# EMPLOYMENT TRIBUNALS

**Claimant:** Mr S Panton

**Respondent:** Bright HR Limited

**Heard at:** Manchester (in public, by CVP) **On:** 7 September 2021

**Before:** Employment Judge McDonald (sitting alone)

**Representatives**
For the claimant: Mr C Henshall (Solicitor)
For the respondent: Mr J Potts (Solicitor)

# RESERVED JUDGMENT

The judgment of the Tribunal is that:

1. The claimant was not a disabled person for the purposes of section 6 of the Equality Act 2010 during the relevant period.

2. As a result, all the claimant's claims against the respondent are dismissed.

3. The final hearing listed for 30 November and 1-2 December 2021 will be cancelled.

# REASONS

## Introduction

1. By a claim form dated 27 April 2020 the claimant brought claims that the respondent had subjected him to harassment related to disability contrary to sections 26 and 40 of the Equality Act 2010 ("the 2010 Act") and discrimination arising from disability contrary to sections 15 and 39 of the 2010 Act.

2. The entire claim depends on the claimant being able to show that he was a disabled person during the period when the alleged acts of discrimination took place ("the relevant period"). The relevant period started on 2 December 2019 and ended on 17 January 2020. In his claim form he says that during the relevant period he suffered from depression and post- traumatic stress disorder ("PTSD") and relies on both as disabilities under the 2010 Act.

3. At a Case Management hearing on 12 November 2020 Employment Judge Horne ordered that there should be a preliminary hearing to decide whether the claimant was a disabled person for the purposes of s.6 2010 Act during the relevant period.

4. I conducted that preliminary hearing on 7 September 2021. The claimant was represented by Mr Henshall and the respondent by Mr Potts. The claimant attended and was cross examined by Mr Potts. Mr Henshall and Mr Potts made brief oral submissions. There was no time to give my judgment on the day. Because I was reserving my decision, I gave the parties the opportunity to make written submissions by 10 September 2021 which they both did. I have not set out the submissions in full but have referred to them where relevant.

5. There was an electronic bundle of 116 pages ("the Bundle"). References in this judgment are to page numbers in the Bundle.

**Issues**

6. The relevant case-law makes it clear that in deciding whether the claimant as a disabled person I need to decide whether, during the whole of the relevant period:

- the claimant had an impairment which was either mental or physical?
- the impairment affected the claimant's ability to carry out normal day-to-day activities?
- that adverse effect was substantial?
- the adverse effect was long-term?

7. Deciding whether the adverse effect was "long-term" means deciding whether it had lasted for 12 months, was likely to last for 12 months or was likely to recur.

**Evidence and Findings of Fact**

<u>The evidence</u>

8. The Bundle included the claimant's disability impact statement (pages 40-41), GP records (pp.42-60), further medical evidence relating to his admission to hospital following an overdose in December 2019 (pp.76-85) and NHS information about medication the claimant was prescribed at various times (pp.86-115). There was no expert medical report. The GP records referred to letters and fit notes which were not included in the Bundle. I can only take those into account to the extent their contents were quoted in the GP records at pp.42-60.

*The Disability Impact Statement*

9. The claimant's disability impact statement was brief and short on detail. It consisted mainly of a list of bullet points setting out the "physical and mental impairments" suffered by the claimant and the day to day activities affected. It said (paragraph 1) the claimant relied on two impairments namely depression and "complex PTSD". The PTSD is related to childhood abuse. As Mr Potts pointed out, the "complex" element of the PTSD impairment was not included in the claimant's

claim form. For the reasons given below, this change in description of the PTSD was not significant to my decision.

*The GP Records*

10. The GP records were in two parts. The first was the record of GP consultations (pp.42-57). They covered the period 16 April 2018 to 24 February 2021 and provided details of those consultations including in some cases quotes of referral letters and fit notes. The second part (pp.58-61) provided information about matters such as immunisations, repeat prescriptions, allergies and "Problems" (both active and significant past). They covered a far longer period, recording immunisations dating back to 1992 but the information included was limited to a date and a single line entry.

