EMPLOYMENT TRIBUNALS

Claimant: Miss S Burtoft

Respondent: Tangerine Holdings Limited

HELD AT: Manchester **ON:** 1 August 2017

BEFORE: Employment Judge Sherratt

REPRESENTATION:

Claimant: Miss J Hughes, Counsel
Respondent: Mr S Lewinski, Counsel

JUDGMENT

The judgment of the Tribunal is that the claimant was at the material time, 2 November 2016, a person with a disability for the purposes of section 6 of the Equality Act 2010 and her claim shall proceed to the final hearing scheduled to take place from 27-29 November 2017.

REASONS

Introduction

1. At a preliminary hearing on 12 May 2017 Employment Judge Franey listed a preliminary hearing to determine whether in November 2016 the claimant had a physical impairment which had a substantial adverse effect on her ability to carry out normal day-to-day activities, ignoring the effect of any medication, and which was at that time likely to last for 12 months or more.

2. The claimant provided a statement for the purposes of section 6 of the Equality Act 2010 to the Tribunal and to the respondent on 2 June 2017. Copies of her medical records were provided to the respondent.

3. In correspondence thereafter the respondent did not concede the question of disability and wanted an expert medical report.

4. The question of a medical report came before me at the start of this hearing and I determined that it was not necessary for there to be an expert medical report in order for the Tribunal to reach a conclusion on the question of the claimant's disability status.

The Facts

5. In her ET1 the claimant indicated that she provided her services to the respondent as a temporary agency member of staff from 11 October 2015 until she was taken on as a full-time permanent employee on 4 January 2016. She alleges that after a period of absence due to developing spondylosis and degenerative disc disease, her claimed disability, she returned to work and shortly thereafter was dismissed on 2 November 2016 for what she describes as the spurious reason of failing to have the necessary skill set to be able to carry out the job at the required level and therefore not being an effective member of the customer service team. The claimant says that the true reason for her dismissal was her disability.

6. The respondent's dismissal letter refers to the claimant's attitude, work level, work accuracy and standard procedure issues as the reasons why the claimant's employment was terminated.

7. The claimant contends that from July 2016 she met the definition of disability by virtue of her degenerative disc disease and cervical spondylosis. Her symptoms were extreme back pain, dizziness due to trapped nerves in her neck, headaches and weakness in her arms. She had substantial difficulty with a number of day-to-day activities which were listed. She took pain relieving medication without which she would not have been able to function at all. The condition was a permanent one and so the effects were long-term. The claimant advised her manager of this orally during a conversation in July 2016.

8. The claimant's evidence in chief was provided in her impact statement referred to above and in a supplemental witness statement. Her partner also provided a witness statement. Both were cross examined.

9. The claimant was born in July 1980.

10. When she was aged approximately 18 her left shoulder dislocated. She did not have treatment at the time it first happened and subsequently the shoulder has from time to time dislocated causing the claimant pain. She would relocate it herself or it would spontaneously relocate.

11. The claimant provided GP records going back to September 2014 when she registered with Harrowside Surgery. Significant past problems were listed in the records as 5 July 2016 migraine, 22 July 2016 classical migraine, 2 August 2016 cervical spondylosis without myelopathy and 13 September 2016 recurrent joint dislocation of the shoulder region.

12. The 5 July 2016 entry details the problem as migraine (first) following a history of trap spasm. Sumatriptan tablets and ibuprofen gel were prescribed.

13. On 14 July 2016 the surgery received the results of an x-ray of the claimant's cervical spine.

14. On 22 July 2016 the problem was classical migraine (first) with a history of migraine/visual disturbances/nausea/neck ache. See x-ray report of the cervical spines. Further medication was prescribed.

15. The 2 August 2016 entry is for cervical spondylosis without myelopathy (first) for which the claimant was to be referred to a physiotherapist.

16. On 2 September 2016 the history is recorded as:

> "Started with neck pain two months ago, had x-ray, CX spondylosis. Been referred for physio appointment not until end of September. C/O pain in right arm and right leg two weeks, headache every day, also migraine as well. C/O arms are aching and feels weak. On examination neck movement was limited to all directions, worse on right side due to pain…"

17. Further medication was prescribed and a fit note was issued advising that the claimant was not fit for work because of cervical spondylosis from 2 to 16 September 2016.

18. On 13 September 2016 the claimant attended her GP again in respect of cervical spondylosis without myelopathy when she was certified as unfit for work for four weeks for the same reason. At this visit a second problem was noted – recurrent joint dislocation of the left shoulder region.

