EMPLOYMENT TRIBUNALS

Claimant: **Mr C Rogers**

Respondents: **(1) The Press Association**
(2) Easysoft Limited

Heard at: Leeds **On:** **8 November 2018 (and in chambers on 14 November 2018)**

Before: Employment Judge Bright (sitting alone)

Appearances
For the claimant: In person
For the respondents: Mr N Siddall (Counsel for First Respondent)
Mr B Frew (Counsel for Second Respondent)

RESERVED JUDGMENT ON PRELIMINARY ISSUE

The claimant was not a 'disabled person' for the purposes of the Equality Act 2010 at the material time.

REASONS

Background

1. Mr Rogers presented claims on 4 April 2018 of disability discrimination concerning the withdrawal by the First Respondent ("PA") of an offer of employment to him in November 2017 following an alleged conversation with the Second Respondent ("Easysoft").

2. Mr Rogers' complaints are:

   2.1. Section 13 Equality Act 2010 ("EQA"), direct discrimination in relation to Easysoft disclosing to PA that he suffered from a mental health condition and PA withdrawing its offer of employment. Mr Rogers says he was treated less favourably by both respondents than a hypothetical comparator because his asserted or perceived disability materially influenced the respondents' conduct.

2.2. Section 15 EQA, discrimination arising from disability against PA. Mr Rogers says PA had concerns about employing someone who had been signed off work for mental health reasons, which was 'something arising' in consequence of his disability and that those concerns materially influenced PA's decision to withdraw the offer of employment.

3. The preliminary hearing held on 8 November 2018 was to consider whether Mr Rogers was a 'disabled person' as defined by the Equality Act 2010 ("EQA") at the material times. If Mr Rogers is found to have been a disabled person, both complaints set out above will proceed. If Mr Rogers is found not to have been a disabled person, the section 15 complaint will be dismissed. The section 13 complaint may be dismissed (if the claim is pursued on the basis of Mr Rogers' actual disability) or it may proceed (if the claim is pursued on the basis of a perceived disability).

4. It was agreed at a previous preliminary hearing on 21 August 2018 that the issues for this preliminary hearing were therefore:

4.1. Did Mr Rogers have a mental impairment at the material times (20 to 24 November 2017), namely depression?
4.2. If so, did the impairment have a substantial adverse effect on his ability to carry out normal day-to-day activities?
4.3. If so, was that effect long term? In particular, when did it start and:
4.3.1. Had the effect lasted for at least 12 months?
4.3.2. Was the effect likely to last at least 12 months?
4.4. Were any measures being taken to treat or correct the impairment?
4.5. But for those measures would the impairment be likely to have had a substantial adverse effect on his ability to carry out normal day-to-day activities?

Evidence and submissions

5. Mr Rogers gave evidence on his own behalf and Easysoft called Mr S Hill, owner and managing director, to give evidence. The parties also provided an agreed bundle of documents of 106 pages. I read only those pages to which I was directed by the parties. References to page numbers in these reasons are references to the pages in the agreed bundle.

6. Mr Siddall made written and oral submissions which I have considered with care but do not repeat in full here. In essence it was submitted that:
6.1. Mr Rogers' evidence on his alleged disability was not reliable, what he told the GP flatly contradicted what he now says, the GP records are more reliable and his statement to PA on 25 November 2017 shows a willingness to mislead.
6.2. Either the GP notes show there was no disability or Mr Rogers cannot discharge the burden of proof. His pleaded symptoms only amount to low mood, not a depressive disorder, there can be no finding of a mental impairment and even if he gets over the other hurdles, he cannot show that the effect was long term.

7. Mr Frew made oral submissions endorsing those of Mr Siddall and making some further submissions. I have considered those submissions with care but do not repeat them in full. In essence, Mr Frew submitted in addition that, in the **DLA Piper** case (see below), the Employment Appeal Tribunal ("EAT") highlighted the distinction between symptoms of low mood and anxiety caused by clinical depression and those arising from adverse life events. Mr Rogers has described adverse life events and reported these to his GP, the effect of which was not constant and did not amount to a disability.

8. Mr Rogers made oral submissions which I have considered with equal care, but do not repeat here in full. In essence, he submitted that:

   8.1. His condition lasted up to 2 years and did not tie in with specific events. The effects, such as driving to Glasgow, were part of a deep depression.

   8.2. One in 5 people suffers mental health problems, but less than 1 in 5 presents to their GP with them. He presented 4 or 5 times with his condition, but did not want to talk about it. He played down the effects when he was in a clinical environment, but then broke down at home. Many people who take their own lives do not exhibit a medical history as clear as his.

