EMPLOYMENT TRIBUNALS

Claimant: **Ms A. Kunicki**

Respondents: **Commissioner of Police for the Metropolis**

Heard at: **London Central** **On: 12 January 2018**
Before: **Employment Judge Goodman**

Representation
Claimant: in person
Respondent: Ms L. Bell, counsel

PRELIMINARY HEARING JUDGMENT

The claimant is not a disabled person within the meaning of the Equality Act 2010.

REASONS

1. This preliminary hearing is to decide whether the claimant was disabled within the meaning of the Equality Act 2010.

2. Other issues within these claims of discrimination because of sex, race and disability are listed for final hearing from 17 May to 21 June 2018. The claims, first presented in August 2016, concern events from 2011 onwards, though there is some relevant background in a claim for earlier harassment which was settled. The claimant is still serving as a police constable for the respondent.

Evidence

3. The claimant had prepared a witness statement on the impact of impairment on the ability to carry out day-to-day activities. This sets out the position in early 2017. I also read an earlier draft from November 2016 which included some of the same material but focused more on her ability to do her job and how events at work related to her impairment. The respondent accepted the claimant's evidence on this, and she was not cross-examined.

4. The claimant told the Tribunal she accepted the accuracy of the symptoms recorded from time to time in her GP records, and explained that she still drinking

at the same levels except on working days when she limits herself to 2 pints of lager.

5. I also read the general practice records for February 2007 to March 2017 in the hearing bundle, including reports from counsellors and hospitals, and the occupational health records, which include reports from two consultant psychiatrists to whom she was referred.

6. There was expert evidence obtained for the tribunal proceedings, from psychiatrist, Dr Amir Bashir, who was jointly instructed on 11 April 2017. There is a report of 23rd of May 2017 which is based on a review of the records, the claimant's impact statement, and two interviews with her. There is then a follow-up report, answering questions addressed to Dr Bashir by both the claimant and the respondent. Finally there is a report on 30 November 2017 to cover the extended period. This is based on respondent's instructions only. I read these reports, and the letters of instruction, and the letters asking questions of the expert.

7. The claimant submitted to the tribunal a CBT assessment report of 4 April 2017, from Dr Usha Suryanarayan, who has a doctorate in clinical psychology, but not a medical qualification. The claimant had planned to obtain a full report from a psychologist, but following a preliminary hearing for case management before Regional Employment Judge Potter on 7 December 2017 she had abandoned this, and was considering obtaining a psychiatric report of her own, though as of today she had not taken steps to select or instruct an expert.

Refusal of Postponement

8. This morning the claimant handed to the tribunal a note of advice given to her by a barrister volunteering for the employment tribunal litigant in person support scheme (ELIPS) she had consulted yesterday, giving general advice on how to prepare and proceed, and saying she should consult her GP if she felt too unwell to go ahead. She also produced a letter from her GP, Dr. Sabrina Ahmed, dated 11 January 2018, saying that her anxiety and depression have recently worsened, and she was suffering from panic attacks and insomnia related to the ongoing case. The letter asked if the tribunal would "take this into consideration and delay the court hearing date if possible".

9. After adjourning to read the written evidence, I declined to adjourn the preliminary hearing. Summarising the reasons given then: (1) the doctor clearly relates the panic attacks and insomnia to the litigation, and does not give a prognosis. If this hearing is adjourned because the claimant is unwell, there is no reason to think that she will not be unwell at any postponed hearing; (2) it is an old case, dealing with events from at least September 2011, and because of the temporal scope of the allegations it needs a long hearing. If adjourning the preliminary hearing means the hearing cannot go ahead in May, resolution of the liability issues may be delayed by 6 to 12 months. This is clearly not in the interests of justice, and particularly puts the respondent at a disadvantage in that the evidence is more stale, and more resources are tied up in the claim; (3) listening to the claimant answer questions and clarify documents in the 15 minutes before adjourning, she sounded calm and lucid and able to reason. The written material is familiar to her, even if she only saw the paginated bundle recently. I am sure she finds the hearing stressful, and may feel she is not doing her best, but she seems to be doing adequately. Balancing these factors and having regard to the overriding objective to deal with cases justly and fairly, it is better to hear the preliminary issue today than to put it off to an unknown date when the claimant may be no better, and risk postponing the full hearing.