19. On 28 September 2016 there was a further fit note in relation to cervical spondylosis without myelopathy but the claimant may be fit for work taking into account a phased return and workplace adaptations with the doctor suggesting half time for one month with workstation adaptations.

20. On 25 October 2016 the claimant was reviewed and a further fit note was issued for the same reason indicating the claimant may be fit for work "with altered hours and adaptations – current situation is acceptable – please extend for a further four weeks".

21. There are no other significant entries in the claimant's medical records before her dismissal.

22. On 15 September 2016 the claimant's GP wrote to a Consultant Orthopaedic Surgeon in connection with the recurrent dislocation of the claimant's left shoulder because it was giving her considerable problems.

23. The claimant was seen towards the end of October 2016 and the report to her GP typed on 1 November 2016 referred to the claimant reporting that she has had:

> "…Multiple dislocations resolved with self relocation over the years. Recently it has been dislocating multiple times during the week and self relocating. She has learned to adapt her day-to-day activities with disuse…Her symptoms are worse and she is keen now to go through the orthopaedic pathway with a view of surgical stabilisation."

24. On 19 October 2016 at 10:04 the claimant, having returned to work, sent an email to her partner saying:

> "My collarbone is killing, think I will need to wear my sling tomorrow…"

25. According to the claimant, it was in or around the beginning of July 2016 when she started to develop pains in her neck. She was finding she was struggling to get comfortable in bed and her sleep was being disturbed. It was painful to move her neck from side to side or up and down and to lift things. She was especially uncomfortable at work, holding the telephone between shoulder and chin while speaking on the telephone and using a computer. She went to the GP who arranged for an x-ray to determine the cause of her daily pain.

26. As a result of the x-ray on 12 July 2016 the claimant was formally diagnosed on 2 August 2016 with cervical spondylosis. According to her GP, this was something usually found in people aged 60 or over. She was placed on pain relieving medication and referred to a specialist and to a physiotherapist. In the referral letter to the physiotherapist the GP also referred to spondylosis of the lumbar spine. The clinical notes only have a reference to a physiotherapist and not to a specialist.

27. Again according to the claimant the pain increased until by the end of August it was constant. She was struggling to get up in the morning and also suffering from migraines. It was painful to lift her arms which ached and felt very weak so it was difficult to get herself washed and dressed and she struggled to carry out jobs around the house, such as cooking and cleaning and she relied on her partner to do these. She was able to make it through the day at work but was finding it extremely painful and exhausting.

28. On 2 September 2016 the GP provided additional medication to try to alleviate the pain and signed her off work.

29. By the end of September 2016 the claimant was feeling better as her medication had started to take effect and the pain had decreased. She was anxious to get back to work. There was still pain and lots of things she could not do such as lifting shopping bags or hanging out washing, but if she paced herself and limited the tasks she undertook she could manage some things herself like getting washed and dressed. On 28 September 2016 the GP confirmed that she could return to work on a phased basis in accordance with the fit note referred to above.

30. The claimant spoke to her manager saying she was fit enough to come back to work on reduced hours with adaptations such as a headset.

31. The claimant returned to work on 3 October 2016 for four rather than eight hours a day without any other adaptations.

32. From July 2016 the claimant says that she suffered from chronic pain, pins and needles type pain in her neck going up into her head, pins and needle type pain in her lower back especially down her right side from hip to ankle, dizziness, loss of balance and migraines.

33. The claimant's day-to-day activities were affected, including:

(a) Difficulty caring for children as unable to take them out anywhere involving periods of walking or standing.

(b) Difficulty walking distances longer than 200 metres. Unable to participate in family outings. Going to the shops is difficult.

(c) Sleep disturbance due to pain.

(d) Struggle to sit for lengthy periods causing issues at work.

(e) Difficulty preparing or cooking a simple meal.

(f) Difficulty carrying out domestic chores such as washing and cleaning.

(g) Difficulty bathing and getting dressed. Partner assists.

(h) Difficulty washing, drying and straightening hair as difficult to keep arms raised above head for any length of time.

(i) Difficulty managing toilet needs.

(j) No longer socialise as too painful to go out, often tired and lack motivation.

34. The claimant believes that if she were not to take the medication, based on how she was feeling between July 2016 and the end of September 2016, she would not be able to get out of bed and live her life day-to-day because of constant pain preventing her having any quality of life.

35. In her supplemental witness statement the claimant recounted that she suffered from migraines for a number of years prior to the onset of this condition. They were fairly mild compared to the ones she now suffers from. The recent migraines are caused as a result of the neck pain from the cervical spondylosis. Once she has taken her migraine medication she has to take herself off to bed until the symptoms have subsided, but this is not usually until the next day. The claimant accepted in cross examination that she had not had any time off work with migraines from 3 October to her dismissal.

