EMPLOYMENT TRIBUNALS (SCOTLAND)

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Case No: 4102478/2019

Preliminary Hearing Held at Dundee on 30 September 2019

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Employment Judge A Kemp

15 **Ms S Orrock** **Claimant**
Represented by
Mr R Russell
Solicitor

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Goodfellows of Dundee Limited **Respondent**
25 **Represented by**
Mr W Lane
Solicitor

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JUDGMENT OF THE EMPLOYMENT TRIBUNAL

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The claimant is a disabled person under section 6 of the Equality Act 2010.

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REASONS

Introduction

1. The claimant has alleged disability discrimination and unfair dismissal. The respondent denies the allegations and does not accept that the claimant is disabled.

2. This Preliminary Hearing had been fixed by Notice dated 23 July 2019. It was to determine solely whether or not the claimant was a disabled person as defined by section 6 of the Equality Act 2010.

Evidence

3. The Tribunal heard evidence from the claimant, and from Mrs Jackie Soutar a director of the respondent. There were documents spoken to that the parties had prepared in a single bundle.

Facts

4. The Tribunal found the following facts to have been established:

5. The claimant is Ms Sandra Orrock.

6. The respondent is Goodfellows of Dundee Limited. It is a retail bakery and operates a number of branches.

7. The claimant was employed by the respondent as Branch Manager from 22 June 2009.

8. On 14 July 2014 the claimant's fiancé was admitted to hospital having suffered a stroke. The claimant was absent from work at that time. She consulted her GP who noted that she was very upset and tearful, with high blood pressure.

9. On 26 September 2014 the claimant was prescribed Fluoxetine, which is an anti-depressant, by her GP, with a dosage of 20mg capsules, one to be taken daily, following a consultation that day. On 9 October 2014 the claimant attended her GP and reported that Fluoxetine had made a "big difference."

10. She was prescribed that medication on a regular basis from and after that date.

11. On 22 September 2015 she consulted her GP for severe lower back pain. She was prescribed analgesia which included tramadol, and diazepam to reduce anxiety. She was absent from work for a period (the duration of which was not given in evidence).

12. On 28 September 2015 the claimant was unable to mobilise, and her GP made a home visit. There were further consultations on 13 and 26 November 2015, and on 29 December 2015 she was advised that she may be fit for work in eight weeks' time.

13. On 8 February 2016 the dosage of the Fluoxetine prescribed for the claimant was increased to up to four times daily.

14. On 13 May 2016 the claimant was prescribed 120 capsules of Fluoxetine, which his likely to have been exhausted in about July 2016.

15. By 27 September 2016 the claimant was noted by her GP to have stopped taking fluoxetine, and had been "weaned off it".

16. In October 2017 there was a disciplinary investigation into the claimant at work. She consulted her GP on 31 October 2017 and reported that she was very stressed at work, tearful, and not sleeping. She was provided with a fit note, and was absent from work from that date. She was not on that date prescribed with medication.

17. After a further consultation with her GP on 10 November 2017, her GP again prescribed Fluoxetine, with one 20mg capsule to be taken daily. It was noted on that date that no disciplinary action had taken place following the investigation, which held that she had no case to answer.

18. When the claimant returned to work on 8 December 2017 she did not have a formal return to work interview, and no documentation for that was completed, but she did have an informal meeting with her line manager Mrs Jackie Soutar.

19. The claimant continued to take either Fluoxetine under prescription from her GP, or by a different anti-depressant Mirtrazipine, from 10 November 2017 continuously. The dosage of Fluoxetine was increased to up to four times daily on 26 January 2018.

20. The claimant has been prescribed periodically other medication for other conditions that included back and neck pain, which were analgesia such as tramadol and paracetamol.

21. She was also prescribed periodically medication to reduce anxiety, such as diazepam, which included such prescriptions on 31 October 2017 and 31 August 2018.