*The further medical evidence*

11. The further medical evidence consisted of documentation relating to the claimant's admission to Bronte Ward at Wythenshawe Hospital (part of Greater Manchester Mental Health NHS Foundation Trust) on 2 December 2019 following an overdose and his discharge on 19 December 2019 (pp.76-85). There was also publicly available NHS information about Mirtazapine, Sertraline and Promethazine. There was no dispute that the first two are anti-depressants. There was no dispute that the third is an antihistamine prescribed for insomnia but also for allergies and hay fever (pp.96-106).

Findings of Fact

12. Paragraph 2 pf the claimant's disability impact statement set out the "Physical and mental impairments" suffered by the claimant because of his disability as a list of bullet points:

- Suicidal thoughts
- Anxiety
- Broken Sleep
- Flashbacks
- Intense feelings of guilt (at times)
- Restlessness
- Emotional Unawarness (sic)
- Low self esteem
- Low mood
- Insecurity
- Reduced confidence

13. The "Details of the normal day to day activities which the Claimant contends have been adversely affected by disability at the time of the alleged discrimination" were set out paragraph 3 of his statement. They were set out as a list of bullet points:

- Sleep disturbance
- Leaving the house (Mood dependant)
- Avoiding social gatherings (Mood dependant)
- Interacting with others both on a personal and professional level
- Failing to look after general well-being
- Relationship difficulties"

14. "The dates between which the Claimant's ability to carry out normal day to day activities has been adversely affected and the date or approximate date on which the Claimant says he became disabled" were set out in at paragraph 4 of his statement In that paragraph the claimant said that:

- he had suffered from depression and complex PTSD since 2007 "although officially diagnosed in late 2019".
- His ability to carry out normal day to day activities has "on a recurring basis" been adversely affected since then as a result".
- The Claimant's mental impairments are "likely to continue and recur at further stages throughout his life".

15. Mr Potts's cross examination focussed on the absence of a diagnosis of depression and/or PTSD (complex or otherwise) in the claimant's medical records. He did not challenge the claimant's evidence about what he said were the effects of his impairments. I therefore accept that evidence as unchallenged.

16. Turning to the GP records, they only provide detailed evidence from April 2018. Chronologically, the first mention of mental health issues is on 18 March 2019 (p.56). Dr Abbs carried out a first mental health review. The notes of that consultation record that the claimant attempted suicide in 2018 and that the claimant reported having difficulty concentrating, episodes of depression with thoughts of suicide occasionally. It records the claimant feeling anxious and experiencing insomnia. The claimant reported mood swings, "zoning out" a lot, sitting in his own world and biting his fingers a lot. The GP recorded that on examination the claimant appeared a little anxious but was well presented with good speech and eye contact and no evidence of thought disorder. At that point the claimant had no further thoughts of suicide or self-harm. At the time of that consultation, the claimant reported that he had a girlfriend and was a partner in a telesales business. He also reported that he was a moderate smoker of cigarettes and a daily cannabis user. Dr Abbs advised him that cannabis can cause mental health problems.

17. Dr Abbs referred the claimant to the Community Mental Health Team. His referral explained the claimant was concerned he might have ADHD because his

biological brother has ADHD. The claimant had explained that he was fostered, that his biological mother drank during pregnancy and that he was abused by a foster parent. Dr Abbs was not convinced the claimant had ADHD “but he does appear to have mental health problems that are affecting his ability to fulfil his activities of daily living and so think he would benefit from a review by the community health team”.

18. The outcome of that referral is not clear-there are various entries between May and July 2019 and references to scanned documents which were not themselves in the Bundle. They include a letter from a consultant at the Manchester Royal Infirmary Mental Health on 9 July 2019 the contents of which are not recorded in the GP notes.

19. The next entry of significance is on the 9 August 2019 (p.55). The claimant had a long consultation with Dr Al-Gailani, a locum GP. The claimant attended to discuss his ongoing anxiety. The notes record his reporting low mood “at times” which he said was long standing. He reported his concentration levels varying from day to day. He did not have suicidal thoughts or thoughts of self-harm but did not want his mood to get worse to make him have those thoughts again. The claimant was still using cannabis on a daily basis and he was advised of the importance of stopping. Dr Al-Gailani signposted the claimant to contact IAPT (the NHS’s Improving Access to Psychological Therapies service). He also prescribed 50 mg of Sertraline to be taken daily. That was to be reviewed after 7 days in light of the claimant’s previous overdose. At the time of that consultation, the claimant was living with his partner who was supportive. He reported that the overdose in 2018 was after arguments with his partner.