36. When the claimant went to see the GP on 13 September 2016 she took the opportunity to discuss her shoulder dislocation as she was conscious this was a problem that needed resolving at some point. According to the claimant this is completely unrelated to the cervical spondylosis. The shoulder problem has not been resolved but she can live with it for the time being. The pain is limited to the shoulder joint itself and does not radiate elsewhere. It is a very different type of pain from the one in her neck.

37. The claimant takes approximately 30 tablets each day including:

(a) Gabapentin – for nerve pain.

(b) Naproxen – an anti-inflammatory to relive pain in back and neck.

(c) Dihydrocodeine – pain relief for severe pain.

(d) Hyoscine Butylbromide – to treat stomach cramps which is a side effect of other medication.

(e) Lactulose – to treat constipation which is a side effect of the other medication.

(f) Promethazine Hydrochloride – to aid sleeping.

(g) Rizatriptan – migraine relief.

(h) Omeprazole – to protect stomach from strength of painkillers.

(i) Sumatriptan – migraine relief.

(j) Paracetomol – pain relief.

38. From her ET1 the claimant referred to 2 November 2016 when she was feeling much better and she had decided to approach management to ask if she could return to normal hours and normal responsibilities, but before this could be done the respondent held a meeting which led to the termination of her employment.

39. In cross examination the claimant was asked about the 5 July 2016 migraine where there was no reference to spondylosis. She said it would tie in with the date when she was referred for an x-ray of her spine. She agreed that spondylosis was the only reason given for her sickness absence from work. Her migraines had been more recurrent since the diagnosis of spondylosis. She did not agree she had exaggerated their effect. They were more serious from July 2016. They increased from once every three months to two migraines a week. She agreed that her statement as to going to bed could not be true if she had not taken time off work, but she did not like to take time off work.

40. The claimant agreed that the cervical spondylosis was a degenerative condition which could have varying degrees of seriousness and although treatable with an operation there was a high risk of problems. The medication took away some of the pain.

41. The claimant was taken to a document in the bundle which came from the internet dealing with cervical spondylosis:

> "It is a condition where your cartilage and bones wear down because of age thus resulting into abnormal spinal function. It usually strikes individuals over 40 years old… Symptoms include neck stiffness and pain, tingling, weakness, numbness or pain in hands, chest, arms and shoulders, abnormal reflexes, lack of coordination and loss of bowel and bladder control. Treatment usually

> includes over the counter pain medications and anti-inflammatory medicines, muscle relaxants, corticosteroid injections, rest, physical therapy, back braces and even hospitalisations with tractions to immobilise the neck. Prognosis of patients undergoing non operative treatment is excellent. In fact about 80-90% of patients report improvement however symptoms may recur to about one third of patients. If all other conventional method of treatment fails and your pain gets worse then surgery might be the only option left, although studies have shown mixed results when it comes to its effectiveness."

42. An NHS Choices extract on symptoms of cervical spondylosis makes reference to neck pain and shoulder pain which can be severe in some cases. Occasional headaches may also occur which usually start at the back of the head, just above the neck and travel over the top to the forehead. Pain usually comes and goes with flare-ups followed by symptom free periods. Around one in ten people develop long lasting (chronic) pain.

43. The claimant had not been offered any operative treatment.

44. The claimant managed to wash and dress with the help of her partner and she went to work. Although she had had physiotherapy the physiotherapist said that it was not the right sort of therapy for her so she stopped after four sessions.

45. With regard to the shoulder mentioned on her 13 September visit to the GP, there was a recurrent joint dislocation causing problems at that time. It had happened a couple of times. The claimant asked to be referred to the consultant. The shoulder was not mentioned in the first witness statement on disability because it was not the issue. It happened rarely but did at the time of her visit to the GP so she mentioned it. She could live with the shoulder problem. It was not a regular thing. She was not relying on the shoulder as a disability. It had not dislocated in the previous six months since they moved to a new house. The shoulder did not stop her from doing anything. Before she had the issues with her spine it never stopped her doing things. The shoulder did give considerable problems. It was very painful. She would cry but she would pop it back in and continue with her day. It would not make her go off work.

46. The medication mainly improved the claimant's condition. Symptoms had been improved when she went back to work on 3 October 2016. The shoulder had popped out the day before she wrote the email to her partner making reference to it. The collar bone was painful.

47. When the claimant went for the appointment with regard to the shoulder although she had told the truth the doctor may have exaggerated things in the letter to her GP.

