EMPLOYMENT TRIBUNALS

Claimant **Respondent**

v

Mr C Zagorski **North West Anglia NHS Foundation Trust**

Heard at: Watford ET (in public, by video)

On: 2 May 2023

Appearances:

For the claimant: **Ms H Winstone**, counsel

For the respondent: **Ms H Barney**, counsel

RESERVED JUDGMENT

The claimant did not have a disability within the meaning s.6 Equality Act 2010 at the relevant times.

REASONS

The Hearing

1. This was an open preliminary hearing ordered by the Tribunal on 22 February 2023 to (*inter alia*):

   determine whether the complaint(s) of unlawful disability discrimination contrary to the Equality Act 2010 should be dismissed if the claimant is not entitled to bring it if they do not have a disability within the meaning of section 6 and schedule 1 of the Act.

2. The claimant was represented by Ms Winstone and the respondent by Ms Barney. I am grateful to both Counsel for their submissions and assistance to the Tribunal.

3. For the hearing the parties submitted a bundle of documents containing 330 pages. The bundle included the claimant's disability impact statement and medical records. The respondent submitted the EAT decision in *Igweike v*

TSB Bank plc [2020] IRLR 267, to which both Counsel referred me in their closing submissions.

4. The claimant gave sworn evidence and was cross-examined.

5. At the end of the hearing, I reserved my judgment on the question of disability and listed a further preliminary hearing (case management) on 16 June 2023 at 2pm by video to case manage the claim to a final hearing (to be listed at the next hearing).

The Background

6. The claimant was employed by the respondent as a Consultant Radiologist, from 1 October 2019 until 6th July 2022. Early conciliation started on 12 September 2022 and ended on 24 October 2022. The claim form was presented on 24 November 2022.

7. The claimant brings complaints of constructive unfair dismissal, discrimination arising from disability, failure to make reasonable adjustments and of being subjected to detriments on the ground that he has made a protected disclosure.

8. In sum, the claimant complains that the respondent has failed to take reasonable steps to accommodate his disability (migraines and debilitation) by failing to reduce his onsite hours and to allow the claimant to work from home. He also complains that the respondent treated him unfavourably because of sickness absence arising from his disabilities.

9. The claimant also claims that he was subjected to various detriments by the respondent on the ground that he had made a protected disclosure by complaining that the software used by the respondent to carry out breast cancer MRI scans was unreliable. The claimant claims that by treating him in the way complained of the respondent has breached the implied term of trust and confidence and he resigned in response to that.

10. The respondent denies all the claims. The respondent does not accept that the claimant had a disability at the relevant times. The respondent also contends that the claimant's complaints based upon acts or omissions before 13 June 2022 are out of time and the tribunal does not have jurisdiction to consider them.

The Facts

11. The claimant commenced working for the respondent on 1 October 2019 as a Consultant Radiologist three days a week: - two days at the respondent's hospital in Peterborough and one day remotely from home. In addition to his role as Consultant Radiologist, the claimant performed the role of Deputy Foundation Training Programme Director. This was a pastoral role providing

support to junior doctors, for which the claimant received additional remuneration. At the same time the claimant worked one day a week in Kettering as a locum, which also involved travelling there and back. He also did some private work from home.

12. The claimant's wife suffered an injury while giving birth to their triplets in 2015 and require care assistance. The claimant is the principal care for his wife and their children. At the relevant times the children were 5 years of age. The claimant's caring responsibilities involve the claimant frequently having to attend on them during the night.

13. In August 2021, the claimant relocated to Surrey to be closer to his family. This increased his commute distance to the respondent's hospital in Peterborough from 35 minutes to 2.5 – 3 hours, one way. The claimant drove to work.

14. The claimant worked long hours, some days up to 12-13 hours. This was in addition to the travel time.

15. In late December 2019 - early January 2020 the claimant developed headaches. On 16 January 2020, he had a telephone consultation with his GP. The GP recorded that the claimant: "*feels run down, excessively tired 3weeks, physically exhorsted (sic). started to have headaches, constant, "can not (sic) shift them", he says, mainly frontal or above heair (sic) line. occasional episodes of dizziness, flashes of bright light few times. had episode of black vision …. occasional nausea, no vomiting. works long hours in hospital, some days up to 12-13 hrs/day and 2 hrs driving*". The claimant was referred to a specialist neurologist for consultation.

16. The consultant neurologist saw the claimant on 23 January 2020. The consultant neurologist recorded the claimant's symptoms (frontal dull, pressure-like headache with nausea and extreme fatigue), his busy working life, extended commute and extensive caring responsibilities for his wife and children. The consultant noted that the claimant and his wife were concerned about the possibility of these symptoms being of MS or another serious brain decease. A blood test and MRI were organised. The consultant neurologist concluded that one possibility for the symptoms could be simply exhaustion from chronic overwork and discussed with the claimant "lifestyle adjustments" if the analysis prove normal.

17. On his second visit on 12 February 2020, the consultant reassured the claimant that his analysis and the MRI scan were fine. The consultant observed:

    After job planning he will work 1 day each week from home from his NHS post at Peterborough. He continues travelling 1 day to Kettering. He discussed the possibility that they might obtain help over night at home. Dr Zagorski is often up through the night nursing the children or his wife assisting with catheterisation, nightmares or psychological problems.

They do have a helper and nanny in the day time. The one problem with overnight care would be sleeping arrangements as their triplets have separate bedrooms in their 4-bedroom accommodation.

The claimant was prescribed Amitriptyline 10 mg once a day.

18. The claimant had consultations in his GP practice on 19 March, 24 March, 30 March and 28 May 2020. These were about the claimant's asthma and suspected Covid-19. No reference was made to migraines or debility.

19. The claimant was seen by the consultant neurologist again on 7 July 2020. The consultant recorded that the claimant was still suffering from headaches and that the prescribed medication was not effective and making the claimant drowsy. The claimant was prescribed a different medicament – Topiramate 25mg. The consultant neurologist recorded in his letter that the claimant was getting little sleep because of his caring responsibilities for his wife and children and that was aggravating his headaches and leaving him feeling exhausted. In the consultant's opinion assistance with the overnight responsibilities was likely to significantly help the claimant with the symptoms.