Findings of Fact

10. The claimant grew up in Sweden, her parents separated when she was young, she was bullied at school and her education was interrupted when her mother remarried. In her mid-teens she went to live with her father, but he was drinking. She had a bout of anorexia. She worked as a waitress, and continued to do so when she moved to the UK at age 22. As well as bullying at school she described colleagues ganging up on her when she was working in restaurants, and has gone on to describe similar behaviour when working with the police. She continues to have difficult relations with her parents and half siblings; she has had a number of unsatisfactory relations with men. She has stated to doctors that throughout her life she has felt an outsider and has had difficult interpersonal relations.

11. For a number of years she has drunk alcohol to excess. In 2009 she saw her general practitioner about mental health difficulties, and was referred to an alcohol worker when it became clear she was drinking around 112 units per week. In December 2010 when she went to UCH A and E feeling lonely and unhappy, she reported sleep difficulties which she attributed to the police shift pattern, and that she was drinking wine increasingly of, and was "quite conscious of the alcohol-related problems". The doctor's impression was an acute stress reaction with underlying emotionally unstable personality trait. The GP referred her to an alcohol counsellor, but in February 2011 drinking is still high and in March 2011 she specifically declined therapy for alcohol consumption, wanting psychotherapy instead, and was told that this was difficult on the NHS while she was still drinking at such high levels. She discussed this again in May 2011 when she was reported to have said that if she could not have psychotherapy then "I might as well kill myself", in the context of discussing alcohol use possibly preventing her from making use of therapy. The counsellor concluded that she had not attempted or contemplated suicide, but sometimes told people she was suicidal so as to get concern and help. She was drinking alcohol "at a hazardous level" drinking at least a bottle at night on her own, and was still doing so in October 2011. In December 2013 there was a report of continuing excess alcohol intake, and she was declined counselling because she could not commit to attend regularly.

12. In June 2014 the respondent's occupational health service referred her to a psychiatrist, Dr David Price, who concluded she had mild clinical depression complicated by alcohol misuse and dependence personality traits.

13. In December 2015 she was referred again to a psychological therapist at Camden, who noted symptoms of depression and anxiety and stress with colleagues, and that she admitted drinking excessively, saying she had always been reluctant to engage in conversation about the drinking "as people than focus on the drinking rather than trying to get to the root of the problems". During 2016 she underwent a course of dynamic interpersonal therapy. She discussed a repeating pattern in interpersonal relationships of defensive action out of anger or avoidance, and that she had deep-rooted fears of abandonment and often felt misunderstood and alone, as reported when this course of treatment ended in October 2016.

14. In March 2016 she had also been seen by another psychiatrist, Dr Mervi Pitkanen, again when referred by the respondent's occupational health service. He concluded she had mild to moderate mixed symptoms of anxiety and depression. She had no obsessive-compulsive symptoms, no perceptual or thought abnormalities, and cognitively appeared intact. The diagnoses were Mixed Anxiety and Depressive Disorder, and Harmful use of Alcohol. He advised cutting the alcohol, and taking an antidepressant (fluoxetine). The claimant declined the antidepressant, and has explained the tribunal that this is because

police officer she has seen suicides because they have to stop taking antidepressants. From October 2016 though she has been taking mirtazapine which has helped her sleep.

15. She also reduced her alcohol intake, but continues to drink heavily (one to two bottles of wine) unless she is working next day. Blood tests in March 2017 showed increased liver enzymes.

16. The claimant in that statement confirms that she has had periods of time off work with stress and depression. (The psychologist reports absence from work from October 2015 to July 2016, and again from September 2016, it is not clear when she went back to work after that). She no longer engages in reading and painting, previous hobbies which gave her pleasure, but she has been able to resume writing a diary. She finds herself buying good food on her days off, then feeling unable to eat it and throwing it away. She only cooks occasionally and gets takeaways instead. There have been times when she delayed washing clothes until she has run out of clean ones, and has had to hand wash a uniform before going on shift. At work she found herself picking out the CAD cases she felt she could cope with, and was rebuked for not taking the first in the pile. She cries her colleagues do not treat her "nicely". She spends much time on own, has no partner to socialise with, complains of no family support, and broods that she can only travel alone, has no one to be with Christmas or in the summer, and that any savings she makes will only be spent on her parents' funerals. She describes herself as introverted, irritable and short tempered when she is not a "wet blanket of depression". She describes gym membership but it is not clear from the statement how often she goes.