20. On 16 August 2019 Dr Sfeir carried out a “Depression Interim Review” (p.54). The notes report “low mood” for “a long time” with the claimant suggesting this stemmed from his adoption and physical abuse in his childhood. The claimant reported no suicidal thoughts and no thoughts of self-harm. He confirmed that he had only used cannabis once that week and was not a heavy drinker. Dr Sfeir increased the dose of Sertraline to 100mg after a further week and provided the claimant with self-referral details to the Manchester psychological well-being service.

21. On 11 September 2019 Dr McLeod carried out a further Depression interim Review (p.53). The claimant reported feeling better with 100mg Sertraline with “some down days but fleeting”. He confirmed that he was sleeping better, was finding work easier and had no thoughts of self-harm or suicide. He did not have much appetite but was eating ok. He was getting good support from his partner. Dr McLeod put the 100mg Sertraline on repeat prescription.

22. On 9 October 2019 Dr Singh carried out a Mental health review. The claimant reported that although the Sertraline had good benefit initially, he now felt they were not really doing much. He reported his mood being up and down with more down days. The notes record that a lot of that seemed to be work related (the claimant having started work for the respondent some 3 months before). He had no thoughts of self-harm or suicide. He was using cannabis “most days”. The GP found him well-kempt with good eye contact and reactive. They had a long chat about cannabis use including how regular use can have an impact on mood and anxiety. The notes also record that it is difficult to ascertain how much of the mood disorder could be drug related and that advice was given that medication may not work well when there is

ongoing regular cannabis use. The Sertraline dose was increased to 150 mg and the GP also referred the claimant to a drug and alcohol service.

23. On 6 November 2019 Dr Morris carried out a Depression medication review (p.52). With the increased Sertraline dose the claimant reported that his mood was better but was still "up and down". His concentration had improved and there were no thoughts of self-harm. He had not attended the drug and alcohol team and was not keen to engage with them. He had reduced his cannabis use to weekends only. The GP recorded that he was well kempt and dressed appropriately. He was to remain on sertraline with a further review in 2-3 months and in the meantime the claimant was to rearrange counselling.

24. Dr Frank carried out a further Depression Interim review on 19 November 2019 (p.51). The claimant reported feeling low for a while although some days were better than others. He referred to a dispute at work and concerns that changes to his contract might have a knock-on effect on a proposed house move. He reported not doing a lot outside work, no exercise and poor sleep and diet. Dr Frank reported that "Objectively" he felt the claimant's mood was low. He did however engage well, have good eye contact and was calm and relaxed throughout.

25. On 30 November 2019 the claimant was referred to Trafford & South Manchester Mental Health Liaison Service by staff at Wythenshawe Hospital A & E after he took an overdose including 1000mg of Sertraline (p.80). On 2 December 2019 he reluctantly agreed to be informally admitted to Bronte Ward at Wythenshawe Hospital. His evidence, which I accept, was that it was made clear to him that if he did not agree to such an informal admission, he would have been detained involuntarily under the Mental Health Act 1983. He remained on Bronte Ward until discharged on or around 19 December 2019.

26. The letter from Nike Odularu, Mental Health Practitioner, to the claimant's GP about his admission (pp.80-82) reported that the claimant was currently homeless, having checked into a hotel following the breakdown of his relationship with his girlfriend on the day before the overdose. The claimant had said his influence is destructive and that his partner had found his on and off anger hard to manage. He believed that problems occur in his presence and that he had corrupted his partner. He reported daily cannabis use which was "out of control".

27. The letter contained a section called "mental state examination" which noted that the claimant's appearance was dishevelled with limited engagement, adequate eye contact, coherent speech but with relevant but limited engagement and a low tone. His mood viewed objectively was "flat affect and depressed". He reported poor concentration for many years and poor memory for many years. He declined to talk about his thoughts but reported a history of suicidal thoughts.

