EMPLOYMENT TRIBUNALS

Claimant: Mr P Woods

Respondent: Merseyside Fire and Rescue

HELD AT: Liverpool (by CVP) **ON:** 1 December 2021

BEFORE: Employment Judge Johnson

REPRESENTATION:

Claimant: Ms S Crawshay-Williams (counsel)
Respondent: Mr T Kenward (counsel)

JUDGMENT

The judgment of the Tribunal is that:

1. The claimant was disabled within the meaning of section 6(1) of the Equality Act 2010 at the material time, being from 1 June 2020 and continuing when the claim form was presented on 28 April 2021.

2. Accordingly, the complaint of disability discrimination can proceed, and the case will be listed for a preliminary hearing case management to confirm the relevant issues, list the claim for a final hearing and make appropriate case management orders.

3. The claimant's earlier complaints brought against the respondent under case numbers: 2403221/2020 and 2418484/2020 are unaffected by this decision.

REASONS

Introduction

1. This claim arises from the claimant's employment with the respondent authority as a fire fighter and his ongoing health problems which he alleges were caused by discrimination in his workplace.

2. This is not the first Tribunal claim which he has brought arising from his employment with the respondent. He had previously presented claims under case numbers 2403221/2020 (presented on 13 April 2020) and 2418484/2020 (presented on 30 November 2020). These claims raised complaints of discrimination on grounds of race, victimisation and unlawful deduction from wages.

3. The preliminary issue which was considered at this hearing related to a complaint of disability discrimination brought in the claim issued under case number 2405492/2021. The claim form was presented on 28 April 2021 following a period of early conciliation from 27 February 2020 until 13 March 2020. In addition to disability discrimination, the claimant brought complaints of race discrimination and victimisation.

4. This case was considered by Employment Judge Buzzard on 18 June 2021. He decided that there should be a preliminary hearing listed to take place on 1 December 2021 in order that the preliminary issue of whether the claimant was disabled within the meaning of section 6(1) Equality Act 2010 could be determined.

5. Employment Judge Buzzard also determined that this claim would ***not*** be combined with the two earlier claims referred to above and added that this was a matter which could be revisited at a later date depending upon the outcome of the preliminary hearing listed before me.

6. Appropriate case management orders were made by Employment Judge Buzzard on 18 June 2021 to ensure that the case was ready for the determination of the preliminary issue, which included the provision of an impact statement by the claimant and relevant medical evidence.

The Issue

7. The single issue for consideration at this hearing was as follows:

    a. Did the claimant have a disability as defined in section 6 of the Equality Act 2010 at the time of the events the claim is about *[to be determined by the Tribunal*]? The Tribunal will decide:

        i. Did he have a physical or mental impairment: the claimant asserts severe anxiety disorder/depression?

        ii. Did it have a substantial adverse effect on his ability to carry out day-to-day activities?

iii. If not, did the claimant have medical treatment, including medication, or take other measures to treat or correct the impairment?

iv. If so. would the impairment have had a substantial adverse effect on his ability to carry out day-to-day activities without the treatment or other measures?

v. Were the effects of the impairment long-term? The Tribunal will decide:

1. did they last at least 12 months, or were they likely to last at least 12 months?

2. if not, were they likely to recur?

8. Employment Judge Buzzard was clear in his Note of Preliminary Hearing that even if the claimant was found to be a disabled person at this preliminary hearing, it would still be open to the respondent to argue that there is an issue as to whether the respondent knew or ought to have known this at the time of the alleged discriminatory acts, ('material time'). As such, even if the claimant is found to be disabled at the material time, the respondent can still rely upon the defence of lack of actual or imputed knowledge at the final hearing.

Evidence Used

9. The claimant gave evidence in support of the preliminary issue. His impact statement was the witness statement which he used for his evidence in chief. This was augmented by evidence given in cross examination, judicial examination and re-examination. I recognised that he found the process somewhat stressful and reminded him that he could take breaks when necessary.

10. The respondent did not call any witness evidence to rebut the asserted disability.

11. There was a joint hearing bundle of 449 pages which included the proceedings, case management orders, impact statements and medical records.

12. Counsel for both parties helpfully produced submissions/skeleton arguments and this were of great assistance in directing me to the relevant documents in this preliminary hearing.

The factual background to the alleged disability

<u>The relevant period where mental health issues have been experienced</u>

13. The claimant ('Mr Woods') has been employed by the respondent fire authority ('the authority') as a fire fighter for many years and continues to be employed by them.

14. Mr Wood's mental health problems began in late 2017/early 2018. He took six months of sickness absence and further periods of sickness absence from 9 December 2019 to 2 December 2020 and from January 2021. During this time, Mr Woods believes that he has experienced discrimination in the workplace in connection with his race and he believes that this affected his mental health. As this preliminary hearing is restricted to the preliminary issue of disability, no findings are made as to any alleged discriminatory acts and reference is made to these matters by way of background information only.

<u>The parties' positions concerning the question of disability at the beginning of the hearing</u>

15. In his impact statement Mr Woods argues that his mental health impairment and/or the anti-depressants which he has been taken to ameliorate the condition have caused him to suffer from physical symptoms. He says he has been left fatigued, with headaches, upset stomachs, dizziness, dry mouth as well as causing him to be restless and nervous. He then suggests that the illness is "*not only a mental illness but a physical one"* in that "*I've suffered symptoms like stomach cramps, chest pains, bloatedness, despair, isolation, low moods, and my self-esteem was gone"*.

16. In terms of the impact that these health problems have had on Mr Woods' normal day to day activities they can summarised as follows:

    (a) "*There's been days where I've been unable to get out of bed, wash or eat*".
    (b) "*At times I could not see my children due to the state I was in …. I could not take my children to the park or play with them or be the dad I usually am*".
    (c) "*My wife had to manage work and look after our kids, this was very hard for her as we were in lockdown there was no help from friends or family*".
    (d) "*Most days I would not be able to get out of bed, I just wanted to be left alone I would be angry and irritable and have a feeling of no hope, this went on for months and my feelings would be up and down with suicidal thoughts*".
    (e) "*I was unable to do any fitness training which I love to do*".
    (f) "*I had no energy and was fatigued due to not sleeping at night as I would be awake with worrying thoughts in my mind. I would have night terrors if I fell asleep*"
    (g) "*At times I was also unable to drive as a result of the medication as it made me sleepy and dizzy*".