Facts

9. I made the following findings of fact. Where there was a dispute on the facts, I resolved it, on the balance of probabilities, on the evidence before me.

10. It was agreed that the material time was the period 20 to 24 November 2017.

11. The respondents challenged the veracity of Mr Rogers' account of his condition and its effect on him. They argued that the version he now gives of this alleged condition and its effect upon him is inconsistent with the history given to his treating GP at the relevant time. The respondents submitted that Mr Rogers' evidence was unreliable and that the GP notes were the best guide to his true condition.

12. The GP notes (pages 60 – 65) record the following:

   12.1. No history of Mr Rogers' mental health being raised with a doctor until 20 January 2017, when the GP recorded low mood, specific issues (unemployment, "certain situations", driving penalties), symptoms of being a "little snappy, aggravated, intermittent low mood", but that Mr Rogers was sleeping "ok", coping well with his 15 month old baby, had no self-harm or suicidal thoughts, could see a brighter future and thought he would feel better when his driving penalties were sorted out. The diagnosis was stress or low mood, as a normal reaction to his current life situation. The GP specifically recorded that he was "not currently fitting with depressive disorder" and advised him against anti-depressants.

   12.2. A further telephone call on 20 January 2017 in which the claimant stated that he would like to start taking anti-depressant medication. He was prescribed a starting dose of 20mg fluoxetine daily.

   12.3. A further history of 7 attendances at the GP between March and October 2017 for gastric and oesophageal/chest complaints, but no reference to mental health.

12.4. An entry on 1 November 2017 when he attended with work stress, had restarted anti-depressants and was "passively suicidal". The GP recorded that he had taken the anti-depressants for one month but it was "no help", that he had gambling debts, did not sound to have any 'me' time as a release, and was advised that the anti-depressants were unlikely to help, so to stop taking them. Mr Rogers was issued with a sick note and told to use the time to "reappraise: more exercise and engagement with friends".

12.5. Further entries on 9 November 2017 and 23 November 2017 described "work-based stress" but "more positive, feels mood contextual to work which now resolved" and, on 23 November 2017, "much more positive in self, stress alleviated from old employment, starts new job next week. Reviewed learning re stress management and wellbeing, factors to consider and perhaps incorporate into lifestyle etc. Discharge agreed today".

12.6. The next entry dated 21 December 2017 recorded Mr Rogers reporting ongoing anxiety and, on 22 December 2017, depression.

12.7. On 4 January 2018 it is recorded that he had a "new episode" of depression, and he was prescribed a starting dose of Sertraline (50mg) daily.

13. I find that the medical records therefore indicate that Mr Rogers was not diagnosed with depression at any time until possibly 22 December 2017 or 4 January 2018, (and even those entries are not explicit as to diagnosis). The GP notes record, rather, two occasions of low mood and stress in response to specific triggers (on 20 January 2017 and 1 November 2017), followed by further attendances in November and December 2017, when his mood fluctuated because of work related stress. There is no clear reference in the medical records to any effects on Mr Rogers' normal day-to-day activities. There is a reference to "engaging with friends" and "exercise" on 1 November 2018, which may imply that he was not doing those activities or had ceased doing those activities. The time period of the medical records, while almost spanning a year, appears to have significant gaps during which it appears Mr Rogers was not taking medication or under his GP for mental health issues. Mr Rogers now says he suffered effects until June 2018 but there are no medical records in the bundle after 4 January 2018. There is therefore no evidence of any effects lasting 12 months.

14. However, the GP notes are not the only evidence available to me. Mr Rogers gave evidence, by way of an 'impact statement' (pages 46 – 48). In that statement he recorded feeling the effects of depression in June 2016 after being made redundant. He recorded becoming more introverted, becoming withdrawn, choosing to sit in the car rather than help with his son's nursey run and working from a pub rather than having to interact with people. He reported that his sleep was "terrible". He described these effects as continuing for the next two years, until June 2018. He reported giving up playing golf, travelling in a separate car to his family to avoid their company and having sudden attacks of severe anger, causing him to hit walls or kick items, throw plates and scream and cry in bed. He reported that his condition caused tension and distance in his relationship with his partner and he spent less time with friends. He reported being unable to concentrate and sitting in a boardroom at work browsing the internet or looking out of the window because he could not concentrate. There was no evidence presented, other than the GP notes, which could corroborate any of these assertions.