20. The claimant had consultations with his GP on 31 July, 6 August and 10 September 2020. These were about a skin condition and suspected Covid-19. No reference was made to migraines or debility.

21. On 20 November 2020, the claimant had a consultation with his GP. The GP recorded that the claimant was seeing a neurologist due to headaches and the prescribed medication was not helping.

22. On 4 March 2021, the claimant had a consultation with his GP. The GP recorded the claimant's complaint of feeling exhausted, his night care responsibilities for his wife and children, long working hours, and disturbed night sleeps.

23. On 10 March 2021, the claimant's GP sent the claimant a text message about respite care options for his wife and children.

24. The claimant had consultations with doctors in his GP practice on 12 March, 29 March and 7 October 2021. These were about chest pains and blood tests. No reference was made to migraines or debility.

25. In November 2021, the claimant took on additional responsibilities of an appraiser. This was a paid role. This responsibility was in addition to his roles as Consultant Radiologist and Deputy Foundation Training Programme Director

26. On 19 November 2021, the claimant had a telephone consultation with a medic in his GP practice. The medic recorded that the claimant was struggling with his workload, that he was suffering from sinusitis, and had a history of

headache. She also recorded that the claimant said that there were no red flags with the headache.

27. On 7 December 2021, the claimant commenced sick leave, from which did not return to his radiologist duties.

28. On 14 December 2021, the claimant's GP recorded that the claimant had a huge amount of stress at work, that he had been asking for a reduction in the workload, felt exhausted and had fallen asleep while driving, and continued to have persistent headache with intermittent visual disturbance. The GP recorded the claimant's family care responsibilities, and that the medication slowed up migraines. The record states: *"eMED3 (2010) new statement issued, not fit for work chat about events and how he is feeling. We both agree that time off is absolutely required to allow him time to rest and see what happens with migraines review 1/12 would like another F2F*". The GP signed off the claimant as not fit for work due to migraine headaches and debility.

29. On 6 January 2022, the claimant had a consultation with his GP. The GP recorded that the claimant was still struggling with migraines, but felt more rested, however, was still very busy due to additional care for his wife and children. The GP advised the claimant to find more time for himself and get more rest. The GP recorded "supportive chat" as the Plan and extended sickness note for another 4 weeks.

30. On 11 February 2022, the claimant had a consultation with his GP. The GP recorded that the claimant was doing OK, his migraines had become worse and over Christmas were quite debilitating, but started to improve in January, and had significantly improved since that time, with the claimant starting to read and thinking of doing some gentle exercise. The GP issued a new sickness note for 4 weeks, not fit for work for migraines and debility until 10 March 2022.

31. On 5 March 2022, the claimant had a consultation with his GP. The GP recorded that the claimant was very upset about the respondent not allowing him to reduce his hours, but his mood was reasonable. No reference was made to migraines or debility. The GP issued a new sickness note with the same diagnoses (migraines and debility) until 15 April 2022.

32. The claimant had appointments at the GP surgery on 12 and 20 March 2022 about Covid-19. No reference was made to migraines or debility at those consultations.

33. On 18 March 2022, whilst on sick leave, the claimant completed a colleague's appraisal as part of his appraiser duties.

34. On 22 March 2022, the claimant had another consultation with his GP. The GP recorded that the claimant had said that he was not depressed but work was causing stress to him. No reference was made to migraines or debility.

35. The claimant had a further consultation with his GP on 12 April 2022. The GP recorded that the claimant was having migraines twice a week. The GP issued a new sickness note with the same diagnoses until 9 May 2022.

36. On 9 May 2022, the GP recorded that the claimant had ongoing migraines and requested to extend his sickness note, which the GP did for 8 weeks until 3 July 2022.

37. On 10 May 2022, whilst off sick, the claimant conducted another colleague's appraisal.

38. On 25 May 2022, the claimant's GP recorded that the claimant was struggling with migraine located in the front and back of the head. The GP recorded the there were "*no photophobia, assox nausea , severity 8/10 heavy feeling in the chest , not wheezy , fatigue No FAST symptoms, no neck stiffness, no change in vision, still coughing productive of yellowish green sputum and feeling breathless*".

39. On 7 June, occupation health issued report stating that the claimant was not fit for any work due to significant symptoms of Covid-19.

40. On 8 June 2022, whilst on sick leave and without informing his manager, the claimant attended the respondent's premises in his capacity as Deputy Foundation Training Programme Director to attend the Annual Review of Competency Progression meeting.

41. On 14 June 2022, the claimant's GP recorded that the claimant had been off sick six months for migraines and debility and since contracting Covid-19 was feeling more tired and not having energy.

42. On 16 June 2022, the claimant's GP recorded that the claimant was still feeling exhausted and was mentally fatigued with the situation at work and was talking to the BMA about that.

43. On 15 July 2022, the claimant's GP recorded that the claimant was physically feeling better and less fatigued, that he had resigned from his job because he felt he had no choice was not sleeping and not thinking straight.

44. On 28 July 2022, the claimant's GP recorded under the code "Migraine" that the claimant was doing quite well, but still had disturbed sleep.

45. On 17 September 2022, the claimant's GP recorded that the claimant continued to have headaches, which could last more than 24 hours, medications helped if administered early. The claimant requested referral to a neurologist for migraines. The GP signed off the claimant as not fit for work.

46. On 19 November 2022, the claimant's GP recorded that the claimant was feeling better in himself than how he felt for a long time, that he had been self-

caring and eating well, but his sleep was still disturbed. The claimant asked for his sickness note to be extended. The GP wrote that the next note was likely to be a RTW (return to work) certificate.

47. On 22 December 2022, the claimant's GP recorded that the claimant complained about not sleeping well and of increased frequency of migraines. The GP observed that the claimant's decision to issue a claim against the respondent "*may be preying on [his] mind*."

48. On 4 March 2022, the claimant's GP recorded that the claimant asked for a sick note, that he was doing quite well mentally, considering locum work, but had been physically unwell in the last 1-2 weeks with a chest infection and frequent migraines.