17. The authority e-mailed the Tribunal on 24 September 2021 and confirmed its position concerning Mr Woods' impact statement:

    "*The Respondent confirms that the issue of disability remains contested in this case in which the Tribunal has already listed a Preliminary Hearing for 1st December to determine the issue. The Claimant was directed to confirm the*

physical or mental impairment(s) upon which he relies and to provide a disability impact statement, as well as disclosing medical records. The Claimant subsequently e-mailed stating that the "physical and mental impairment that I rely on are detailed in the statement attached". The Respondent notes that the statement which has been served refers to a diagnosis of severe anxiety disorder and depression but also notes the absence of any specialist input or diagnosis and does not accept that the incomplete medical evidence which has been provided (the computerised GP records are missing page 17 which covers May 2018 to September 2019 and age 6 which covers March 2021 to April 2021) support the extent of the description provided by the Claimant in his disability impact statement or establish that any such condition had a substantial and long-term adverse effect on the Claimant's ability to carry out normal day-to-day activities".

The missing pages were subsequently located, but the Respondent has confirmed that its position otherwise remains as set out above.

<u>The medical evidence available at the preliminary hearing</u>

18. This was a case which was assisted by a significant number of medical reports and fit notes being available as well as the usual GP notes. The GP go back as far as 2017. The disclosed printouts in addition to consultations and requests for fit notes, include a number of online consultation request forms dealing with requests for extended sick notes.

19. Mr Woods' fit notes refer to him suffering from: anxiety disorder, anxiety/panic attacks/work related stress, mixed anxiety and depressive disorder, work related stress, and work stress. While there is a variety of descriptions used for the conditions giving rise to an absence from work, they are all related in that they are connected with mental wellbeing, are connected with work and have a stress/anxiety component. In terms of these absences from work which were authorised by the fit notes, Mr Woods' GP identified mental health problems which appeared to be ongoing, (albeit with periods of Mr Woods being fit for work), from 2 January 2018 until the most recent fit note provided in the bundle, which expired on 5 April 2021.

20. The medical evidence included Occupational Health ('OH') reports which were produced following Mr Woods' sickness absence from December 2017 to May 2018. They were of great assistance in providing a chronology of sickness, attendance at work and the development of Mr Woods' conditions and their symptoms. The summarised chronology is as follows:

    <u>*First absence (27 December 2017 to 20 May 2018)*</u>

    a. 27 December 2017 – OH records first day of sickness with a notification of absence due to work related stress.

    b. 2 January 2018 – Mr Woods' GP records refer to him being signed off work with diagnosis of work- related stress with history being that "*has unresolved discrimination case ongoing and feels work is messing him around unable to go in until resolved not sleeping with anxiety hasn't slept 10 days"*. Zolpidem sleeping pills were prescribed.

c. 9 January 2018 – Dr Gidlow of OH reported that Mr Woods had been absent from work since 27 December 2017 and described him as being "*…very stressed at present and having panic attacks and difficulties sleeping … I've arranged counselling"*.

d. 16 January 2018 – Mr Woods' GP signed him off work and fit notes continued to be issued for further periods until 19 May 2018. I felt it was reasonable to assume that the certificates were extended without an attendance as no further treatment is recorded in GP records during this period of stress related absence. However, he continued to be supervised by the authority's OH medical experts on a regular basis.

e. 6 February 2018 – OH recorded Mr Woods as having panic attacks including a severe panic attack where he experiences chest pain and sweating.

f. 26 February 2018 - OH Dr Gidlow recorded that "*Patrick [Woods] has had increased panic attacks"* and "*has also lost his appetite*".

g. 26 March 2018 – OH Dr Gidlow states that Mr Woods "…*continues to suffer panic attacks …* and his "*sleep is very poor*".

h. 17 April 2018 – OH Dr Gidlow recorded that "*Patrick [Woods] tells me that the issues appear to have been resolved….* [which]…*has reduced his anxiety and panic attacks but he still has difficulty sleeping"*. I accepted that this referred to Mr Woods' belief that his workplace issues had in principle been resolved and this has eased his symptoms. However, I also noted that he continued to have stomach problems although it was not clear whether these symptoms were attributed to his mental health issues or the sleeping tablets that had been prescribed. A gastroscopy was recorded as being awaited by Mr Woods in this report.

i. 1 May 2018 – despite the improvement recorded by OH Dr Gidlow the previous month, he referred to Mr Woods continuing to have panic attacks, albeit that he would be fit for work from 20 May 2018, subject to tests and relevant re-training as appropriate.

21. Mr Woods' GP records suggested that no further mental health issues arose from May 2018 until December 2019. Insofar as his mental health was concerned, he therefore appeared to be asymptomatic or at least did not experience symptoms of a sufficient intensity to cause him to be signed off sick from work or to seek the assistance of his GP.

Second absence (11 December 2019 to December 2020)

22. During his next absence from work, Mr Woods continued to be supported by his GP and OH and with the arrival of the Covid pandemic to the UK in March 2020, it is understandable that some of these referrals would take place remotely given the limitation imposed on patients visiting their GP surgery. The chronology of events during his absence was as follows during December 2019 to December 2020:

a. 11 December 2019 - Mr Woods' GP signed him off work and recorded that he "…*has had panic attacks a few times recently not sleeping not eating very stressed all over issues at work*". The Claimant was prescribed sleeping pills when it was stated "*does not wish SSRI*". I understood that Mr Woods was unwilling to take selective serotonin reuptake inhibitors ('SSRIs'), which are antidepressant medication

b. 30 December 2019 – Mr Woods' GP issued a further sick note which his medical records suggest arose from an e-mail request that he made.

c. 8 January 2020 – OH Dr Babu, recorded that "*I reviewed Mr Woods today, he describes struggling with psychological symptoms of stress over the past month which he attributes to being informed that he would be returning to the role of a Fire Fighter rather than continuing in his role as Watch Manager.… he described experiencing ongoing anxiety with panic attacks, sleep disturbance and variable mood*". "*Mr Woods described having good support from his family but his usual daily activities are affected".* This would suggest that the deterioration in Mr Woods' mental health was connected with issues relating to his role in the workplace.