17. Dr Bashir's May 2017 report concludes that she has personality disorder with mixed traits of paranoia narcissistic (ICD 10: F 60.81) and emotional unstable personality (ICD 10: F 60.0). She also suffers from harmful alcohol use disorder (ICD 10.; F10.1).

18. In his opinion, her feelings of depression and symptoms of anxiety were direct reactions to the interpersonal difficulties and problems in the job. Such states have been there to some extent throughout her life. She used alcohol to deal with her stress. Excessive alcohol can result in depressed mood, reduced concentration, motivation and sleep disturbance. Effects on the day-to-day functioning were due to ongoing stress associated with the circumstances made worse by the harmful quantity of alcohol intake. She was able to cope with day-to-day life, had never been admitted to hospital and lived alone without assistance. Personality disorder, he said, did not on its own negatively affect her ability to do normal daily activities. It was excessive drinking which affected her reactions and emotions, and made the effects of the impairment more obvious and prominent. In his view, recent improvement in symptoms was not down to mirtazapine, as he thought the dose too low, but cutting her alcohol intake.

19. Responding to comments by the claimant, he made various adjustments to factual matters, but disputed that she had post-traumatic stress disorder, avoidant personality disorder, or depression. Her low mood and symptoms of depression were due to alcohol abuse, not depression.

20. The report the claimant had obtained from psychologist Dr Suryanayaran, which was seen by Dr Bashir, was based on the claimant's account, not any records, though she had carried out psychometric tests. These tests showed high scores for depression, anxiety and PTSD symptoms, and the psychologist concluded she would benefit from psychological therapy. There is no mention of alcohol.

21. **Relevant law**

22. Section 6 of the Equality Act 2010 provides that a person has a disability if the person has any physical or mental impairment and the impairment has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.

23. Paragraph 1 of schedule 1 to the Act states that regulations may provide for a condition or a prescribed description to be, or not to be, an impairment, and Regulation 3 of the Equality Act (Disability) Regulations 2010, schedule 1 says, in paragraph 3, "subject to paragraph 2 () below, addiction to alcohol, nicotine or any other substance is to be treated as not amounting to an impairment purposes of the Act". (Paragraph 2 is about addiction to drugs which were originally prescribed as part of medical treatment, which does not apply here).

24. The tribunal was referred to **J v DLA Piper UK LLP UKEAT/02638/09.** It is good practice for a tribunal to state conclusions separately on questions of impairment and adverse effect, and it will usually make sense to start by recording the claimant's ability to carry out normal based activities, then consider impairment.

25. In relation to excluded disability (such as alcohol addiction), in **Power v Panasonic UK Ltd (2003) IRLR 151,** tribunals are directed first to decide whether the alleged disability falls within the definition contained in the Act, and then to consider whether it is excluded by the Regulations.

26. The **DLA Piper** decision also discusses, as general points, making a distinction between depression as an illness, and depressive symptoms which are a reaction to adverse life events. When considering both the adverse effect issue and the impairment issue, tribunals may have to look behind the labels.

Submissions

27. The claimant's case is that she is impaired by reason of depression and anxiety. This is the impairment identified by her at the preliminary hearings on 23 November 2016. On 16 October 2017 she added post-traumatic stress disorder (PTSD). The traumatic stress is not specifically identified, but it can be inferred that she means unpleasant treatment by her work colleagues and the psychologist who concluded there was PTSD said she reported "bullying, sexual harassment and discrimination", but without going into detail.

28. The respondent accepts that the claimant has an impairment which has caused her to suffer long-term adverse effect on her ability to carry out normal day-to-day activities, but the issue is what impairment caused that effect. The respondent argues that the cause of the impairment was alcohol addiction, so excluded from the definition of disabled person.

29. In the alternative, respondent argues that the symptoms of depression and anxiety are not a medical condition, but only a reaction to adverse circumstances.