49. The claimant's GP records do not list migraines or debility as "Active Problems" or "Significant Past". However, the list contains a "stress related problem" diagnosed in November 2015 caused by the stress with preparing for medical school exams, manifesting in feeling of a breakdown, and problems with concentration, sleep and slow-down in thought processes. At that time, the claimant was advised to rest and to see counselling service.

The Law

50. Section 6 of the EqA 2010 defines disability as follows:

> "***6 Disability***
> *(1) A person (P) has a disability if—*
> *(a) P has a physical or mental impairment, and*
> *(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities*."

51. The relevant point in time to be looked at by the Tribunal when evaluating whether the claimant is disabled under s. 6 EqA is not the date of the hearing, but the time of the alleged discriminatory act: ***Cruickshank v Vaw Motorcast Ltd*** [2002] I.C.R. 729.

52. By virtue of s.6(6) EqA 2010 the meaning of disability is supplemented by the provisions of Schedule 1 of the Act. However, there is no specific definition of "impairment" in the EqA 2010.

53. In ***Rugamer v Sony Music Entertainment UK Ltd*** [2001] IRLR 664, the EAT defined "impairment" in the following way (at [34]): "*Impairment" for this purpose and in this context, has in our judgment to mean some damage, defect, disorder or disease compared with a person having a full set of physical and mental equipment in normal. We find that in this case condition. The phrase 'physical or mental impairment' refers to a person having (in everyday language) something wrong with them physically, or something wrong with them mentally*."

54. In ***McNicol v Balfour Beatty Rail Maintenance Ltd*** [2002] ICR 1498, CA, the Court of Appeal held that 'impairment' in this context bears '*its ordinary and natural meaning… It is left to the good sense of the tribunal to make a decision in each case on whether the evidence available establishes that the applicant has a physical or mental impairment with the stated effects*.'

55. In ***Goodwin v Patent Office*** [1999] I.C.R. 302, Morison J (President, as he then was), provided guidance on the proper approach for the Tribunal to adopt when applying the provisions of the Disability Discrimination Act 1995 (the predecessor legislation to EqA). Morison J held (at [3]) that the following four questions should be answered, in order:

    a) Does the claimant have an impairment which is either mental or physical? (the '***impairment condition***');
    b) Does the impairment affect the claimant's ability to carry out normal day-to-day activities …, and does it have an adverse effect? (the '***adverse effect condition***');
    c) Is the adverse effect substantial? (the '***substantial condition***'); and
    d) Is the adverse effect long term? (the '***long-term condition***').

56. In Goodwin the EAT also said at [2]:

    "2. The tribunal should bear in mind that with social legislation of this kind, a purposive approach to construction should be adopted. The language should be construed in a way which gives effect to the stated or presumed intention of Parliament, but with due regard to the ordinary and natural meaning of the words in question…."

57. Underhill J (President, as he then was) in ***J v DLA Piper UK LLP*** [2010] ICR 2010 suggested (at [40]) that although it was still good practice for the Tribunal to state a conclusion separately on the question of impairment, as recommended in ***Goodwin***, there will generally be no need to actually consider the '*impairment condition*' in detail:

    "*In many or most cases it will be easier (and is entirely legitimate) for the tribunal to ask first whether the claimant's ability to carry out normal day-to-day activities has been adversely affected on a long- term basis. If it finds that it has been, it will in many or most cases follow as a matter of common-sense inference that the Claimant is suffering from an impairment which has produced that adverse effect. If that inference can be drawn, it will be unnecessary for the tribunal to try to resolve the difficult medical issues*."

58. At [42] in ***J v DLA Piper UK LLP*** the EAT said:

    42. 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 them as symptoms of low mood and anxiety. The first state of affairs is a mental illness – or, if you prefer, a mental condition – which is conveniently referred to as "clinical depression" and is unquestionably an impairment within the meaning of the Act. The second is not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problems at work) or – if the jargon may be forgiven – "adverse life events". …

    We dare say that the value or validity of that distinction could be questioned at the level of deep theory; and even if it is accepted in principle the borderline between the two states of

affairs is bound often to be very blurred in practice. But we are equally clear that it reflects a distinction which is routinely made by clinicians – it is implicit or explicit in the evidence of each of Dr Brener, Dr MacLeod, and Dr Gill in this case – and which should in principle be recognised for the purposes of the Act. We accept that it may be a difficult distinction to apply in a particular case; and the difficulty can be exacerbated by the looseness with which some medical professionals, and most laypeople, use such terms as "depression" ("clinical" or otherwise), "anxiety" and "stress". Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If, as we recommend at paragraph 40(2) above, a tribunal starts by considering the adverse effect issue and finds that the claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for 12 months or more, it would in most cases be likely to conclude that he or she was indeed suffering "clinical depression" rather than simply a reaction to adverse circumstances: it is a common-sense observation that such reactions are not normally long-lived.

59. The Guidance on matters to be taken into account in determining questions relating to the definition of disability ("**the Guidance**") states, at A3 and A5:

"*A3 The definition requires that the effects which a person may experience must arise from a physical or mental impairment. The term mental or physical impairment should be given its ordinary meaning. It is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness. In many cases, there will be no dispute whether a person has an impairment. Any disagreement is more likely to be about whether the effects of the impairment are sufficient to fall within the definition and in particular whether they are long-term. Even so, it may sometimes be necessary to decide whether a person has an impairment so as to be able to deal with the issues about its effects.*

[..]

A5 A disability can arise from a wide range of impairments which can be:

[…]

- *impairments with fluctuating or recurring effects such as rheumatoid arthritis, myalgic encephalitis (ME), chronic fatigue syndrome (CFS), fibromyalgia, depression and epilepsy*

[..]

- *mental health conditions with symptoms such as anxiety, low mood, panic attacks, phobias, or unshared perceptions; eating disorders; bipolar affective disorders; obsessive compulsive disorders; personality disorders; post-traumatic stress disorder, and some self-harming behaviour;*
- *mental illnesses, such as depression and schizophrenia; produced by injury to the body, including to the brain*".