d. *20 January 2020* – GP issued a further sick note until 3 March 2020 and which the records suggest was issued in response to an e-mail request. This was followed by a consultation on 27 January 2020 with 'Tension type headache (first)' being recorded and a history of headaches for the past two weeks and Mr Woods being *'under a lot of stress'*.

e. 3 February 2020 – OH Dr Sharif, Service Medical Officer reported that, "*Mr Woods continues to experience significant psychological symptoms, specifically anxiety, attributed to perceived work associated concerns as you will be aware of …. he is also having trouble sleeping and has medication for this as and when*".

f. 3 March 2020 – GP issued a further fit note following a request by e-mail with reason given as anxiety disorder.

g. 19 March 2020 - OH Dr Babu recorded, "*I had a telephone consultation with Mr Woods today, he continues to experience psychological symptoms including significant anxiety and sleep disturbance*". The accompanying clinical notes refer to Mr Woods having panic attacks twice a week and using sleeping tablets.

h. 25 March 2020 – GP issued a further fit note to 20 April 2020 recording an anxiety disorder in response to a request by e-mail. This was further extended to 20 May 2020 when a further fit note was issued on 27 April 2020.

i. 28 April 2020 – GP has a telephone conversation with Mr Woods with the problem recorded as being *'Anxiety disorder (Review)' [174]. History given of 'one or two anxiety attacks per day, struggling to sleep and using the prescribed Zopliclone* (a sleeping pill used to treat insomnia), *to help him'*.

j. 30 April 2020 – OH Dr Babu noted that Mr Woods "*described experiencing anxiety with panic attacks, sleep disturbance, fatigue, poor motivation and appetite*". The accompanying clinical notes refer to C continuing to use sleeping tablets.

k. 20 May 2020 – Mr Woods made an online consultation request for extension of his sickness certificate and explained, "*I've been away from the workplace for almost 6 months work with work related stress and anxiety I am taking my employer to the Tribunal my employer has now put me on half pay which within the current situation makes my anxiety a lot worse. Would it be possible for me to do a phased return or just a few hours in the workplace to try to get back to some sort of normality and keep my full pay. I would be willing to do this and think it would help my rehabilitation getting back to work*".

l. 28 May 2020 – the OH report referred to "*Mr Woods described low mood with negative thoughts, irritability and significant sleep disturbance*". I found that this report and the previous online consultation request suggested that the ongoing issues connected with work had affected Mr Woods' mental health symptoms and a downturn had taken place.

m. 1 June 2020 – a further telephone consultation with his GP *'Anxiety disorder (Review)'* recorded Mr Woods' history as "*chronic symptoms related to work problems … shaky/not sleeping poor appetite…some DSH* (understood to mean deliberate self-harm) *thoughts in past but have resolved … having counselling through work"*.

n. 15 June 2020 - a further telephone consultation with Mr Woods' GP *'Anxiety disorder (Review)'* recorded a further fit note being issued with a diagnosis of anxiety/panic attacks/work related stress. It was noted "*no impact from Escital yet – no side effects"*. It was understood that Escital is the antidepressant Escitalopram.

o. 15 June 2020 - OH report of Dr Babu - "*Mr Woods is under the care of his GP and commenced antidepressant medication 2 weeks ago, he has yet to see any significant benefit*".

p. 17 July 2020 – GP provided Mr Woods with a letter which said that,

   "*I can confirm that Mr Woods has been receiving active treatment and input for significant mental health problems from November 2019. I understand this is linked to work related stress. I can confirm he has been issued with sick notes (med 3) by the GP Surgery and his current one expires 15/8/20 I can confirm he is receiving medication for this condition"*.

   I found this to be a significant entry as it suggested that Mr Woods' GP had not linked the mental health issue arising from the first period of absence of work in 2018 to those arising in the second the absence and which began in November 2019.

q. 27 July 2020 – OH report of Dr Babu states, "*Mr Woods described struggling with on-going anxiety, variable mood and sleep disturbance*".

r. 11 August 2020 - Mr Woods completes an online consultation request form with his GP to indicate that he had had symptoms of low mood or anxiety for more than six months. In response to a question as to whether the problem interfered with his ability to do "any of the following", he selected the problem as interfering with, "*Attend to your daily tasks, like work*", "*Eat normally*", "*Sleep normally*", *"Undertake your usual physical activities, like exercise*", "*Carry on with hobbies*" and "*Socialise as normal*".

s. 13 August 2020 – GP records in notes that Mr Woods struggling to sleep and was getting approximately 3 hours of sleep a night. He was recorded as feeling very snappy, irritable and restless on a daily basis. Reference as made to Mr Woods' anxiety disorder and him increasing his escitalopram medication.

t. 19 August 2020 – GP issues a further fit note effective until 20 September 2020 due to anxiety/panic attacks/work related stress.

u. 24 August 2020 - Dr Hayley Hui, Consultant Occupational Health Physician, following a request by the authority for an independent medical practitioner review in the case of a divergence of medical opinion regarding his sickness absence, produced a report which included the following opinion:

"*He subjectively describes still experiencing panic feelings, anxiety and disturbed sleep. He otherwise feels physically well in himself… having assessed WM…* (understood to refer to his role at that time of Watch Manager) …*Woods over the telephone today, my impression is that his absence is related to his perceptions of how he has been treated by the Fire Service which appears to be stemming from the initial grievance in 2017 and further issues which precipitated a further grievance in 2019 and subsequent Employment Tribunal next month. Whilst I do not dispute that his anxiety and panic attacks have developed in reaction to the perceptions of his work concerns and issues, I believe that his current illness has arisen from unresolved issues with management, with allegations towards management that are not as yet proven, rather than an illness or injury which has directly arisen out of authorised duty. In the long term, once the issues are resolved, I would see no medical reason why he should not be able to make a full recovery from the mental health issues and remain physically fit to carry out his full range of duties as Watch Manager in future*".

v. 21 September 2020 – GP issues a further fit note effective until 20 October 2020 due to anxiety/panic attacks/work related stress.