22. On 17 July 2018 the claimant attended her GP so as to be monitored for hypertension, and a high level of blood pressure.. She reported that she found her job “incredibly stressful”. She was subject to regular monitoring, and from 11 September 2018 prescribed propranolol.

23. The claimant was able to attend work regularly save for some periods of absence, the last of which was the said absence up to 8 December 2017, and was generally on time, or a few minutes late for it. Her normal start time was 7.30am. She performed her duties well. Those duties included aspects that required a measure of concentration and attention to detail such as for stock control.

24. The claimant did not inform her line manager Ms Jackie Soutar of any concerns she had over sleep, concentration, her ability to read, or her relationships with family and friends.

25. As a result of the depression and anxiety, during the period from 31 October 2017 onwards, her sleep was poor. Her levels of anxiety were such that she could not get to sleep easily. She had low levels of motivation. She found it difficult to get up in the morning. She found it difficult to go to work. She found work very stressful. She went to bed after being at work. She was in a low mood, and that affected her relationship with her partner adversely. She would arrange less meetings with friends, or make initial arrangements and cancel them or find an excuse not to attend such that her social life was about half of what it had been before she became depressed. On occasions she found it difficult to leave the house because of anxiety. She found concentration difficult. Prior to being depressed she read novels very regularly as a hobby. Latterly, she found that she could not concentrate on a novel for more than two or three pages, and could not read them.

26. On 29 August 2018 an incident occurred at work which led to the claimant being suspended.

27. Following the suspension her condition deteriorated. On 31 August 2018 she did not feel able to go out of the house, and wrote a letter to her GP saying that she was struggling with anxiety and stress due to a situation that arose the previous day, and had not slept. She asked for something to help her. She was retained on fluoxetine, and prescribed diazepam by her GP.

28. She wrote further to her GP on 20 September 2018 and asked for medication to keep her calm. A telephone consultation took place on the following day, when her GP sought to reassure her. No medication was prescribed that day.

29. On 4 October 2018 a report relating to the claimant was prepared by an occupational health physician instructed by the respondent. The question asked by the respondent related to an understanding they held of what the claimant had alleged in respect of the matter being investigated, being that her medication had been responsible for her behaviour. The report stated that this is not what the claimant alleged. The report stated that the claimant “did not feel the medication was responsible for her response but rather her frustration at the situation along with her anxiety state.”

30. The report further stated, amongst other matters, that

> “clinical assessment and validated structured questionnaires confirmed that she has anxiety and depressive symptoms of note at present…… Ms Orrock has symptoms and signs consistent with a significant anxiety and depressive disorder. She has had a long history of anxiety and stress……”

31. On 10 October 2018 the GP noted that the claimant was tearful, mainly exhausted as she could not sleep, and 15mg tablets of Mirtazipine to be taken daily was prescribed as an alternative to Fluoxetine.

32. On 15 October 2018 the claimant was dismissed from the employment.

33. She has been unemployed since then.

34. On 26 October 2018 the dosage of Mirtazapine was increased to 30mg tablets to be taken daily. Prescriptions for that medication, and for propranolol and tramadol amongst others, continued thereafter.

35. The claimant’s GP provided her solicitors with a report dated 18 July 2019, which addressed questions posed in a letter dated 17 April 2019. They included the following questions:

"4. Do you think that each of these conditions [stress, depression and anxiety] would meet the test outlined by section 6 of the Equality Act 2010?

5. In respect of each condition, do you think that there is a substantial adverse effect on her ability to carry out day to day activities?

…

7. What do you think will be the impact upon her ability to carry out her day to day activities without medication/treatment?"

36. The GP provided in the report the following answers to those questions:

"4. ….I would say probably all these can affect a person to some effect becoming disabled to carrying on regular duties.

5. In respect of each condition, they can have an effect on ability to carry out day to day activities as it can affect concentration, motivation etc.

….

7. I am unable to comment whether she will be able to carry out day to day activities without medication or treatment, but, looking at the trend over the last few years, she probably will find it difficult."