Discussion and Conclusion

30. As described by the claimant, something is having an adverse effect on her ability to carry out normal day-to-day activities, such as cooking, eating, doing the laundry on a regular basis, socialising (other than with regulars at the pub), and tackling tasks at work. The respondent does not dispute that there is a substantial adverse effect.

31. Does the claimant suffer depression or anxiety or both? Dr Bashir concluded that she had personality disorder, and alcohol addiction, but not depression. In his

view, the "feeling of depression and symptoms of anxiety" were a direct reaction to the interpersonal difficulties and problems in job. They were reactive emotional states that had been present to some extent throughout her life, and she used alcohol to deal with her stress. Her difficulties in functioning were not due to major depression, but to "ongoing stress associated with her circumstances made worse by the harmful quantity of alcohol intake". I interpret this as his reasoning for concluding, despite symptoms of depression or anxiety, that depression (or anxiety) was not the condition of which they were symptomatic.

32. Other psychiatrists have concluded it was depression at some level – Dr David Price in June 2014 concluded there was mild clinical depression complicated by alcohol misuse, and Dr Pitkanen In March 2016 concluded there was a mixed anxiety/depressive disorder, plus harmful use of alcohol. Neither was being asked what symptoms were caused by which condition, because that was not the purpose of their reports, so there is no analysis of the contribution made by alcohol to her functioning.

33. Dr Bashir's undisputed evidence is that alcohol in excess causes dysphoria and low mood, and concentration, motivation, and sleep. He does not say, but the tribunal recognises, that these can be characteristic of depression, and but for the alcohol use, might be diagnostic.

34. He does point out that personality disorder has been lifelong, but she had functioned well until the drinking became excessive.

35. Looking at the chronology, the claim is for events from 2011, but heavy drinking is reported at least from 2009. It is a feature throughout the period for which disability is claimed.

36. The difficulty with using the psychologist's report on PTSD to analyse the extent to which excess drinking is responsible for the symptoms noted (and reported, in the absence of records, as characteristic of depression, anxiety or PTSD) is that she was not aware that alcohol is a factor. This probably confirms the claimant's earlier reported reluctance even to mention alcohol use because it was her view that there was an underlying problem other than alcohol which needed treatment. The claimant might be right about that, but for present purposes it means the psychologist's report is no help on this issue.

37. Reviewing all the medical material available, I conclude that there is no clear basis for concluding that without the drinking the claimant's reported symptoms are (or would be) identified as resulting from depression or anxiety. Instead, the pattern is that her personality makes interpersonal relations difficult, causing stress to her, and she drinks to avoid this stress, or perhaps comfort herself when finding life difficult. Consumption of alcohol at these levels, whatever the reason, of itself and independently causes symptoms (low mood, poor sleep, and so on) which impair day to day activities.

38. As for the effects of treatment, the correspondence in the GP records shows that therapy was not especially effective in treating the personality disorder, and that various therapists considered it would not be effective unless she reduced her drinking. The claimant declined to use the antidepressant recommended; the dose of Mirtazapine she now takes is not enough for depression but does help her to sleep, and disturbed sleep is as much a result of excess drinking as depression. No question of deduced effect arises, and the treatment pattern tends to confirm that the adverse effects are from the alcohol.

39. There is no evidence to support a diagnosis of PTSD. The traumatic stress is not described, and the report was prepared to consider only whether therapy would

be helpful; the expert was unaware of alcohol as a feature, so does not consider whether it is or is not causing the reported symptoms.

40. I conclude that the substantial adverse effects on the claimant's day to day activities are caused by excessive alcohol consumption, and so excluded from the definition of disability. They are not caused by personality disorder, because although the personality disorder can make relationships difficult, and so cause stress, in the family and at work, historically the evidence points to the claimant having functioned well enough when not drinking to excess, so if the disorder did have an adverse effect, it was not substantial.

41. Accordingly, the claimant is not a disabled person within the meaning of the Equality Act.

42. The remaining claims of race and sex discrimination will be heard in May 2018.

Employment Judge Goodman on 12 January 2018

Note

Reasons for the decision having been given orally at the hearing, written reasons will not be provided unless requested within 14 days of this written record of the decision being sent to the parties.