w. 06 October 2020 – Mr Woods completed an online consultation request with his GP practice which suggested his symptoms had been ongoing for three to six months. He stated that he did not have low mood or depressive like symptoms and also answered in the negative to a question as to whether he had a history of any other mental health condition not previously mentioned and that he did not have any other medical conditions. This did suggest that at this point, Mr Woods believed that his poor health was primarily related to anxiety and stress.

x. 21 October 2020 - GP issued a further fit note effective until 20 November 2020.

y. 22 October 2020 - OH report of Dr Babu recorded "*…he described an improvement in mental health over the past few weeks…. remains on appropriate medication as prescribed which he feels has been helpful. Mr Woods tells me that he is hoping to return to work in the coming weeks. Mr Woods has been struggling with his mental health which he attributes to work related stressors regarding grievances. It is the way these matters are making him feel that are barriers to a return to work".*

z. 26 November 2020 – OH report of Dr Babu reported continuing progress, "*…he continued to see an improvement in his mental health…does continue to experience some anxiety but described feeling better able to manage this and prevent anxiety attacks…Mr Woods is keen to return to work and I consider him fit for other duties…I also recommend he has a phased return to work.'*

aa. 27 November 2020 – GP issues a further fit note effective until 27 December 2020. However, it is understood that Mr Woods actually returned to work in early December 2020.

23. Following Mr Woods' return to work on 2 December 2020, continued to be reviewed by OH as follows:

    a. 7 January 2021 – OH report of Dr Babu recorded, "*Mr Woods described his mental health as mostly stable over the past few weeks … Mr Woods described some improvement in his sleep but experiences on-going anxiety with panic attacks intermittently*".

    b. 25 January 2021 – OH report of Dr Sharif, recorded, "*He is experiencing anxiety and panic attacks, attributed to a combination of perceived work related concerns. In addition to concerns that have been ongoing, Paddy is anxious about his increased risk of Covid whilst working at the station he is at … from a medical point of view I do consider him fit to work on the site if required to do so".*

<u>*Third absence from February to April 2021*</u>

24. Mr Woods then experienced a further period of sickness absence from February 2021 to April 2021 and the following medical reports were produced:

    a. 9 February 2021 – Letter from Aintree Hospitals to Mr Woods' GP describing an attendance involving a 'Vasovagal collapse', which is understood to be a fainting that occurs in response to a sudden drop in heart rate or blood pressure.

    b. 10 February 2021 - OH report by Jamie Sheridan, OH Nurse Adviser. "*Paddy mentions that following his on site accident he continues to experience nausea, tiredness and palpitations, which has been*

advised, is due to various stressors he is currently experiencing" (no evidence of this).

c. 12 February 2021 – Mr Woods completed an online consultation request seeking a GP referral describing that he had been "*suffering from anxiety and stress but lately … been having palpitations*". Describes symptoms of being tired all the time which had lasted for one to four weeks, panic or anxiety or of feeling anxiety or panicky, which had lasted three to six months. He also reported having no appetite, not being able to sleep at night, having no motivation and not wanting to socialise. In response to a question as to whether the problem interfered with his ability to do "*any of the following*", Mr Woods indicated that it affected the following activities, "*Attend to your daily tasks, like work*", "*Eat normally*", "*Sleep normally*", *"Undertake your usual physical activities, like exercise*", "*Carry on with hobbies*" and "*Socialise as normal*".

d. 15 February 2021 - OH report of Dr Sharif noted that Mr woods "*fainted on station … when he gets anxiety he gets chest pain and palpitations gets them quite frequently over last few months at work … over the last week no further panic attacks, but anxious and not sleeping very well, tired, irritable, 2 – 3 hours sleep, affecting concentration ability to focus the next day, looking after kids while he is off tells me he will never get in the car if he is feeling anxious*". He went on to say that, "*Paddy* [Mr Woods] *describes a recent fainting episode at work. He was reviewed by a cardiologist in A+E who feels that this was likely secondary to anxiety and a panic attack. He was advised to see his GP for referral to Broadgreen which may help to further reassure him. Paddy remains anxious, however he has not experienced any further panic attacks during his absence. He feels tired and his sleep is disturbed. This is impacting upon his concentration. His perceived work concerns remain on-going. In my opinion I consider him currently unfit for work. However, I would anticipate a return to work in an adjusted duties role in 1 – 2 weeks, provided his sleep routine improves*".

e. 16 February 2021 – GP record Mr Woods as experiencing mixed anxiety and depressive disorder. He was switched from Escitalopram to Mitrazapine, (antidepressant medication). The history recorded "*underlying issue seems to be on-going grievance with work".* "*Tells me the Judge at Tribunal needs information stating he has unresolved/on-going mental health problems related to work – apparently his occupational health service can't do this as they represent his employer (?)".* His GP also recorded, "*We clarified no red flag physical symptoms and went over all the recent (negative) tests … he agrees he gets severe panic attacks with physical symptoms*". Reference was also made to fleeting thoughts of self-harm.

f. 15 March 2021 - OH notes of Dr Sharif record "*change in meds from GP advised to reduce Escitalopram started on Mirtazapine since 10 days during medication change 10 days ago – felt suicidal, could not*

get out of bed since he has been feeling better, taking kids to school, going on walks currently no thoughts of self harm or suicide, main anxiety -work concerns, pay, feeling unsupported, meds make him very tired and poor concentration, slurred speech in the mornings, shakes, helping him sleep at night but waking up still occasional panic attacks and anxiety".

g. 15 March 2021 – the corresponding OH report of Dr Sharif described "*Paddy has commenced a new medication approximately 10 days ago, to help with his sleep and anxiety problems. After an initial setback in his mental health during this medication change, things are slowly improving, however he is experiencing some side effects, particularly tiredness and some speech disturbance in the morning*".

h. 29 March 2021 - OH report of Dr Sharif. "*Paddy remains absent. During his absence, he is experiencing improvement in some of his symptoms and is sleeping better. His anxiety has also improved and there have been no more panic attacks/faints. He is taking medication for his anxiety, which does make him more tired/drowsy in the mornings with occasional word finding difficulties. This symptom is being monitored by his GP. It is hoped that this will improve as he gets used to his medication, however his GP will consider changing the time that he takes his medication if his symptoms persist*".