[..]

60. The EHRC Code of Practice on Employment, at paragraph 7 of Appendix, puts it succinctly "*What it is important to consider is the effect of the impairment, not the cause.*"

61. However, in ***Walker v Sita Information Networking Computing Ltd*** [2013] UKEAT/0097/12, Langstaff P said: "*That is not to say that the absence of an apparent cause for an impairment is without significance. The significance is, however, not legal but evidential. Where there is no recognised cause of [the alleged 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*."

62. In ***Herry v Dudley Metropolitan Council*** UKEAT/0100/16, [2017] ICR 610, referring to para [42] of ***J v DLA Piper UK LLP***, the EAT said this:

'*55. This passage has, we believe, stood the test of time and proved of great assistance to Employment Tribunals. We would add one comment to it, directed in particular to diagnoses of "stress". In adding this comment we do not underestimate the extent to which work related issues can result in real mental impairment for many individuals, especially those who are susceptible to anxiety and depression.*

56. Although reactions to adverse circumstances are indeed not normally long-lived, experience shows that there is a class of case where a reaction to circumstances perceived as ad-verse can become entrenched; where the person concerned will not give way or compromise over an issue at work, and refuses to return to work, yet in other respects suffers no or little apparent adverse effect on normal day-to-day activities. A doctor may be more likely to refer to the presentation of such an entrenched position as stress than as anxiety or depression. An Employment Tribunal is not bound to find that there is a mental impairment in such a case. Unhappiness with a decision or a colleague, a tendency to nurse grievances, or a refusal to compromise (if these or similar findings are made by an Employment Tribunal) are not of themselves mental impairments: they may simply reflect a person's character or personality. Any medical evidence in support of a diagnosis of mental impairment must of course be considered by an Employment Tribunal with great care; so must any evidence of adverse effect over and above an unwillingness to return to work until an issue is resolved to the employee's satisfaction; but in the end the question whether there is a mental impairment is one for the Employment Tribunal to assess.

[…]

71. It is true that in paragraph 42 Underhill P said that in a case where mental impairment was disputed the ET might begin with findings as to whether there was a long-term effect on normal day-to-day activities, because reactions to adverse circumstances were not usually long-lived. He was, however, not setting out any rule of law; he was considering a case where the principal diagnosis in issue was depression; and he did not rule out the possibility of a reaction to adverse circumstances which was long-lived. As we have explained above, when commenting on J v DLA Piper, there can be cases where a reaction to circumstances becomes entrenched without amounting to a mental impairment; a long period off work is not conclusive of the existence of a mental impairment.'

63. In ***Igweike v TSB Bank plc*** [2020] IRLR 267, HHJ Auerbach, having reviewed the authorities on the question of identifying an impairment, held at [46] – [55] (*my underlining*)

"*46. I turn first to ground one. Mr Young did not go quite so far as to say that the Judge necessarily erred, purely because he addressed the impairment question before he addressed the questions of substantial and long-term adverse effect. That indeed is not the law. In concurrence with the discussion in Herry, I do not read the discussion at para 42 of J v DLA Piper UK LLP as laying down a rigid rule of law to that effect. It is guidance as to an approach that may be helpful, particularly in a certain type of case, where, if the Tribunal does find that there was a substantial and long-term adverse effect, the Tribunal may then consider that that finding in turn supports an inference that that effect was caused by some impairment.*

47. There may, it can be said, be a risk in such a case that if the Tribunal considers the impairment question first – and finds none established – it may fail sufficiently to turn its mind to whether such an effect, if found, might have affected its conclusion on the impairment question. However, what matters ultimately is not the running order in which the Tribunal discusses or presents its conclusions on these aspects, but whether, by the end of the decision, it has erroneously failed to find that there was such an effect, and/or, if so, whether it

has, or has also, erroneously failed to draw the inference, taking account of such a finding, that there was an impairment.

48. The main substance of ground one, and Mr Young's argument on it, was as to whether the Tribunal had properly considered the evidence about the impact which the Claimant said his bereavement had had on him. In my judgment the Tribunal did consider the Claimant's evidence about that, and accepted it and made findings of fact accordingly, in particular in paras 3 and 28 of its Decision. The Judge plainly under-stood that the Claimant relied on the effects of his grief reaction, starting from the time of his father's passing, as the thing which established his disabled status. The Judge said, in terms, 'It is this that the Claimant relies on to establish that he was disabled from that time.'

49. I turn to the argument that the Judge erred, because he wrongly found that the Claimant could not make good his case for lack of supporting medical evidence, and that the Judge thereby wrongly assumed that a cause had to be identified, and/or that such cause had to be a clinically well-recognised condition. Once again, I do not agree that this is what the Judge did. Firstly, the Judge said nothing at all about there being a lack of an apparent cause for the experience which the Claimant described. He plainly accepted that this was a genuine description of the reaction he had experienced, to the loss of a loved one.

50. Secondly, while there is no longer a rule of law that a mental impairment must be clinically well-recognised, nor is there any rule that such an impairment cannot ever be made out without medical evidence, nevertheless, as the discussion in both J v DLA Piper UK LLP and Morris explains, it is a practical fact that, in some cases of this type, the individual's own evidence may not be sufficient to satisfy the Tribunal of the existence of an impairment. In some cases, even contemporary medical notes or reports may not be sufficient, and expert evidence prepared for the purposes of the litigation may be needed. To say all of this is not to introduce either of these legal heresies by the back door. The question is a purely practical or evidential one, which is sensitive to the nature of the alleged disability, the facts, and the nature of the evidence, in the given case.

51. Returning to this Decision, I see nothing in the Judge's remarks, at the end of para 3 or in para 28, to suggest that he thought that, as a matter of law, medical evidence of a certain kind was a necessary requirement to establish an impairment. I also see no basis at all to infer that the Judge thought that it was still the law that a mental impairment had to be a clinically well-recognised illness. It seems to me that all that the Judge was doing, in para 3, was remarking on the fact that there was, in this case, no contemporaneous medical evidence from the relevant period, which might, had it been present, have been relied upon evidentially to support the Claimant's case that there was an impairment.