28. In the section headed "risk assessment" the letter recorded "deterioration in mood due to psychosocial stressor". It also recorded under "collateral information" a friend reporting that the claimant "had not be[en] himself for weeks" (p.82).

29. The discharge documentation included two discharge prescriptions (pp.76-79). Both were dated 19 December 2019 and included a prescription for 15 mg of Mirtazapine for one week. Both gave the "reason for admission" as "low mood" but

the "principal diagnosis" and "additional diagnosis" boxes were left blank. Both gave the rationale for prescribing mirtazapine as "low mood, insomnia".

30. The "Discharge Summary" (pp.82-83) also has "none" for the "Primary Diagnosis" with the "Additional Diagnosis" box left blank. Page 2 of the Discharge Summary repeats the information about the claimant's admission reported to his GP by Nike Odularu. Under the heading "History of Substance Misuse" the summary records cannabis and cocaine use with the cannabis use increasing and being used daily. The summary includes notes relating to the claimant's progress while on Bronte ward. In relation to the first ward round on 2 December 2019 it records the claimant feeling as though he cannot be bothered with anything, feeling demotivated, not wanting to eat and not looking after himself properly. It refers to a previous overdose attempt some months previously using paracetamol. (I think that must be a reference to the incident in 2018). It records his having been prescribed Sertraline which the claimant was taking regularly but felt was not effective. The notes for the second ward round on 12 December 2019 record that the claimant felt that over the last week things had improved. It records him saying that the ward had been helping him deal with ongoing issues. The claimant reported that his mood had been up and down in the last few days and that he was still struggling to sleep. He was having vivid dreams since stopping cannabis on admission. The notes record the claimant saying that he felt there had been no change in mood or energy levels since admission, that he was able to play and enjoy games on the games console, and that his concentration was "ok". It also records the claimant reporting that he snapped when stressed and that he was worried about what he could do with two others if he was angry. The claimant's view at that point was that if he was to be discharged he would return back to his previous mood. The notes record the claimant being prescribed Mirtazapine to help with his mood and sleep and that he was going to be discharged with Home Based Treatment Team ("HBTT") follow up.

31. Under the heading "Summary and formulation of diagnosis (where indicated)", the notes record that the claimant had presented following an overdose with apparent intention to end his life "on a background of low mood likely exacerbated by the recent breakdown of his relationship". The summary notes the background of drug use, his having no fixed abode as well as having a "difficult childhood which has likely contributed to his low mood".

32. As Mr Potts submitted, the discharge documentation does not in terms refer to "depression" or to "PTSD" (complex or otherwise).

33. After discharge on 31 December 2019 the claimant had a consultation with Dr Dhanjal. The GP notes (page 50) confirm that the Home Treatment Team was speaking to the claimant every other day. He was now living with his partner and her parents. He was taking Mirtazapine and had also started taking Promethazine on the previous day. At that point the dose of Mirtazapine had been increased to 30mg. The notes record that the claimant had been "seen by psychology yesterday" and had been referred for psychology therapy in the next 4-6 weeks. Dr Dhanjal issued a fit note. The fit note itself was not in the Bundle but the notes record the diagnosis as "mental health problems". The fit note was from 31 December 2019 to 5 February 2020.

34. There are further entries relating to contact between the GP surgery and the HBTT which confirmed that HBTT was currently prescribing the claimant's

medication. The claimant was then due to have a further appointment with the GP on 22 January 2020 but cancelled it. It was rescheduled for 27 January 2020 when he saw Dr Short (page 49). That appointment took place after the "relevant period" which I am considering. It records the problem as "depressive disorder" and confirms the issue of a further fit note for 27 January to 20 February 2020 with a diagnosis of depressive disorder. The notes are not very full, and it is not therefore clear to what extent that diagnosis is retrospective i.e. covers the relevant period as opposed to the position from 27 January 2020 onwards. Of relevance to my decision, however, is the claimant's confirmation during that consultation that he had "not touched cannabis for a while". When taken with the discharge summary, I find that the claimant had not used cannabis since his admission to Bronte ward on 2 December 2019.