i. 12 April 2021 - OH report of Dr Sharif. "*Paddy has returned to work and is currently undergoing a phased return. He notes an improvement in his mental health, and the medication he is currently taking seems to be helping. He denies any significant anxiety, he is sleeping well and feels able to concentrate. He is exercising regularly and this is having a positive impact upon him*".

j. 26 April 2021 - OH report of Dr Sharif. "*Paddy has been managing well since he returned to work on other duties. Although some anxiety remains, largely in relation to his work concerns, he is managing his symptoms well and there is no functional deficit in his activities of daily living. He is sleeping well and able to concentrate. He can adjust the timing of his medication so that any side effects do not impact upon work*".

k. 10 May 2021 - OH report of Dr Sharif noted that Mr Woods was keen to return to work. Denies any concentration difficulties. He was recorded as saying, *'He cannot envisage himself having any significant anxiety or panic attacks when he returns, and tells me his anxiety is more related to the work concerns he has regarding allegations, and working alone'.*

l. 21 June 21 - OH report of Dr Sharif noted that, "*Paddy has since returned to full operational duties and is managing well on the whole. He does report some perceived work concerns in relation to feeling pressured by management and he tells me has received multiple workplace inspections in a small space of time without adequate notice*

for many. This increases his anxiety and he has to return to his GP. In my opinion he remains fit for full operational duties. It would be advisable for Paddy to undergo a stress risk assessment".

m. 1 July 2021 - OH report of Dr Sharif, noted "*I understand concerns were raised regarding Paddy's medication and his safety to drive during a risk assessment. Having assessed Paddy today, he is stable on his medication which he commenced in early March 2021 with no changes to his dose and he reported no side effects from his medication. I consider him medically fit to drive*".

Medicine and counselling

25. It can be seen from the records that Mr Woods was prescribed medicine by his GP to assist in relieving the symptoms which he was complaining about and which were described above. In summary, Mr Woods began taking Zopiclone from 11 December 2019 to assist with his sleeping difficulties. He was later prescribed the antidepressant Escitalopram, which is referred to in the medical records on 1 June 2020, although it is not clear when this treatment began. However, Mr Woods moved from Escitalopram to the antidepressant Mirtazapine on 16 February 2021. It is understood that Mr Woods remains on Mirtazapine and I accept that Mr Woods has continued to use medication to relieve the symptoms connected with his anxiety since late 2019.

26. Mr Woods was also offered counselling which involved 7 sessions between 6 February 2018 and 24 August 2020.

Mr Woods' oral evidence

27. Mr Woods was subject to extensive cross examination during the hearing from Mr Kenward. At times he became irritable and uncooperative. While I recognised that we were dealing with an issue which had caused him a great deal of emotional anguish, the way in which he responded to questions that were quite reasonably put to him, did not assist his case.

28. There was a degree of inconsistency concerning his evidence regarding 'e consult' appointments which at times he attributed to restrictions arising from Covid, even though many of his appointments took place before the pandemic arrived at the UK in late March 2020. I took judicial notice of the practice which many GPs have operated for a number of years whereby renewal of sick notes could be requested by phone or electronically using email or an online portal.

29. Although there was reference made in the medical records to suicidal ideation on 1 June 2020, Mr Woods described these thoughts as being *'sporadical'* and *'I told my GP that I couldn't get them out of my head'.* While I accepted that these thoughts did occur from time to time, I did not hear sufficient evidence to support a sustained period where suicide that was something being contemplated. That said, I acknowledge that for periods of time, he was having *'dark thoughts'* which caused him considerable anguish.

30. However, I accepted his evidence that he was someone who did not like taking tablets and delayed taking antidepressants because he was concerned that he could become dependent upon them. I also accepted his evidence that the symptoms of the conditions which he experienced could be described as *'a rollercoaster'*, (to use his words). This meant that there were good days and bad days while he was absent from work.

31. Mr Woods challenged the evidence of Dr Hui who was instructed by the authority to produce a report on 24 August 2020 and which was discussed above. He said that he objected to the report as it was not independent because it was the authority who instructed them. However, when Mr Kenward put it to him that her findings that *'his current illness has arisen from unresolved issues with management, with allegations towards management that are not as yet proven, rather than an illness or injury which has directly arisen out of authorised duty',* he confirmed that he did not dispute that.

32. There was some discussion concerning the way in which Mr Woods accessed counselling or other talking therapies. It was probably fair when he said that the waiting list for NHS support was likely to be lengthy and not surprisingly, he explored other options including the mental health charity MIND who provided him with a 'self help pack'. He confirmed in my questioning of him, that while he did access counselling sessions from work, he did not find them helpful because of the way everything he said was 'jotted down' by the counsellor. Instead, he said that he had found the most help from an app which he downloaded onto his mobile phone called CALM in 2018. He explained it required a subscription of £70 per year and enabled him to access meditation exercises, counselling and tutorials. He gave convincing evidence that this app had relaxed him and reduced his anxiety.

33. The symptoms which he referred to as being the most persistent from 2019 onwards was sleep deprivation, tiredness, stomach cramps, diahorrea, anxiety and panic attacks. These appear to have continued until Spring 2021 when his health was recorded as improving significantly, although as Dr Sharif reported on 10 May 2021, his ongoing use of antidepressants has stabilised his symptoms.

The Law

34. A person is disabled within the meaning of section 6(1) of the Equality Act 2010 ('EQA') if he or she has "a physical or mental impairment" which has a "substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities".

35. Substantial is defined as meaning "more than minor or trivial" in section 212(1), EQA. Paragraph 5, schedule 1 EQA provides that an impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if measures are being taken to treat or correct it and, but for that, it would be likely to have that effect Likely means "could well happen", not that it is more probable than not. In relation to this matter, Ms Crawshay-Williams and Mr Kenward both referred me to the case of ***SCA Packaging Ltd v Boyle*** **[2009] ICR 1056** as being

relevant concerning this matter. Mr Kenward emphasised in cases of current impairments at the date of the alleged discriminatory act in question which have not lasted 12 months, the Tribunal will have to decide if the substantial adverse effects of the condition are likely to last for at least 12 months. He added that paragraph C3 of the Guidance on Matters to be taken in account in Determining Questions relating to the definition of Disability 2011 ('the Guidance') and ***SCA Packaging*** advised that the word "*likely*" means "*could well happen*".