52. Then, in para 28.1.1, he referred to this fact about the state of the evidence again and considered whether the facts he had found, as to the symptoms described by the Claimant himself, were sufficient to support the inference that there was an impairment. He concluded at para 28.1.2 that they were not, because they were, 'in many ways a typical reaction to the loss of a well-loved close relative.'

53. Mr Young says that the Judge nevertheless erred because, in para 28.1.3, he showed that he had wrongly assumed that a grief reaction could not be an impairment unless or until it had developed into a depression. The discussion in Herry is, I think, pertinent here. Herry and the present case are plainly not factually on all fours. Herry was about the type of case in which a reaction to circumstances at work is found to have expressed itself in entrenched or intransigent behaviour. In that case, that reaction was also found to have had little or no adverse effect on normal day-to-day activities. However, the discussion in Herry makes a more general point, that a reaction to adverse events or circumstances does not, even if a clinician describes it (in that case) as stress, necessarily by itself bespeak the presence of an impairment. The Judge in the present case cited this passage in Herry and referred to the distinction between an ordinary reaction to adverse life events as such, and impairment, in terms, at para 14 of his Decision. It is fair to assume that he then had this distinction in mind when he later set out his conclusions in para

54. It seems to me that on a fair reading of the Decision as a whole, the Judge was doing no more in paras 28.1.1 through to 28.1.4, than to apply this valid general conceptual distinction to a case in which the adverse life event was bereavement through the loss of a loved one. In some cases, bereavement may lead to ordinary symptoms of grief which do not bespeak any impairment. In others, they may lead to something more profound which is, or develops into, an impairment over time. A clinician using the word 'depression' may be regarded as one form of evidence that this indeed is what has happened in a given case; but, to repeat, the matter is one for the appreciation of the Tribunal, drawing on the totality of the evidence, and the application of a clinical label is neither necessary nor, if it has been applied, conclusive.

55. Mr Young suggested that there were particular policy considerations that applied in the type of case with which Herry was concerned, because, were the law otherwise, an individual could, by adopting an intransigent or entrenched stance, then adduce support for their own case that they were disabled in law. I agree that a case of that sort would be different in that respect from one in which an individual, plainly not by any conscious decision, reacts to the experience of bereavement. However, that difference does not affect the validity of the insight that there is still a valid distinction to be drawn between a normal reaction to an adverse and tragic life event and something that is more profound and develops into an impairment. That is a distinction which it seems to me was properly applied by the Judge to the circumstances of this case.

64. S. 212(1) of the EqA defines "*substantial*" as meaning "*more than minor or trivial*."

65. In ***Rayner v Turning Point*** [2010] 11 WLUK 156, HHJ McMullen QC held, at [22], that although the question of whether there is a "substantial" adverse effect is a matter of fact for the Tribunal to determine.

66. The cumulative effects of an impairment should be taken into account when working out whether it is substantial. An impairment might not have a substantial adverse effect on a person's ability to undertake a particular day-to-day activity in isolation. However, it is important to consider whether its effects on more than one activity, taken together, could result in an overall substantial adverse effect.

67. Appendix 1 to the EHRC Employment Code of Practice also provides guidance on the meaning of "substantial" 6: "*Account should… be taken of where a person avoids doing things which, for example, causes pain, fatigue or substantial social embarrassment; or because of a loss of energy and motivation*."

68. Whether an impairment has a substantial effect is for the Tribunal to decide, taking account of the relevant Guidance. The Guidance sets out a number of factors to consider including: the time taken by the person to carry out an activity [paragraph B2]; the way a person carries out an activity [B3]; the cumulative effects of an impairment [B4]; the cumulative effects of a number of impairments [B5/6]; the effect of behaviour [B7]; the effect of environment [B11] and the effect of treatment [B12]

69. In ***Anwar v Tower Hamlets College*** EAT 0091/10 the EAT said that it was not "*necessary error of law in describing the effect as more trivial and yet also describing it as minor*". The EAT said at [23]:

"23. The argument to the contrary is to the effect that the words "minor" and "trivial" are not synonymous. They are both included in the guidance. They have different nuances. "Trivial" may be at a lower level than "minor". Accordingly, there is no necessary error of law in describing the effect as more trivial and yet also describing it as minor. If that be right, it said that the terms of paragraph 12 demonstrate precisely what his thinking was and that his thinking follows the kind of approach which is exemplified in the guidance at paragraph B1. It is said that the conclusion to which he came on the evidence was a conclusion to which he was entitled to come and does not remotely approach the level of error which could properly be described as perverse.

24. In my judgment, the grounds raised by the Appellant in respect of this issue are not persuasive. This is not a statute. It is a document giving guidance which has to be regarded. There is nothing, in my judgment, wrong in law or amounting to a misdirection of law for an Employment Judge to conclude that an effect of an impairment was more than "trivial" and yet still "minor" as opposed to "substantial".**"**

70. This case, however, was decided before the definition of "substantial" was made part of a statute by reference to the identical wording in the previous version of the Guidance and the Code of Practice issued under the Disability Discrimination Act 1995.

71. However, in ***Aderemi v London and South Eastern Railway Ltd*** 2013 ICR 591, EAT, the EAT said at [14] (*my underlining*):

"*14. It is clear first from the definition in section 6(1)(b) of the Equality Act 2010 , that what a Tribunal has to consider is on adverse effect, and that it is an adverse effect not upon his carrying out normal day-to-day activities but upon his ability to do so. Because the effect is adverse, the focus of a Tribunal must necessarily be upon that which a Claimant maintains he cannot do as a result of his physical or mental impairment. Once he has established that there is an effect, that it is adverse, that it is an effect upon his ability, that is to carry out normal day-to-day activities, a Tribunal has then to assess whether that is or is not substantial. Here, however, it has to bear in mind the definition of substantial which is contained in section 212(1) of the Act. It means more than minor or trivial. In other words, the Act itself does not create a spectrum running smoothly from those matters which are clearly of substantial effect to those matters which are clearly trivial but provides for a bifurcation: unless a matter can be classified as within the heading "trivial" or "insubstantial", it must be treated as substantial. There is therefore little room for any form of sliding scale between one and the other*."