Claimant's submission

37. The following is a basic summary of the submission. The claimant suffered a mental impairment. It caused adverse effects on normal day to day activities which was substantial, in the sense of not minor or trivial as confirmed in ***Goodwin v Patent Office***. Reference was made to the medical reports from occupational health and the GP. It was accepted that these did not state in terms that the claimant was a disabled person, or an opinion to that effect, but the former used words such as "significant" and "of note" when describing symptoms, and the history had gone back to 2014. Whilst there had been a period when anti-depressant medication was not taken, that required to be considered in the context of the overall period of about five years. Such medication would not be prescribed unless there was a sufficient reason. The

claimant's evidence should be accepted. Her quality of life had been affected adversely. The effect was both substantial and long-term. I was invited to hold that the claimant was a disabled person.

5 **Respondent's submission**

38. The following is a basic summary of the submission, on which Mr Lane had prepared a written skeleton. The onus was on the claimant - ***Kapadia v London Borough of Lambeth.*** The respondent did not challenge that the
10 claimant had a mental impairment, but argued that there was no substantial effect on normal day to day activities. The GP report was vague and qualified, and the GP records were not consistent with the contention made. The records did not mention social interactions, concentration or reading. Where there was reference to difficulty in getting up that was in the context of mobility issues.
15 The fourth element was work, where there were some entries, but under reference to ***J v DLA Piper,*** a distinction should be drawn between a reaction to adverse life events, and a clinical condition. The GP records confirmed that there was the former not the latter. There was also an absence from the witness evidence, in that if there were substantial effects at work they would
20 have become manifest and brought to the attention of the manager, which did not take place. There was an absence of clear medical evidence, but the onus was on the claimant and if there was a gap in it, that was an issue for the claimant – ***Royal Bank of Scotland plc v Morris UKEAT/0346/10***.

25 39. He also argued that the effect was not long term. The effect of the impairment, rather than the condition itself, had to be long term. That is assessed at the date of the alleged discrimination – ***Richmond Adult Community College v McDougall [2008] EWCA Civ 4.*** Likely meant could well happen – ***SCA Packaging Limited v Boyle [2009] UKHL 37.*** There was nothing in the reports
30 to confirm that, nor did the GP records show it. There were discrete examples of reactions to life events. The GP report did not give positive evidence of the effect were there to be no medication. When medication did cease for a period of about one year up to the restarting of fluoxetine the claimant did not report

with any adverse effects or her underlying depression and anxiety. He invited me to find that the claimant was not a disabled person.

Law

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40. Section 6 of the Equality Act 2010 ("the Act") provides as follows:

> "(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.
> (2) A reference to a disabled person is a reference to a person who has a disability."

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41. "Substantial" means more than minor or trivial under Section 212(1) of the Act.

42. The onus is on the claimant – ***Kapadia v London Borough of Lambeth [2000] IRLR 699.*** Guidance was given in ***Goodwin v Patent Office [1999] ICR 302.*** There requires to be a causal link between the impairment and the substantial adverse effect but it need not be direct – ***Sussex Partnership NHS Foundation Trust v Norris EAT 0031/12.*** It does however require to be based on the evidence.

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43. In ***J v DLA Piper [2010] IRLR 936*** the EAT commented on matters at paragraph 42 as follows:

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> "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

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'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'."

44. What is "long-term" is defined at Schedule 1 paragraph 2 of the Act as follows:

"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."

45. The effect of treatment is referred to at paragraph 5 of the Schedule as follows:

"**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…."

46. Where it is necessary to project forward to determine whether an impairment is long-term (under paragraph 2(1)(b) of Schedule 1), in ***SCA Packaging Limited v Boyle [2009] ICR 1056***, Baroness Hale, with whom the other Justices of the Supreme Court agreed, clarified that in considering whether something was likely, it must be asked whether it could well happen.