36. Paragraph 2(1) of Schedule 1 of the EQA provides that the effect of an impairment is long-term if it has lasted or is likely to last for at least 12 months or is likely to last for the rest of the life of the person affected.

37. Ms Crawshay-Williams also referred to the case of ***Cruickshank v VAW Motorcast Ltd*** **[2002] ICR 729, EAT** which held that the time at which to assess the disability (whether there is an impairment which has a substantial adverse effect on normal day-to-day activities) is the date of the alleged discriminatory act. She also reminded me of the case of ***All Answers Ltd v W*** **[2021] EWCA Civ 606, CA** where it was determined that the date of the discriminatory act is also the material time when determining whether the impairment has or is likely to have a long-term effect.

38. Mr Kenward reminded me that it is important to note that the issue of how long an impairment is likely to last (or would have been likely to last) should be determined at the date of the discriminatory act and not the date of the Tribunal hearing as considered in ***Richmond Adult Community College v McDougall*** **[2008] ICR 431**, CA. He also referred to paragraph C4 of the Guidance which stresses that anything that occurs after the date of the discriminatory act will not be relevant.

39. Ms Crawshay-Williams referred me to two further cases. Firstly, ***Patel v Metropolitan Borough Council*** **[2010] IRLR 280**, where Slade J held, "It will no doubt be necessary in most if not all cases falling within … (b) that a diagnosis will have to be given in order to obtain a prognosis of the likely duration of the effects of an impairment." Secondly, ***Nissa v Waverly Education Foundation Ltd*** **UKEAT/0135/18**, where the EAT held that a diagnosis will not necessarily be determinative.

40. Mr Kenward made specific submissions on the law relating to the question of disability involving mental health components. He referred to the case of ***Morgan v Staffordshire University*** **[2002] ICR 475** which explained that in a case where there is a mental health component the absence of clear expert medical evidence is significant.

41. He went further by referring to decision of Underhill P in ***J v DLA Piper UK LLP*** **[2010]** at paragraph 33 and there is a distinction to be drawn between depression as a medical/clinical matter and the reaction to "adverse life events' such as problems at work. It is worth repeating the relevant extracts which Mr Kenward provided in his written submissions for this hearing at paragraph 33 -

"*In reaching that decision it made a distinction between, on the one hand "clinical depression'; which would be an impairment and, on the other hand, "as Dr Brener puts it, Sunday night syndrome, or as Dr Gill puts it ' possible medicalisation of employment problems" which would not. That "non-impairment" alternative is not very well expressed; but in our view it is adequately clear that what the Tribunal meant was a situation where the Claimant was suffering symptoms of low mood - in its phrase, "despondency demotivation and anxiety" - not because of "clinical depression" but simply as a reaction to problems at work. We return to this distinction below”*:

And at paragraphs 42 to 43 -

"The first point concerns the legitimacy in principle of the kind of distinction made by the Tribunal, as summarised at paragraph 33(3) above between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to 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".

42. Finally, Mr Kenward referred to the case of **Herry v Dudley Metropolitan Council [2017] ICR 610, EAT**, where the EAT upheld a Tribunal's decision that an employee was not disabled, even though he had to take a long-time off work because of stress, where his condition had been a reaction to difficulties at work rather than a mental impairment. While the EAT accepted that work-related issues can result in real mental impairment, especially for those who are susceptible to anxiety and depression, it contrasted these circumstances with those where unhappiness with a decision or a colleague, a tendency to nurse grievances or a refusal to compromise are not, of themselves, mental impairments: they may simply reflect a person's character or personality.

Claimant's Submissions

43. Ms Crawshay-Williams submitted that Mr Woods has suffered from anxiety and depression since 2018, following his absence from work on 27 December 2017. As a result of his impairment, he had suffered from a number of adverse effects on his day-to-day activities which included sleeping, eating, concentrating, driving, washing, eating, getting out of bed, taking his children to the park playing with his children, and fitness training. She asserted that the effect on these activities was substantial. In terms of medical evidence, she reminded me that the medical notes record Mr Woods as first

experiencing the effects on these activities from 2018. An example which she referred to was that Mr Woods' sleeping difficulties were first recorded on 2 January 2018 and his eating difficulties/loss of appetite were first recorded on 27 February 2018.

44. Accordingly, she submitted that the effects of Mr Wood's anxiety and depression on his day-to-day activities were significant, had begun in January 2018 and likely to last at least 12 months long. She said that even if the disability was not clear in January 2018, from 2 January 2019, 12 months had elapsed after he first began experiencing sleeping and eating difficulties arising from his mental health impairment.

Respondent's Submissions

45. Mr Kenward referred me to paragraph 40 of Mr Woods' details of claim, which states that he relies upon the mental impairment of stress and anxiety and argues that the authority "*has recognised his mental impairment as being in existence for at least 12 months and thus is known to be a long-term impairment*".

46. However, he correctly asserts that the requirement under section 6 EQA is not simply that the condition is long term but that the Claimant has a physical or mental impairment which "*has a substantial and long-term adverse effect"* on his "*ability to carry out normal day to day activities"*.

47. He firstly argued that Mr Woods failed to comply with the requirement of the case management orders made by Employment Judge Buzzard in that he failed to confirm the physical or mental impairment(s) upon which he relies. Mr Kenward said that instead, he e-mailed the respondent on 27 August 2021 enclosing his impact statement, but that this statement does not specifically identify the impairments relied upon. He submits that Mr Woods simply makes numerous references to his "*mental health problems*" (and "*physical problems*"), without identifying a specific impairment, save that there is a reference in the final paragraph to being diagnosed with "*severe anxiety disorder and depression*". The context is such that it is not clear that the various symptoms described in the body of the Statement are being stated to be symptoms of any condition of "*severe anxiety disorder and depression*".