15. The respondents submitted that Mr Rogers was exaggerating the effect of his condition in his impact statement and that the GP records are the true record of his state of mind and its effect on his normal day-to-day activities at the material time.

16. Mr Rogers acknowledged in his impact statement that the GP notes did not report substantial adverse effects of his condition. He explained that this was because he down-played his condition and its effects when he saw the GP. He says, when he saw the GP in January 2017 for example he tried to hide his condition, but after the appointment realised he needed antidepressants. When asked about the apparent discrepancy between the impact statement and the GP notes in cross examination Mr Rogers explained that his partner pressured him to attend the GP, that he did not feel comfortable being honest about his mental health and that his presentation at the GP was not therefore a true reflection of his condition.

17. I noted that Mr Rogers' evidence about his condition and its effects at the preliminary hearing included significant details which were not included in his impact statement. He reported, in particular, an occasion in 2016 when he drove from Leicester to Glasgow without reason because he felt suicidal and depressed. That occasion is not mentioned in his GP notes, his claim form, his further information nor his impact statement. When questioned about it in cross examination, he accepted that, if he did not mention it when he saw the GP a month later, it was probably because he had recovered and tried to "play it down". He suggested that he did not come across as the "stereotype" of someone with depression and accepted that he withheld information from the GP, even though he understood that the GP needed that information to treat him. Mr Rogers also suggested at the preliminary hearing that his GP had attributed his concerns about his other conditions (gastric/chest issues) to stress and anxiety. This too was not mentioned in the GP notes, his claim form or impact statement and, when pressed, he accepted that it was in fact a GP friend who suggested the connection. I considered that these omissions from his previous evidence were significant.

18. I accepted Mr Rogers' submission that many people with mental health difficulties, even suicidal tendencies, never present to their GP, and it can be very difficult to own to having mental health difficulties. However, despite going to the GP apparently specifically to obtain help with his mental health, Mr Rogers did not simply down-play the effects, he told the GP the opposite of what he now says was the reality. For example, on 20 January 2017 he told the GP he was 'sleeping ok', while impact statement records that he was 'sleeping terribly'. He explained in cross examination that that was because he might have had a week's good sleep in the lead up to the GP appointment, but I do not accept that, had he been sleeping terribly for a long period of time, he would have omitted to mention that when asked about his sleep. He accepted that the impression he gave the GP was that he was not suffering from depression. It is not plausible, in my view, that Mr Rogers would repeatedly go to see the GO but tell them the opposite of the truth, if he was indeed suffering ongoing depression with the symptoms he describes in his impact statement.

19. The respondents referred me to a letter from Mr Rogers to PA (page 103) in which he refuted that he had any mental ill-health difficulties, as evidence that Mr Rogers was being untruthful either in that letter or in his impact statement. I

accepted Mr Rogers' evidence that an employee who believes they have been denied a job offer because of actual or perceived mental health difficulties may well seek to refute that. However, it is clear that both that letter and the impact statement cannot be a true account of his mental health, as they contradict each other.

20. On balance, I found that Mr Rogers' evidence was inconsistent. What he said in his claim form and further information differed from his impact statement which differed from his evidence in cross examination. None of that evidence was consistent with his GP records or the letter on page 103. He suggested at this preliminary hearing that his depression manifested in different ways and that at certain times he expected life to improve and so anticipated improvements which did not manifest. However, I found some of his explanations (for example, that he was in "the depths of depression but not anticipating that it will happen again") to be contrived and contradictory, such that they became implausible. His evidence that he went to the doctor for help with his depression but then downplayed it to such a degree that he was advised against anti-depressants and not given a diagnosis of depression was also contradictory.

21. On balance, I found the contradictions too significant to ignore. I therefore find that Mr Rogers' evidence was not plausible. I preferred the evidence presented by the GP notes and the letter at page 103, as the only contemporaneous records of Mr Rogers' account of his condition. There is not sufficient evidence for me to conclude that Mr Rogers has intentionally exaggerated his condition however. I consider that it is more likely that his recollection of his previous condition has been coloured by subsequent events. But for that reason, I consider the contemporaneous documents a more reliable source of evidence than the impact statement and his evidence at the preliminary hearing.

22. I have not attached any particular weight to Mr Hill's observations that Mr Rogers appeared to lead a full and busy life in and outside his employment, as these appeared to have little foundation and related mainly to the issue of the Easysoft's knowledge of any disability.

The law

23. Section 6 EQA provides:

(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

24. Schedule 1 EQA provides:

2. Long-term effects

(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.