72. In ***Paterson v Commissioner of Police of the Metropolis*** 2007 ICR 1522, EAT, Mr Justice Elias (the President, as he then was) emphasised that in assessing an impairment's effect on a claimant's ability to carry out normal day-to-day activities, a tribunal should not compare what the claimant can do with what the average person can do, but what the claimant can do and what the claimant could do without the impairment. And for the effect to be substantial it "*must fall outwith the normal range of effects that one might expect from a cross section of the population', but 'when assessing the effect, the comparison is not with the population at large… what is required is to compare the difference between the way in which the individual in fact carries out the activity in question and how he would carry it out if not impaired*".

73. "*Day to day activities*" encompass activities which are relevant to participation in professional life as well as participation in personal life, and that the Tribunal should focus on what the claimant cannot do, not what they can do.

74. In ***Elliot v Dorset County Council*** UKEAT/0197/20/LA HHJ Tayler points out that, once again, it is difficult to look at this question in isolation – for example, how is it possible to decide whether there is a "substantial adverse effect" on normal day to day activities without first identifying which "normal day to day activities" are affected?

75. The Guidance provides the following examples of what is meant by "normal day to day activities". "*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"*.

76. In the Appendix to the Guidance, an illustrative non-exhaustive list of factors is set out which, if experienced by a person, would be reasonable to regard as having a substantial adverse effect on normal day to day activities. There is a separate list of what it would not be reasonable to regard as having a substantial adverse effect on normal day to day activities.

77. An illustrative and non-exhaustive list of factors which, if they are experienced by a person, it would be reasonable to regard as having a substantial adverse effect on normal day-to-day activities, includes:

    - *Persistent general low motivation or loss of interest in everyday activities;*
    - *Frequent confused behaviour, intrusive thoughts, feelings of being controlled, or delusions*
    - *Persistently wanting to avoid people or significant difficulty taking part in normal social interaction or forming social relationships, for example because of a mental health condition or disorder;*
    - *Persistent distractibility or difficulty concentrating;*

78. An illustrative and non-exhaustive list of factors which, if they are experienced by a person, it would not be reasonable to regard as having a substantial adverse effect on normal day-to-day activities, includes:

    - *Inability to concentrate on a task requiring application over several hours*;

79. Finally, Schedule 1, part 1, para. 2 of the EqA 2010 defines "long-term" as follows:

    "The effect of an impairment is long-term if –
    it has lasted for at least 12 months,
    it is likely to last for at least 12 months, or
    it is likely to last for the rest of the life of the person affected".

80. Tribunal must analyse all three scenarios envisaged in paragraph 2 of schedule (see ***McKechnie Plastic Components v Grant*** UKEAT/0284/08).

81. '*Likely*' has been held to mean it is a "*real possibility*" and '*could well happen*' rather than something that is probable or more likely than not (***SCA Packaging Ltd v Boyle*** [2009] ICR 1056).

82. In that case the Supreme Court upheld Girvan LJ in the Court of Appeal (at [19]):

> "*The prediction of medical outcomes is something which is frequently difficult. There are many quiescent conditions which are subject to medical treatment or drug regimes and which can give rise to serious consequences if the treatment or the drugs are stopped. These serious consequences may not inevitably happen and in any given case it may be impossible to say whether it is more probable than not that this will occur. This being so, it seems highly likely that in the context of paragraph 6(1) in the disability legislation the word "likely" is used in the sense of "could well happen*".

83. The Guidance states that conditions with effects which recur only sporadically or for short periods can still qualify as long term impairments for the purposes of the Act. If the effects on normal day to day activities are substantial and are likely to recur beyond 12 months after the first occurrence, they are to be treated as long-term. The guidance sets out examples of impairments with effects which can recur beyond 12 months, or where the effects can be sporadic [C5 and C6]

84. The guidance sets out that it is not necessary for the effect to be the same throughout the period which is being considered in relation to determining whether the 'long-term' element of the definition is met [C7]

85. The Guidance sets out what should be considered in relation to the likelihood of recurrence. Essentially this means that all circumstances should be taken into account including the way in which a person can control or cope with the effects of an impairment, which may not always be successful.

86. At [C9] the Guidance states:

> *"C9. Likelihood of recurrence should be considered taking all the circumstances of the case into account. This should include what the person could reasonably be expected to do to prevent the recurrence. For example, the person might reasonably be expected to take action which prevents the impairment from having such effects (for example, avoiding substances to which he or she is allergic). This may be unreasonably difficult with some substances"*.

87. In ***Tesco Stores Ltd v Tennant***, UKEAT/0167/19, the EAT held that, where the claimant's condition was found to have the necessary substantial adverse effect, but the claimant provided no evidence that the condition was "likely" to last for at least 12 months, the Tribunal erred in finding the respondent liable for acts of discrimination before the effects had in fact lasted for 12 months.

88. It is for the claimant to prove that he is disabled, that is to show, on the balance of probabilities, that he satisfies all four elements, that is that:

a) he has a mental or physical impairment,
b) the impairment affects his ability to carry out normal day-to-day activities,
c) the adverse condition is substantial, and
d) that the adverse condition is long term.

Analysis and Conclusions

89. The claimant pleads his case on the issue of disability as follows:

"6. Due to work and personal pressures the Claimant's health began to deteriorate and he became unwell. The Claimant will say that, despite being open with the Respondent throughout about his health, he was not supported, and the Respondent showed little concern for his health.

7. Due to his state of health the Claimant had multiple non-consecutive periods of absence during 2020-2022, which were all dealt with informally. Due to his commute (approx. 2.5 hours), workload and personal circumstances, the Claimant became increasingly exhausted, leading to him suffering with migraines and debility. The Claimant has been suffering with the symptoms of his disability from early 2020 and has been in continuous communication with the Respondent about his state of health from that time. Over time, the Claimant's migraines were getting more regular and more intense until they became debilitating.