48. By 2 November 2016 the claimant agreed that there had been significant recovery. She was not 100% but sufficiently better to try to do full-time hours. The symptoms decreased.

49. The claimant agreed that although at work she could not lift anything and had regular breaks people would have seen an improvement in her condition, allowing her to return to full-time hours.

50. The claimant agreed she had not subsequently returned to the GP in relation to spondylosis until February 2017.

51. The claimant's partner, Mr Carl Stevenson, gave evidence in support of the claimant and was cross examined to the extent that he agreed that his statement was based upon what the claimant had told him and what he had observed. He gave evidence as to the assistance that he provided to the claimant in relation to her personal care and in their home.

Submissions

52. For the respondent Mr Lewinski referred to **Richmond Adult Community College v McDougall [2008] IRLR 277**, a decision of the Court of Appeal consisting of Lords Justices Pill, Sedley and Rimer on 17 January 2008 in relation to the Disability Discrimination Act 1995, precursor to the Equality Act 2010.

53. In the judgment of Lord Justice Pill:

> "The decision, which may later form the basis for a complaint to an Employment Tribunal for unlawful discrimination, is inevitably taken on the basis of the evidence available at the time. In my judgment, it is on the basis of evidence as to circumstances prevailing at the time of that decision that the Employment Tribunal should make its judgment as to whether unlawful discrimination by the employer has been established. The central purpose of the Act is to prevent discriminatory decisions and to provide sanctions if such decisions are made. Whether an employer has committed such a wrong must, in my judgment, be judged on the basis of the evidence available at the time of the decision complained of."

54. Lord Justice Rimer on the question of whether the claimant was a disabled person at the time of the commission of the allegedly discriminatory act said:

> "Whether her impairment was 'so likely to recur' required an assessment of the evidence available at the relevant time. That was the only evidence to which the employer could have regard in determining whether the respondent was a disabled person who might require special consideration. It was also that evidence to which the Employment Tribunal had to have regard in considering the same question."

55. In **Richmond** the claimant, who had a history of mental health problems, had an episode lasting some six months but no evidence of a likelihood of recurrence. It was held to be necessary to look at the evidence available at the time and not with the benefit of hindsight.

56. In this case, Mr Lewinski submitted, the evidence available to the employer as at 2 November 2016 was of an employee who had been off sick for less than a month, who had returned on a phased basis allowing her to be ready to go back to full duties. The claimant was on an upward trajectory. She had had time off to recover, had returned on a phased basis was wanted to go back full-time. This followed the usual course. On the basis of Richmond, without hindsight, there was no reason to believe the claimant would deteriorate.

57. There is no expert evidence available to the Tribunal but he quoted the article which refers to 80/90% improving – the vast majority improve. The claimant has a variable condition that lots of people get some form of. Not everyone who has it is disabled. It is necessary for the Tribunal to look at the impairment as at 2 November 2016. The claimant had not said when she could not do cooking etc. She had indicated in answer to the Tribunal that her walking might not have been limited at the start of the problem but it was now.

58. The claimant had exaggerated the evidence as to the migraines.

59. The shoulder problem corresponded with when the claimant was off sick. The time the shoulder improved coincided with the claimant's return to work. The claimant was in severe pain when it dislocated and if this happened several times a week then she would be in constant pain. See the letter from the consultant who can only have got the information from the claimant.

60. The claimant had not suggested the shoulder was a disability. It was something she could live with, but this was part and parcel of her pain and symptoms leading to the improvement on 2 November 2016.

61. By 2 November 2016 the claimant was on an upward trajectory suggesting she was one of those in the vast majority where her symptoms would improve and she could do full-time work. The claimant, in his submission, had not been able to demonstrate she was disabled then, other than with hindsight.

62. Miss Hughes made submissions on behalf of the claimant. Much of the claimant's evidence as to what she could and could not do had not been challenged. She had told her manager of her diagnosis.

63. Looking at the medical records it was hard to see a picture of recovery. The evidence is clear that the problem was long-term and substantial.

64. The Tribunal should take a purposive approach to the decision on the question of disability. The claimant told her employer of a long-term illness and she went from doing well to being dismissed.

65. The shoulder injury was a red herring. In her submission there was little correlation between the shoulder and the spondylosis.

The Relevant Law

66. Section 6 of the Equality Act 2010 provides that:

> "(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."