47. There has been guidance issued by HM Government which the Tribunal requires to take into account, being the ***Guidance on Matters to be taken into Account in Determining Questions Relating to the Definition of Disability (2011***) ("the Guidance") which states at paragraph C3 that "likely" should be interpreted as meaning that "it could well happen", not that it is more probable than not that it will happen, and has the following commentary about normal day to day activities at paragraph D3:

> "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. Normal day-to-day activities can include general work-related activities, and study and education related activities, such as interacting with colleagues, following instructions, using a computer, driving, carrying out interviews, preparing written documents, and keeping to a timetable or a shift pattern".

48. The Appendix provides "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." The examples include ones where a person would experience difficulties with an activity. One is "Persistent general low motivation or loss of interest in everyday activities". Another is "Persistent distractibility or difficulty concentrating".

49. A broad view is to be taken of the symptoms and consequences of the disability as they appeared during the material period, see ***Cruickshank v VAW Motorcast Ltd [2002] 729, EAT***.

Discussion

50. I was satisfied that the claimant was a credible and reliable witness. She gave her evidence candidly, and clearly. She did not seek to exaggerate matters, and her evidence included acceptance of the limitation of the written GP records when that was put to her. I accepted her evidence as to the conditions from which she suffered, the effects of them on her, and the impact that that had had on her life.

51. Mrs Soutar was also a credible and reliable witness, but she gave brief evidence to the effect that no issue of personal interactions, concentration or motivation had been brought to her attention. She was aware of the claimant being absent from work in October to December 2017, but accepted that no formal return to work interview had taken place, and that the only occupational health report commissioned was that dated 4 October 2018. She did not herself do so, and could not say why the question asked related to an understanding of what the claimant had alleged, being that her behaviour had been caused by medication, which was not in fact what the report stated the claimant alleged. She did not dispute the terms of the medical reports, and although I accepted her evidence that the claimant had not told her of difficulties with concentration, motivation or social interactions that was not I considered either surprising given the circumstances, or a factor that led to the conclusion that the claimant's evidence on such issues was not credible and reliable.

52. The oral evidence was supplemented by written evidence, the most material parts of which were (i) the GP notes of consultations and records, including records of prescriptions given (ii) the occupational health physician's report and (iii) the GP report.

53. The section 6 test has three elements (i) did the claimant have an impairment (ii) if so was there a substantial adverse effect on normal day to day activities and (iii) if so was it long term. I shall address each in turn.

(i) Impairment

54. The first question is whether or not the claimant has a mental impairment. I am satisfied that she does, and that it is depression and anxiety. That is accepted by the respondent.

(ii) Effect

55. The second question is whether the impairment caused a substantial adverse effect on normal day to day activities. It has three elements, (i) what the mental impairment caused (ii) whether the effect was adverse and (iii) whether it was substantial. What the impairment caused was complex, partly as the professional evidence with regard to it was limited. The GP report did not address fully and clearly the questions asked. The submission that the claimant had not proved that the effect was substantial in terms of the statute, and separately had not been caused by the impairment, was a strong one.

(a) Cause

56. The claimant has a long standing history of depression and anxiety. That is clear from the GP records, GP report and occupational health report. Whilst the occupational health physician was not asked to address specifically whether or not the claimant was a disabled person, the report is I consider evidence of importance, coming as it does from an occupational health physician instructed by the respondent who carried out an assessment, including consideration of the result of a questionnaire, and a finding of a "significant anxiety and depressive disorder" with a "long history of anxiety and stress", which dates from September 2014.