48. Mr Kenward asserted that Mr Woods' GP notes were insufficient to establish that he or she was suffering from a disabling depression, particularly as words such as 'anxiety', 'stress' and 'depression' featuring in GP notes do not amount to proof of a mental impairment without further explanation. It is a matter entirely for the Claimant to decide how he proves he is a disabled person. He added that simply bring signed off work due to 'stress', 'work stress', or 'work-related stress', does not necessarily mean that a claimant is disabled for the purposes of the EQA. It is necessary to demonstrate a physical or mental impairment.

49. He said that while Mr Woods' impact statement refers to a diagnosis of a severe anxiety disorder and depression which is long term in nature, the medical records do not provide any such diagnosis in the medical records, whether from his GP or medical specialist. He noted that the GP records do

refer to an attendance with a problem described as mixed anxiety and depressive disorder on 16 February 2021, with the relevant fit note recording "*mixed anxiety and depressive disorder – severe*". Mr Kenward argued that this description should be contrasted with the diagnosis given on earlier fit notes of anxiety disorder.

50. He then argued that the description provided by Mr Woods in his impact statement is not fully consistent with the medical evidence. He refers to an example being the description which he gave regarding side effects caused by the medication and the absence of medical evidence linking symptoms such as an upset stomach with the medication which he was taking at the time.

51. Another example that he gave was where Mr Woods describes there days when he has been unable to get out of bed, wash or eat, whereas in contrast the medical records certainly do not suggest that this was a regular occurrence or that there was any problem with self-care. He said that relevant references were restricted to "*poor appetite"*. Similarly, he refers to Mr Woods' statement where he says that most days "*I would not be able to get out of bed*" and that there is no suggestion in the medical records that this was a regular state of affairs or an ongoing situation.

52. In relation to the question of whether the identified impairment had an adverse effect on normal day-to-day activities was substantial, Mr Kenward referred to the Guidance and in particular Section D which deals with the issue of normal day-to-day activities and whether a person's ability to carry out such activities is substantially and adversely affected by the impairment in question. He noted that D3 of the Guidance gives examples of normal day-to-day activities, namely things people do on a regular and daily basis, such as 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.

53. In terms of what activities can be considered 'normal day-to-day activities', Mr Kenward noted that Appendix 1 to the EHRC Employment Code ('the Code'), states that they are activities are carried out by most men or women on a fairly regular and frequent basis, and which gives examples such as walking, driving, typing and forming social relationships.

54. Having referred to both the Guidance and the Code, he noted that sleeping is not listed and submitted that this was because it is not an activity, being 'the reverse of an activity'. He supported this argument by submitting that the concept of normal day-to-day activities originally derives from the Disability Discrimination Act 1995 ('DDA'), where normal day-to-day activities were identified as mobility; manual dexterity; physical coordination; continence; ability to lift, carry or otherwise move everyday objects; speech, hearing or eyesight; memory or ability to concentrate, learn or understand; or perception of the risk of physical danger (Schedule 1 paragraph 4(1) DDA). He acknowledged that this statutory requirement has not been replicated in the

EQA, but submitted that this does not have the effect of converting sleeping into an activity for these purposes.

55. In summary, Mr Kenward submitted that the medical evidence does not justify the case as to the effect of any condition described in Mr Woods' statement. He remarked that there was no specific medical input relating to the mental health issues complained of and no proper diagnosis of a medical condition. He asserted that as the onus is on the claimant to prove he is a disabled person within the meaning of section 6(1) EQA, the Tribunal should find that he has not proven that he is disabled.

Discussion

56. In considering the question of disability under section 6(1) EQA, it is appropriate to adopt a staged approach before determining whether or not a claimant was disabled.

Physical or mental impairment

57. Mr Woods relies upon impairments of anxiety and depression and while they may well produce symptoms which have a physical dimension such as fatigue and sickness, they are manifestations of an underlying mental health problem either in terms of the condition itself, or the medication prescribed to ameliorate its effects upon the body.

Substantial adverse effect

58. For the effect to be substantial, it must be something that is more than trivial or minor as described in section 212 EQA.

59. Mr Woods referred to a number of conditions within his impact statement that suggested he had days where he could not get out of bed, was unable wash or eat properly, was unable to look after his children, was generally fatigued, had night terrors and could not drive because of the medication he was taking.

60. The medical records provided certain effects which appeared with regularity, and which coincided with his absences where he was unfit to work.

61. The first absence during the first half of 2018 made numerous references to panic attacks with chest pain and sweating being experienced, poor sleep and poor appetite.

62. The absence during 2020 again referred to panic attacks, poor sleep, poor eating, headaches and at the point when he was prescribed antidepressants in mid-2020, intrusive dark thoughts being experienced. Poor motivation was also recorded, and his condition was described at one point as being 'significant psychological symptoms'.

63. The absence which took place during 2021 began because of chest pains and palpitations, but again anxiety, poor sleep and poor appetite continued to be an issue.

64. There was a broad consistency in the symptoms which Mr Woods described to OH and his GP and the mental health issues related to anxiety appeared to be triggering a number of physical symptoms and these became particularly challenging during the second absence in 2020.

65. Both counsel referred me to the Guidance concerning the definition of disability. I noted that in section A3 of the Guidance I was reminded that it is not necessary to identify a cause for the impairment. Section D3 describes normal day to day activities as being things that people do on a regular or daily basis. Mr Woods had not been considered by a consultant psychiatrist, psychologist or similarly qualified specialist during the relevant period of the case, but there was no suggestion from the medical records provided by his GP and OH that he was exaggerating his recorded symptoms.

66. As I described above, Mr Kenward provided me with submissions to explain why sleep could not be considered a normal day to day activity and it is fair to say that it is not something that is specifically identified within the Guidance. However, while I appreciate the point that he was making in his submissions, I find that sleep is something that forms part of everyone’s normal daily regimen and in order to be able to get up in the morning, there will of course have to have been some sleep taking place for a person to avoid serious fatigue. It is of course a question of degree, but the medical evidence reveals a continuing problem of sleep deprivation which was probably caused by the anxiety and panic attacks, and which would have had an *attritional* effect on Mr Woods over time to a point where it was certainly more than trivial or minor as provided by section 212 EQA.

67. It must also follow that poor appetite is also something that has a substantial adverse impact when occurring over a prolonged period, which was something that the medical evidence identified during the absences from work.

