In case I am wrong about the Claimant's epilepsy and vitiligo having a substantial adverse effect separately, I have gone on to consider the position cumulatively. As set out above, there is a substantial overlap between the adverse effect relating to the Claimant's epilepsy and vitiligo, in relation to the restricted lifestyle this had led to, her ongoing fearfulness and the difficulties in carrying out workplace cleaning or cooking tasks. Her concerns interlink and reinforce her in the belief that she is in danger and needs to take various protective steps. The adverse effect as a whole is plainly both long term and more than minor or trivial.

Disability

103. The Claimant was a disabled person at material times within section 6 of the Equality Act 2010 by reason of epilepsy and vitiligo. She was not disabled by reason of cancer, psychosis or dermatitis.

Employment Judge Maxwell

Date: 21 January 2019