…

3. Effect of medical treatment

(1) An impairment is to be treated as having a substantial adverse effect on the ability of the person concerned to carry out normal day-to-day activities if –

(a) measures are being taken to treat or correct it, and

(b) but for that, it would be likely to have that effect.

(2) "Measures" includes, in particular, medical treatment and the use of a prosthesis or other aid.

25. Mr Siddall directed me to a number of relevant cases in his written skeleton argument, of which the following are most useful:

25.1. **Aderemi v London and South Eastern Railway Ltd** [2013] ICR 591 in which the EAT held that the focus of a Tribunal must be upon what a claimant cannot do as a result of his physical or mental impairment and that, unless a matter can be classified as within the heading "trivial" or "insubstantial", it must be treated as substantial.

25.2. **Mutombo-Mpania v Angard Staffing** [2018] UKEAT/0758/17 in which it was stated that evidence of a condition's broad effect was not sufficient: "It was not sufficient for [the claimant in that case] to refer to headaches, tiredness and so on without linking that to his ability to carry out the activity…"

25.3. **Anwar v Tower Hamlets College** [2010] UKEAT/0091/10 in which it was held that an effect can be more than trivial, yet still minor rather than substantial.

25.4. **Herry v Dudley MBC** [2016] UKEAT/0100/16, approving a passage at paragraph 42 from **J v DLA Piper** UKEAT/0263/09**,** in which the EAT drew a distinction between clinical depression and reaction to adverse circumstances and recommended that a tribunal start by considering the adverse effect issue and, if the Tribunal "*finds that the claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for 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".*

Determination of the issues

26. Following the approach in **J v DLA Piper**, rather than focus on whether Mr Rogers was diagnosed with clinical depression and therefore had a mental impairment, I propose to consider the effects of his condition first. As set out at paragraph 14 above, there is no clear reference in the medical records to any effects on Mr Rogers' normal day-to-day activities. While his impact statement recorded that his sleep was terrible, there was a clear reference in the GP notes to his sleep being 'ok'. At best, there is a recommendation to consider "engaging with friends" and "exercise" on 1 November 2018, which may imply that he was not doing those activities or had ceased doing those activities. That may accord with him giving up golf and withdrawing from social contact, as reported in his impact statement, but given the lack of clarity in the GP notes and my concerns about the reliability of the impact statement, I did not consider that there was sufficient evidence to discharge the burden of showing that any adverse effect on his day-to-day activities was more than minor or trivial.

27. Separately, even if Mr Rogers succeeded in showing that his condition had a substantial adverse effect on his day-to-day activities, there is insufficient evidence that that effect lasted for a year, was likely to last for a year or likely to recur. The relevant entries in the GP notes, while almost spanning a year, appear to have significant gaps during which it appears Mr Rogers was not taking medication or under his GP for mental health issues. Not only that, but he was attending the GP with other concerns and, although he now says he considered that they may have also been symptoms of stress or depression, he accepted that he did not raise that with the GP at the time. I do not find it plausible that he attended a number of consultations with his GP to diagnose symptoms, which he attributed to his mental health problems, but he failed to mention both that attribution and that he was suffering substantial adverse effects on his normal day-to-day activities as a result of his mental health.

28. I find that it did not have a substantial long term adverse effect on his normal day to day activities. I accepted the respondents' submission that Mr Rogers may have suffered some episodes of reactive stress or low mood, but that there was insufficient evidence to suggest that there was sufficient length of effect for it to be down to 'clinical depression' rather than adverse life events. The distinction drawn in the cases of **J v DLA Piper** and **Herry** seems particularly relevant, and in the circumstances, I conclude that Mr Rogers did not therefore suffer from a mental impairment. The medical records themselves indicate that Mr Rogers was not diagnosed with depression at any time until possibly 4 January 2018, (and even that entry is not explicit as to diagnosis). The GP notes record, rather, two occasions of low mood and stress in response to specific triggers (on 20 January 2017 and 1 November 2017), followed by further attendances in November and December 2017, when his mood fluctuated because of work related stress. I find that any mental impairment and/or substantial adverse effect only commenced in November 2017 and did not last for 12 months nor was likely to last for 12 months or recur, on the basis that the GP records end on 4 January 2018 and Mr Rogers himself says he recovered in around June 2018.

29. I therefore find that the claimant was not a 'disabled person' at the material times, for the purposes of the Equality Act 2010

14 November 2018

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Employment Judge Bright

Sent to the parties on:

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For the Tribunal:

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