8. The Claimant's health deteriorated further throughout 2021, became increasingly exhausted and persistently suffered from migraines.

[..]

Disability

43. As stated above, the Claimant will say that, owing to his health condition or (sic) migraines and debilitation, he meets the legal test for disability pursuant to s.6 EA. The Claimant will say that this health condition is a mental impairment, which is longstanding (having been persistent since 2020), and had a substantial adverse effect on his ability to undertake day to day activities.

90. In his disability impact statement, the claimant deals with two conditions (migraines, and exhaustion and debility) separately.

91. With respect to exhaustion and debility the claimant says:

24. I also began suffering from exhaustion and debility in early 2020. My exhaustion and debility which I consider to have been caused by my work responsibilities and extended commute is exacerbated by the care I need to provide during the nights to my wife.

25. The exhaustion and debility I suffer is associated with:
the mental and physical symptoms of:
o chronic tiredness,
o feeling drained and weak,
o lack of concentration,
o impaired decision making and judgment, and
o reduced short-term memory.

26. The exhaustion and debility I suffer from impacts my ability to do day-to-day activities such as engaging in cooking, cleaning, dressing or bathing. These activities take longer than they would ordinarily due to my symptoms causing me to move and think more slowly.

27. My exhaustion and debility led me on 12 May 2021 to crash my car after falling asleep at the wheel.

28. The effects of my exhaustion and debility are long-term. I began to experience the effects in early 2020 and I continue to struggle with the symptoms.

29. I have always been open to the Respondent about my health issues, the severity of my conditions and the way my work was contributing to worsening its effects.

92. In cross-examination the claimant accepted that his caring responsibilities for his wife and children, long working hours and extensive commute were significant cause for him feeling exhausted. It is hardly surprising. Putting in a 12 - 13-hour work shift after having to drive 2.5 - 3 hours, then returning home and having to attend to three young children and assist his wife with her needs during the night and as a result not having a proper night rest, is likely to leave any person feeling exhausted and drained.

93. I have no criticism but sympathy for the claimant. His dedication to his family can only be applauded. However, the symptoms he describes and attributes to the alleged impairment of "exhaustion and debility" seem to me being no more than the symptoms of a normal physical and emotional reaction to the extremely demanding work-life conditions the claimant found himself in.

94. Put it simply, he was very tired. Not having any respite from his gruelling schedule, his tiredness kept accumulating, and the symptoms were getting worse. There is nothing unusual about that. An athlete engaging in a tough endurance physical event will feel progressively more tired the longer he or she goes and is very likely to suffer the same or similar symptoms as the claimant describes. This, however, does not make the athlete a disabled person.

95. I accept that such chronic exhaustion might develop into a clinical condition such as myalgic encephalitis or chronic fatigue syndrome, fibromyalgia, or depression. However, that is not the claimant's case. On the contrary, his medical records not only do not disclose any such diagnosis, but record that the claimant himself reported to his GP that he was not depressed.

96. In my judgment, what the claimant calls "exhaustion and debility" is not an impairment in the sense this term is to be understood under s.6 EqA, but what the ETA described in ***J v DLA Piper*** and the subsequent cases quoted above as "*a reaction to adverse life events*". Whilst the claimant's case is not of a reaction to bereavement as in ***Igweike v TSB Bank plc***, or an "*entrenched position*", as in ***Herry v Dudley Metropolitan Council***, and is not about stress, anxiety or depression, I see no reason why the same principles should not apply here.

97. I also find that it would be contrary to the natural meaning of the word and the legislative intent to describe the claimant's condition of "exhaustion" in those circumstances as an "impairment".

98. For these reasons, I find that the claimant has failed to prove the impairment condition.

99. I am also not satisfied that the "exhaustion and debility" can properly be considered as "substantial" and "long-term".

100. As noted above the Guidance at [B7] explain that in considering the question of substantial adverse effect "*[a]ccount should be taken of how far a person can reasonably be expected to modify his or her behaviour, for example by use of a coping or avoidance strategy, to prevent or reduce the effects of an impairment on normal day-to-day activities*".

101. The claimant was advised by his neurologist consultant and his GP that his chronic overwork, work commute and significant caring responsibilities were likely causes of the symptoms, which the claimant says were the symptoms of exhaustion and debility. He was advised to make changes to this lifestyle, have more rest, seek additional help for his caring responsibilities.

102. I find that it was reasonable to expect for the claimant to make these changes. However, instead the claimant chose to move at a significant distance from his workplace, which increased his commute time from 35 minutes to 2.5 - 3 hours. His evidence is that he moved to be closer to his family. However, it appears that this "trade-off" did not result in the claimant having less demanding schedule.

103. Of course, it is not for me to tell the claimant how he should have organised his work-life balance. However, what I do find is that if the claimant had made reasonable changes to his extremely demanding schedule, as it was recommended to him, the adverse effect on his day-to-day activities would not have been substantial.

104. I anticipate the claimant might say that it was precisely what he wanted the respondent to do by allowing him to work less and to work from home as a reasonable adjustment. However, the duty to make reasonable adjustments arises only if the claimant can prove that he had a disability within the meaning of the Equality Act, and not before.

105. For the same reasons, I find that the effect was not "long-term". As the claimant's medical records show, after leaving the respondent's employment, he started to feel much better and less fatigued. I, of course, am cognisant of the fact that the assessment of whether the long-term condition is satisfied must be made looking at the situation as it was at the time of the alleged discriminatory conduct and not with the benefit of hindsight. However, the evidence of the significant improvement in the claimant's level of exhaustion

and fatigue simply confirms my conclusion that the longevity of the effects was directly linked to the claimant's not making reasonable changes to his lifestyle.

106. It follows that I find that the claimant did not have a disability within the meaning of s.6 Equality Act 2010 by reason of "exhaustion and debility".

Migraine

107. I accept, and it was not argued otherwise by the respondent, that migraine is a medical condition that amounts to an impairment. Whether it is physical or mental impairment is not material and not something I need to resolve to determine the issues before me.