35. The subsequent entries in the GP notes relate to the period after the "relevant period" and do not seem to me to relate back to that period. I cannot take them into account in deciding issues such as the likelihood of any adverse effect continuing after the relevant period.

**Relevant Law**

The Meaning of "disability" in the 2010 Act

36. Section 6 of the 2010 Act, so far as is relevant, provides:

> **"(1) A person (P) has a disability if –**
>
> **(a) P has a physical or mental impairment, and**
>
> **(b) The impairment has substantial long-term adverse effect on P's ability to carry out normal day-to-day activities.**
> **…"**

*Adverse Effect*

37. Section 212(2) of the 2010 Act provides that an effect is "substantial" if it is more than minor or trivial.

38. Paragraph 2 of Schedule 1 to the 2010 Act defines "long-term" in this context. It provides:

> **"(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,**
>
> **(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…"**

39. For paragraph 2(1)(a) of Schedule 1 to the 2010 Act to apply, the effect of an impairment must have lasted for at least 12 months at the time when the alleged discriminatory act (or acts) took place (**Tesco Stores v Tennant UKEAT/0167/19**).

40. The likelihood of recurrence within the meaning of paragraph 2(2) of Schedule 1 to the 2010 Act is to be assessed as at the time of the alleged discriminatory act (or acts) took place: see (**McDougall v Richmond Adult Community College [2008] ICR 431, Court of Appeal)**. The same applies to the assessment of whether the effect of the impairment is likely to last for 12 months under paragraph 2(1)(b) of Schedule 1 (**Singapore Airlines Ltd v Casado-Guijarro [2013] 9 WLUK 65, EAT**).

41. In cases to which paragraph 2(1)(b) of Schedule 1 of the 2010 Act applies the correct question for the Tribunal is whether viewed at the time and without the benefit of hindsight, the substantial adverse effects of the impairment were likely to last at least 12 months. That is a decision to be reached having regard to all the contemporaneous evidence, not just that before the employer. In reaching that decision the Tribunal is not concerned with the actual or constructive knowledge of the employer (**Lawson v Virgin Atlantic Airways Limited UKEAT/0192/19/VP**). However, it is an error law for an Employment Judge to take into account subsequent events in making that assessment.

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42. "Likely" in this context means something that "could well happen" and is not synonymous with an event that is probable: (**SCA Packaging Ltd v Boyle [2009] ICR 1056, Supreme Court)**.

43. An impairment is to be treated as having a substantial adverse effect on the ability of an employee to carry out normal day-to-day activities if measures are taken to treat or correct it and, but for such measures, it would be likely to have the prescribed effect: see para 5 of Schedule 1 to the 2010 Act. This is usually referred to as the "deduced effect".

44. The Secretary of State's Guidance on Matters to Be Taken into Account in Determining Questions Relating to the Definition of Disability (2011) ("the Guidance") http://odi.dwp.gov.uk/docs/wor/new/ea-guide.pdf gives guidance to help a Tribunal decide whether an impairment has a substantial effect on normal day to day activities. At paragraph D.2 and D.3 of the Guidance it explains what "normal day to day activities" means:

> **"**D.2**. The Act does not define what is to be regarded as a 'normal day-to-day activity'**. It is not possible to provide an exhaustive list of day-to-day activities, although guidance on this matter is given here and illustrative examples of when it would, and would not, be reasonable to regard an impairment as having a substantial adverse effect on the ability to carry out normal day-to-day activities are shown in the Appendix.
>
> D3. In general, day-to-day activities are things people do on a regular or daily basis, and examples include shopping, reading and writing, having a conversation or using the telephone, watching television, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and travelling by various forms of transport, and taking part in social activities. Normal day-to-day activities can include general work-related activities, and study and education-related activities, such as interacting with colleagues,

following instructions, using a computer, driving, carrying out interviews, preparing written documents, and keeping to a timetable or a shift pattern."