67. Schedule 1 to the Equality Act 2010 provides supplementary provision with regard to disability. Of relevance here is paragraph 2, long-term effects, which provides that:

> "(1) The effect of an impairment is long-term if –
>
> (a) It has lasted for at least 12 months,
>
> (b) It is likely to last for at least 12 months, or
>
> (c) It is likely to last for the rest of the life of the person affected.
>
> (2) If an impairment ceases to have a substantial adverse effect on a person's ability to carry out normal day-to-day activities, it is to be treated as continuing to have that effect if that effect is likely to recur."

68. The effect of medical treatment is dealt with at paragraph 5 which provides:

> "(1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities, if –
>
> (a) Measures are being taken to treat or correct it, and
>
> (b) But for that, it would be likely to have that effect.
>
> (2) 'Measures' includes…medical treatment…"

69. Guidance on matters to be taken into account in determining questions relating to the definition of disability (2011) was issued by the Secretary of State under the Equality Act 2010.

70. From the Guidance:

> "'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.
>
> Whether a person is disabled for the purposes of the Act is generally determined by reference to the effect that an impairment has on that person's ability to carry out normal day-to-day activities."

71. As to "substantial", a substantial effect is one that is more than a minor or trivial effect as stated in the Act at section 212(1).

72. Where an impairment is subject to treatment, the impairment is to be treated as having a substantial adverse effect if, but for the treatment or correction, the

impairment is likely to have that effect. In this context, "likely" should be interpreted as meaning "could well happen". The practical effect of this provision is that the impairment should be treated as having the effect that it would have without the measures in question.

73. When looking at long-term effects "likely" should be interpreted as meaning that it "could well happen".

74. In assessing the likelihood of an effect lasting for 12 months, account should be taken of the circumstances at the time the alleged discrimination took place. Anything which occurs after that time will not be relevant in assessing this likelihood. Account should also be taken of both the typical length of such an effect on an individual and any relevant factors specific to this individual (for example, general state of health or age).

75. Normal day-to-day activities are things people do on a regular or daily basis. Examples include shopping, reading and writing, having a conversation, getting washed and dressed, preparing and eating food, carrying out household tasks, walking and taking part in social activities.

Discussion and Conclusions

76. I find that the claimant has a physical impairment in the form of cervical spondylosis without myelopathy as diagnosed by the claimant's GP on 2 August 2016 following an x-ray of her cervical spine.

77. The claimant was not cross examined on the contents of her witness statement in relation to the impact of the impairment on her normal day-to-day activities. The claimant set out a number of day-to-day activities that were adversely affected, and on the basis that "substantial" is to be taken as meaning more than trivial, I find that the matters described by the claimant amount to a substantial adverse effect on her ability to carry out normal day-to-day activities.

78. Mr Lewinski submits that the claimant was affected by her shoulder dislocating as well as by the spondylosis. I am satisfied that the claimant, having lived with her problematic shoulder for some 18 years and suffered the pain from it following each episode of dislocation, is able to distinguish between pain emanating from her shoulder and that from her cervical spine. The claimant was certain that the adverse effect on her ability to carry out normal day-to-day activities was caused by the spondylosis and not by the problem with the shoulder. I accept her evidence on this point.

79. I find that without the medical treatment, in the form of medication, the claimant would have been even more severely restricted. The evidence is that the medication helped the claimant to do more things for herself and that it enabled her to get back to work.

80. As to long-term, I must take account of the circumstances at the time the alleged discrimination took place in early November 2016.

81. The claimant had been diagnosed in August 2016. The diagnosis was of a situation that would be permanent rather than something that might recur. She did not have a "bad back" which would recover after three months and thereafter not recur unless the claimant did something to cause further problems. The claimant was diagnosed with a degenerative condition of the spine, usually striking individuals over 40 years old, when she was just 36. Although with medical treatment the claimant improved, without it she would have been in constant pain.

82. As at 2 November 2016 the effect had not lasted for 12 months. In my judgment given the nature of the diagnosis this is a permanent physical condition, rather than a transient physical or mental condition that would be unlikely to recur, and therefore was, from the time of the first onset, likely to last for at least 12 months and is likely to last for the rest of the life of the claimant.

83. I remind myself that the American extract refers to the prognosis of patients undergoing non operative treatment being excellent, with 80-90% reporting an improvement; however symptoms may recur to about one third of patients. Whilst there is reference to improvement there is no evidence of the condition being cured.

84. I therefore conclude that the claimant was at the material time, 2 November 2016, a person with a disability for the purposes of section 6 of the Equality Act 2010 and her claim shall proceed to the final hearing scheduled to take place from 27-29 November 2017.

Employment Judge Sherratt

7 August 2017

RESERVED JUDGMENT AND REASONS
SENT TO THE PARTIES ON

10 August 2017

FOR THE TRIBUNAL OFFICE