108. The impairment condition, therefore, is satisfied, and the real question is whether the claimant's migraines had a substantial adverse effect on the claimant's ability to carry out day-to-day activities, and if so, whether the adverse effect was long-term.

109. The statute (s.212(1) EqA 2010) says that effect will be substantial if it is "*more than minor or trivial*." It is not immediately apparent whether "minor" and "trivial" are used to describe different properties, or intensity, or propensity of the same "effect", or just as synonymous terms. If the former, it is not obvious to me where, as a matter of ordinary language, those lines are to be drawn. If the latter, using two adjectives to describe the same "effect" when one would be sufficient seems superfluous and is unlikely to be what Parliament intended.

110. However, nothing turns on this. The way the definition is worded ("*substantial" means more than minor or trivial*) seems to me that only one of the two qualifications need to be satisfied for the effect to be substantial. That is to say that if I find that the effect was more than "minor" I do not need to consider whether it was more than "trivial" as well, because it would already be substantial, even if I were to find that it was no more than "trivial". Equally, if I find that the effect was more than "trivial", it will be substantial, even if I do not find that it was more than "minor".

111. The claimant describes in his disability impact statements the symptoms of migraine attacks:

- o *vertigo,*
- *o altered vision, including:*
- *o visual Auras, commonly flashing lights and hallucinations,*
- *o on a number of exceptional occasions temporary loss of entire vision.*
- *o nausea and vomiting,*
- *o headache,*
- *o sensitivity to light and sound,*
- *o difficulty focusing,*

o lack of concentration, and
o slowed responses.

112. These symptoms are evidently serious. However, I must assess not the seriousness of the symptoms, as such, but how they, as the manifestation of the claimant's impairment of migraine, affect the claimant's day-to-day activities.

113. The claimant states in his disability impact statement that when he suffers from an occurrence of a migraine his ability to do day-to-day activities is affected substantially. He describes the above symptoms and that when he suffers them, he cannot focus on a computer screen thus making it impossible to do his job. He also says he feels unsteady on his feet and needs to lie down. He says that when symptoms are severe, he cannot read, write, or use screens at all.

114. He says that intensity and duration of symptoms vary from hours to "multiple days", and when they happen, he feels unsafe to work as a doctor.

115. In giving his evidence to the Tribunal, the claimant said that he would typically have migraines once or twice a week. This is consistent with what he reported to his GP. That means that he did not suffer the described symptoms on most of the days during a week.

116. Furthermore, except for one example when on 28 March 2022 the claimant attended a sickness review remote meeting from a dark room because of suffering from migraine (and even then, he asked for the meeting to go ahead), the claimant gave no other concrete examples of when migraine symptoms actually caused him not to be able to undertake a particular activity.

117. On the other hand, the claimant confirmed to me that he continued to drive long distances despite the risk of having a severe migraine attack and did not report to the DVLA what he describes as a "debilitating" condition making him feel unsafe to work.

118. Also, the claimant felt capable of taking on additional work as an appraiser in November 2021 and conducting colleagues' appraisals in March and May 2022, despite being signed off work. In June 2022, he felt able and safe to drive to the hospital in Peterborough to attend a meeting in his capacity as the Deputy Foundation Training Programme Director.

119. His medical records show significant periods when migraines are not raised with his doctors despite the claimant continuing to attend his GP practice with other health problems. The GP records do not record migraines as the claimant's "Active Problems" or "Significant Past".

120. I do have regard to the fact that the claimant's GP had been assessing the claimant as unfit for work due to migraines and debility from 14 December

2011 for four, six and even eight weeks at a time. This, however, in my view, is not conclusive.

121. Firstly, the claimant's evidence is that he had migraine attacks one or twice a week. It is during such attacks he claims his ability to carry out day-to-day activities was significantly affected.

122. The claimant does describe feeling foggy, spaced out, confused, and nauseated during what he calls "the post-migraine stage", and as a result having reduced response and thinking speed. The claimant claims that the post-migraine stage could endure over days and sometimes even into the next migraine episode. He, however, does not say how his ability to carry out normal day-to-day activities is affected during such post-migraine stage. In particular, he does not say what day-to-day activities are affected in that stage. He does not state how much more time he needs to complete such activities when compared with when he is not in the post-migraine stage.

123. Furthermore, the assertion that the claimant's migraines merged into some kind of a constant condition of reduced cognitive functionality with varying degree of intensity does not sit well with the fact that the claimant was able to continue to drive, attend on his demanding caring responsibilities, conduct colleagues' appraisals, attend a meeting in the hospital. It is also not supported by the claimant's medical evidence.

124. Finally, the claimant says in his disability impact statement that "*due to [his] increasing exhaustion [the migraines] began occurring more frequently*". As with respect of exhaustion and debility, in considering whether the migraines impairment had a substantial and long-term adverse effect on the claimant's ability to carry out day-to-day activities, I must take into account whether and if so, how far the claimant could reasonably be expected to modify his behaviour to prevent or reduce such effects. Therefore, my findings at paragraphs 99-105 above are equally applicable to migraines.

125. Stepping back and looking at the entire picture, I am not satisfied that the claimant has discharged the burden of showing on the balance of probabilities that his migraines at the relevant times had a substantial and long-term adverse effect on his ability to carry out normal day-to-day activities.

126. It follows, that I find that at the relevant times the claimant did not have a disability by reason of migraines.

127. Finally, for the sake of completeness, Ms Winstone in her closing arguments said that I should look at both impairments as a "combined disability" because they cannot be separated. I do not accept that. This is not how the claimant pleaded his case on disability, and not how he presented his evidence on this issue.

128. Furthermore, in ***Morgan Stanley International v Posavec*** EAT 0209/13, the EAT held that it was an error of law for the tribunal not to identify

the condition, which the tribunal found was the cause of the disability, and not to indicate what symptoms were attributable to the pleaded conditions.

129. In any event, given my findings and conclusions on each of the two claimed impairments, I am satisfied that even if considered cumulatively they do not amount to a disability within the meaning of s.6 Equality Act 2010.

Employment Judge Klimov

9 May 2023

Sent to the parties on: 10 May 2023

For the Tribunals Office: GDJ

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