45. When assessing whether the effect of the impairment is substantial the Tribunal has to bear in mind the words of section 212(1) of the 2010 Act which confirm that it means more than minor or trivial. The 2010 Act does not create a spectrum running smoothly from those matters that are clearly of substantial effect to those matters that are clearly trivial. Unless a matter can be classed as within the heading "trivial" or "insubstantial" it must be treated as substantial (**Aderemi v London and South-Eastern Railway Ltd [2013] ICR 591**).

46. The Guidance recognises that "Environmental effects" (including stress: see para B11) may have an impact on how an impairment affects a person's ability to carry out normal day-to-day activities. It says that "Consideration should be given to the level and nature of any environmental effect. Account should be taken of whether it is within such a range and of such a type that most people would be able to carry out an activity without an adverse effect" (para D20).

47. Mr Henshall in his written submissions referred me to **Sobhi v Commissioner of Police of The Metropolis UKEAT/0518/12/BA** as authority for the proposition that "a person can be disabled where the impairment has only a single long-term substantial adverse effect on one day-to-day activity: The claimant in that case relied on loss of concentration."

*Impairment*

48. In this case there is a dispute as to whether the claimant had a mental impairment. Mr Potts' submissions focussed in particular on the absence of a diagnosis of depression or PTSD (complex or otherwise). "Impairment" is not defined in the Act. The Guidance (para A3) says the term should be given its ordinary meaning, that it is not necessary for the cause of the impairment to be established and that the impairment does not have to be as a result of an illness.

49. Since 2005 when para 1(1) of Schedule 1 of the Disability Discrimination Act 1995 was repealed, there is no longer a requirement for a mental impairment to be a "clinically well-recognised illness".

50. It will not always be essential for a tribunal to identify a specific 'impairment' if the existence of one can be established from the evidence of an adverse effect on the claimant's abilities (**J v DLA Piper UK LLP 2010 ICR 1052, EAT**).

51. An impairment (certainly a mental impairment) can be something that results from an illness as opposed to itself being the illness. It can thus be cause or effect and there is no need to identify the cause of the impairment. (**College of Ripon and York St John v Hobbs [2002] EWCA Civ 1074**).

52. The significance of the absence of an apparent cause (e.g. a clinically diagnosed medical illness) for an impairment is evidential, not legal: "Where an individual presents as if disabled, but there is no recognised cause of that disability, it is open to a Tribunal to conclude that he does not genuinely suffer from it. That is a judgment made on the whole of the evidence" (**Walker v Sita Information Networking Computing Ltd EAT 0092/12**).

*"Depression" as an impairment*

53. In **J v DLA Piper** (at para 42)**,** the EAT drew a distinction between two states of affairs both of which give rise to the same symptoms, namely "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".

54. The EAT recognised that the borderline between the two states can be blurred in practice but was clear that "it reflects a distinction which is routinely made by clinicians and which should in principle be recognised for the purposes of the [disability legislation]". It suggested that a Tribunal's finding about long-term adverse effect will assist in distinguishing between the two states: "if a Tribunal finds that the claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for twelve 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."

Relevant evidence and correct approach

55. The burden of proving disability is on the claimant.

56. The definition of disability requires a Tribunal to decide four questions (**Goodwin v Patent Office [1999] ICR 302**)**:**

- Does the claimant have an impairment which is either mental or physical?
- Does the impairment affect the claimant's ability to carry out normal day-to-day activities?
- Is that adverse effect substantial?
- Is the adverse effect long-term?

57. These four questions should be posed sequentially and not together – (**Wigginton v Cowie and ors t/a Baxter International (A Partnership) EAT 0322/09)**.

58. It is good practice for Tribunals to state their conclusions separately on each of the questions. However, in reaching those conclusions, Tribunals should not feel compelled to proceed by rigid consecutive stages. Specifically, in cases where the existence of an impairment is disputed it would make sense for a tribunal 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 then to consider the question of impairment in the light of those findings. (**J v DLA Piper UK LLP [2010] ICR 1052, EAT)**.

## Discussion and conclusions

59. In applying the law to my findings of fact I start with the second and third of the **Goodwin** questions. That approach was recommended in **DLA Piper** in cases, such as this one, where the existence of an impairment is disputed.