68. I am not satisfied that sufficient evidence was available to support a substantial adverse effect arose from the difficulties Mr Woods experienced in relation to childcare. While it was something that was affected by his illness, it did not appear to be recorded with sufficient frequency in the medical records to suggest that this was a significant problem.

69. Accordingly, I am left to conclude that the anxiety and panic attacks, consequential poor sleep and appetite and headaches were substantial in their adverse effect, being more than minor or trivial when they took place. They continued over a period of time and required the prescribing of long term medication to relieve their effects.

Long term effect

70. A long-term effect is one that has lasted for at least 12 months or is likely to last for at least 12 months or is likely to last for the rest of the life of the person concerned.

71. Having considered the medical evidence and Mr Woods' oral evidence, I accept that his mental health has been affected since 2018 and during this period he experienced a discrete 5 months away from work with *mental health problems*, followed by 11 months in 2019 and a further 4 months in 2021.

72. However, the initial anxiety attack in later 2017 and which resulted in an absence until May 2018 has not been connected by any of the medical evidence to the later absences of 2020 and 2021. A letter was produced by Mr Woods' GP in July 2020 as described above as suggesting a start point for *'significant mental health problems'* as being from November 2019.

73. It is correct that if an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day to day activities, it should be treated as continuing to have that effect if that effect is *likely* to occur, although there was clearly a general poor motivation which was something which impacted upon all of his day-to-day activities.

74. However, the 2018 episode appeared to resolve without further issue and seemed to subside, without medication and with no reoccurrence of mental health issues until the second absence in December 2019. This first episode seemed to be connected with ongoing workplace issues rather than any obvious underlying health issues and Mr Woods' GP did not connect the first absence with the subsequent second absence in his letter of July 2020.

75. However, the second and third absences appeared to be linked and suggested a longer-term problem which has had to continue to be managed with SSRI antidepressants and which show no sign of being stopped. SSRIs were considered as being appropriate by Mr Woods' GP in December 2019, although there was no indication that the condition was a chronic long term problem. The GP's language appeared to change significantly on 1 June 2020 when they identified *'anxiety disorder (Review)…chronic symptoms related to work problems'.* Antidepressants were also prescribed at this point, and it appeared to me that at this point what was initially seen by all concerned as an acute mental health problem connected with work, had become an underlying mental health issue which while triggered by workplace issues, also suggested an underlying vulnerability to external factors.

76. In the absence of a formal diagnosis from a mental health specialist, I find on balance of probabilities that Mr Woods' condition of anxiety and depression was considered by his GP as a longer-term problem from 1 June 2020. The prescribing of antidepressants indicated that the condition was one of anxiety and related depression arising from that condition and the lengthy prescribing of that medication suggests that stabilisation of symptoms is a long-term process rather than something which can be resolved in a matter of months.

<u>Measures without which the adverse effect would continue?</u>

77. While there was some reluctance on the part of Mr Woods concerning the prescribing of SSRIs or antidepressants, despite them being discussed by his GP in January 2020, a point was clearly reached on 1 June 2020 where it was agreed that they should be prescribed. As is inevitably the case, the medical records suggest that there was some trial and error in getting the correct medication and then allowing time for the active ingredients of the medication to stabilise the underlying feelings of anxiety or depression.

78. While it may be argued that these antidepressants have been prescribed without the diagnosis of a treating psychologist or psychiatrist or other mental health specialist, it can be acknowledged that the prescribing of SSRIs is something that is routinely carried out by GPs as providers of primary health care. Moreover, it can hardly be said that the prescribing of this medication was something that was rushed into by Mr Woods or his GP and it was not until the middle of 2020, halfway through the second absence, when there was consensus that it was an appropriate treatment path.

79. By May 2021, these symptoms had largely stabilised, but it would appear from the recent OH reports of Mr Sharif, that this was largely connected with the prescribed medication. Mr Sharif was not surprised by Mr Woods' belief that the medication assisted him, nor that he may need to remain on this medication for some time. While as an OH physician, he would not wish to contradict the treatment provided by Mr Woods' GP, he seemed accepting that this was a helpful means of ensuring Mr Woods would be mentally prepared to return to work.

80. I was not made aware that this particular treatment would be withdrawn in the near future and assume that it will continue for the foreseeable future. Accordingly, based upon the medical evidence available within the hearing bundle, I find on balance of probabilities that Mr Woods' impairment, while not currently having a substantial adverse effect on his ability to carry out normal day to day activities, that effect would in all likelihood return if the treatment had been or was withdrawn at the present time.

Conclusion

81. For these reasons, I must conclude that Mr Woods was disabled by reason of symptoms arising from his stress and anxiety at the material time and that he became so disabled from 1 June 2020. While medication ameliorates his condition, there is a strong possibility that it would become substantial if the medication was stopped. While this situation may improve in the future, none of the available medical evidence indicates when this improvement may arise. Under these circumstances this remains a condition which is long term in nature, and which was clearly the case to Mr Woods' GP from 1 June 2020.

82. As I explained in the introduction to this judgment, the claimant has, so far, brought three separate sets of proceedings in the Tribunal. The first two claims bring complaints of race discrimination and victimisation. The Tribunal had already listed a final hearing to consider the first two claims brought by the Claimant and has not provided for the third claim to be heard at the same time on the basis that this would potentially significantly increase the time

estimate because the 15 days presently currently provided for these two earlier cases would be insufficient.

83. Accordingly, the Tribunal will still need to make case management orders for the purposes of listing the third claim for a final hearing. Potentially, these case management orders were to be considered at the end of this preliminary hearing, but unfortunately there was insufficient time for the hearing to be concluded on 1 December 2021 and my decision was therefore reserved.

84. Following discussions with counsel upon the conclusion of the preliminary hearing, I agreed that it would be necessary for the case to be listed for a preliminary hearing case management in order that case management orders can be determined, the list of issues reviewed, and the case listed for a final hearing. The parties will be notified of this hearing date in due course.

Employment Judge Johnson

Date 4 January 2022

JUDGMENT SENT TO THE PARTIES ON
10 January 2022

FOR THE TRIBUNAL OFFICE