*Was there an adverse effect on the claimant's ability to carry out normal day-to-day activities and was that effect substantial?*

60. The claimant gave very limited evidence about adverse effect on his ability to carry out normal day to day activities in his disability impact statement. He did not in his oral evidence add to the 6 bullet points at para 3 of that statement. Although that evidence was unchallenged, I do not find it is in itself sufficient to establish the existence of the required substantial adverse effect. The first bullet point is "sleep disturbance" but there is no detail of the frequency or severity of this or how it manifests as a substantial adverse effect on normal day to day activities. The statement refers to (presumably difficulties) "leaving the house" and "avoiding social gatherings". Both are said to be "mood dependant". There is no indication of the severity of the effect or the frequency with which it occurs. The bald statement "Interacting with others both on a personal and professional level" again gives no indication of the specific nature of the difficulties encountered, their severity or frequency. The same is true of the final two bullet points, "Failing to look after general well-being and "relationship difficulties".

61. Turning to the GP notes, I find there is abundant evidence in the GP notes to corroborate the existence of low mood. However, the evidence as to adverse effect on day to day activities is more limited. The clearest statement as to effects is by Dr Abbs on 18 March 2019. In his referral letter to the Community Mental Health Team that the claimant's problems "are affecting his ability to fulfil his activities of daily living". He gives, however, no details of what activities are affected nor to what extent.

62. The rest of the evidence in the GP notes is more mixed. In terms of the claimant failing to look after his general wellbeing, the entries refer to the claimant as being "well kempt" or "dressed appropriately". He is referred to as not having much appetite but eating ok (11 September 2019) but on 19 November 2019 having poor diet. On that date there is also reference to no exercise. The notes do on more than one occasion confirm the claimant reporting poor sleep. When it comes to concentration, the GP notes do record the claimant saying that he "zoned out a lot" (18 March 2019) and that his concentration levels were "varying from day to day" (9 August 2019). The lack of detail makes it difficult to accurately assess how substantial any adverse effect is. I also note that throughout most of the period March 2019 to November 2019 the claimant was able to maintain a relationship and was also working (ether for himself or others). I do not find that the prescription of anti-depressant medication from August 2019 onwards assists me in relation to this aspect of the **Goodwin** test.

63. Turning to the evidence relating to the claimant's admission to Bronte Ward, there is clear evidence at the point of admission and the ward round on 2 December 2019 of an adverse effect in terms of the claimant not eating and failing to look after himself. By the ward round on 12 December 2019 the claimant was reporting no change in mood but that his concentration was "ok" and that his mood was "up and

down". In terms of his interactions with others, he was "snapping" and angry. His mood was not improved but he was able to enjoy playing games on the games console.

64. I find that there is insufficient evidence for me to be able to find that there was a substantial adverse effect on the claimant's normal day to day activities during the period March 2019 up to his overdose at the end of November. The burden is on the claimant to prove the existence of such an effect and his evidence fails to do so. There is evidence of an adverse effect but it is not detailed enough for me to be able to find that it was substantial. In reaching that conclusion I have taken into account the need to disregard the effects of the medication prescribed to the claimant from 9 August 2019 onwards. I accept that in the absence of that medication it is reasonable to assume that any adverse effect would be greater but that does not allow me to "fill in" the lack of detail as to severity and frequency in the claimant's evidence and enable a finding of "substantial adverse effect".

65. I do accept that there is evidence of a substantial adverse effect when the claimant attempted suicide and for his period on Bronte Ward, i.e. from 30 November 2019 to 19 December 2019. After that date, neither the claimant's Disability Impact Statement nor the GP Notes provide sufficient evidence for me to find there was substantial adverse effect on the claimant's day to day activities.

*Was the adverse effect long-term?*

66. I have found that the substantial adverse effect lasted for a period of 3 weeks in November to December 2019. That effect did not last for 12 months and so was not "long term" in that sense.

67. Mr Henshall submitted that the substantial adverse effect was "likely" to last for at least 12 months (Schedule 1 paragraph 2(1)(b)). I have to assess that based on the information available at that time. The information on that is limited. There is no medical report providing any sort of prognosis. The discharge note (page 84) summarises the position as being "a background of low mood likely exacerbated by the recent breakdown of his relationship". I remind myself that "likely" in this case means "could well happen". I find that the substantial adverse effect in this case was triggered by the breakdown of the claimant's relationship. The evidence shows that on discharge the claimant was back living with his partner. I find that absent the trigger of the relationship breakdown the substantial adverse effect was not "likely" to continue for 12 months. For the same reason, I find that I cannot say that the substantial adverse effect was "likely to recur".

*Whether the claimant had an impairment which is either mental or physical?*

68. In light of my findings above, I do not strictly need to decide this question. If I am wrong, and the evidence in the GP notes are sufficient to show that there was a substantial adverse effect on the claimant's day to day activities from 18 March 2019, I would have found that that adverse effect was likely to last for 12 months.

69. Had I done so, I would have concluded that the claimant did have a mental impairment and was a disabled person under s.6 of the Equality Act 2010. I accept that there is no formal diagnosis of either depression or PTSD condition in the medical evidence. Bearing in mind the case law, it is not necessary for there to be a

clinically recognised mental health condition identified as the basis for the claim. Had I been required to do so, I would have found (given that his low mood had by the relevant period persisted for 9-10 months) that the claimant did have a mental health impairment of a depressive nature. I would have found that the prescription of anti-depressants, the categorisation in the GP notes of the encounters with the claimant as "Mental health" reviews and "Depression Interim Reviews" corroborated that.

70. I do not find that there is evidence which would have justified my making a finding that the claimant had PTSD (complex or otherwise). There is not reference to PTSD in the GP notes or other medical evidence on which I can base such a finding.

71. For the sake of completeness, I deal with two submission made by Mr Potts in relation to the issue of impairment (and specifically whether any adverse effect was an effect of the impairment). The first was that the evidence showed that the claimant was a regular user of cannabis. The GP notes record advice that such regular use can lead to low mood. I accept Mr Henshall's submission that the cause of an impairment is not relevant for the purposes of the Equality Act 2010. However, I understand Mr Potts' point to be that it was the cannabis use rather than any impairment which gave rise to any adverse effect. The GP notes I have referred to do provide some support for that. If required, I would, however, have decided that two other aspects of the GP notes pointed in the opposite direction. First, it is evident from the first significant consultation on 18 March 2019 that the claimant took cannabis to self-medicate as a result of the effects he was experiencing. In other words, the effects preceded his cannabis use. Secondly, the evidence shows that the adverse effects persisted even when the claimant reduced his cannabis use (see, for example, the GP entry on 16 August 2019). I would, therefore, have rejected Mr Potts' submission that any adverse effect in this case was due to the claimant's cannabis use rather than the mental impairment.

72. Mr Potts' second submission was that any low mood and associated effect on day to day activities in this case were not due to any impairment but simply to the impact of life events on the claimant. He relied on the distinction made the in **DLA Piper** between these two kinds of "depression". He relied in particular on the letter from Nike Odularu (page 82) which referred to the claimant's deterioration in mood due to "psychosocial stressor". Had I been required to decide this point I would have accepted that events such as the relationship breakup and stressors at work exacerbated the claimant's existing low mood. However, if I had found that there was a substantial long term adverse effect since March 2019, I would have concluded that this case fell into the first "state of affairs" identified in DLA Piper, i.e. one where the low mood had persisted long term (including the in the absence of such stressors) and was due to a mental impairment rather than "reaction to life events".

## Conclusion

73. Nothing in this judgment should be seen as diminishing or dismissing the claimant's experiences. However, I must decide this case applying the legal test set out in the 2010 Act and based on the evidence before me. For the reasons given above, I find that the claimant was not at the relevant period a disabled person for the purposes of the 2010 Act. That is because the substantial adverse effects on his normal day to day activities did not and were not likely to last for 12 months or more nor to recur.

74. His claims against the respondent therefore fail and I have dismissed them in this judgment.

75. The final hearing listed for November 30 and 1-2 December 2021 will be cancelled.

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Employment Judge McDonald

Date 22 September 2021

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON

23 September 2021

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