57. The GP records confirm that the claimant has been prescribed anti-depressant medication since September 2014, save for a period of about 16 months up to November 2017. There was a prescription for Fluoxetine given to her in May 2016, which is likely to have lasted until about July 2017. From 10 November

2017 onwards she has been prescribed anti-depressant medication, such that by the dismissal she had been in receipt of that medication for almost a year, and that was likely at that time to continue, and in fact did continue. She has been prescribed other medication intermittently to reduce the smptoms of her mental impairment, including diazepam to reduce levels of anxiety, and propranolol for high blood pressure and hypertension, for which she has been and is monitored regularly. She did not wish to leave the house on occasion, as supported by letters sent to her GP. Whilst having depression and anxiety, to an extent requiring treatment in such a manner, does not lead to the conclusion of itself that there was a substantial effect on normal day to day activities caused by mental impairment, it is a factor that points towards that. The facts are to an extent in similar vein to those in ***Kapadia,*** although of course each case is fact specific and provides only at best general guidance, and the medical evidence in that case was clearer.

58. The respondent argued that the cause of the adverse effects was life events such as the stroke to her fiancé, back pain, or disciplinary investigations. There was a measure of support for that argument from the terms of the GP notes which were addressed in detail in cross examination. The adverse effect does under the statute have to be caused by the impairment, and not some other matter, such as severe lower back pain.

59. The effects on her clearly did fluctuate, and can be affected, or exacerbated, by incidents either at home or work. The records did refer to such incidents, such as the stroke suffered by her fiancé, the severe lower back pain, and the investigation. But I do not consider that they are simply and solely a reaction to difficult circumstances, or one off events, as was submitted for the respondents in relation to the ***DLA Piper*** case.

60. It appeared to me that the individual entries on which the respondent founded were not the only evidence of what had happened. These were GP notes, which were made for clinical purposes, of a consultation or other contact. The GP records also included the prescriptions issued, and it was clear that the

claimant was being treated for a depressive and anxiety disorder from September 2014, save for a period of about a year or so from about July 2016 to November 2017. Out of the four years between the first prescription of an anti-depressant being given and dismissal, she had prescriptions for anti-depressants for about three of them. This case is one of those of clinical findings having been made, rather than simply a reaction to adverse life events for which there was no medication or diagnosis.

61. The claimant's evidence provided further detail. She said that she had issues such as severe back pain on occasion, but that at the same time she had continuing symptoms of depression and anxiety for which she was being treated. Whilst the GP report is not especially clear, it does I consider give support to the claimant's argument on a fair reading. The inference from it is that the claimant did and does suffer substantial adverse effects on normal day to day activities caused by the mental impairment.

62. In addition, the circumstances overall were I consider more than simply a reaction to an event. For example there was an investigation involving the claimant in October 2017. That led to consultations with her GP. But the outcome of that investigation was, according to the GP records and the claimant's evidence a finding of no case to answer by 10 November 2017. If there had simply been a reaction to the holding of an investigation it would be expected that matters would return to normal very shortly after that finding as the supposed cause of stress, the investigation, had ended. They did not. The claimant remained absent from work for about a further four weeks. She remained on anti-depressant medication from 10 November 2017 onwards. In fact the dosage of anti-depressants was later increased. The prescription of anti-depressants continued up to and beyond the date of dismissal. I consider that one cannot excise the trigger event of an investigation from the underlying condition as easily as was submitted.

63. In the ***DLA Piper*** case, two contrasting examples were given to illustrate the line between someone who is disabled and someone not. The second example

was that of a woman who over a five-year period suffered several short episodes of depression which have a substantial adverse impact on her ability to carry out normal day-to-day activities but who between those episodes is symptom-free and does not require treatment. In such a case, it was said that it may be appropriate, though the question would require medical evidence, to regard her as suffering from a mental impairment throughout the period in question, even between the episodes: the model would be not of a number of discrete illnesses but of a single condition producing recurrent symptomatic episodes. That would then lead to a finding that she was a disabled person.

64. The circumstances of the claimant are not the same as in that example, and the medical evidence in her case is not as clear, but the circumstances are I consider sufficiently close to those of that example that it does provide a measure of support for the conclusion reached above. I also note that in the DLA case the claimant was found to be a disabled person, on appeal, where there had been two separate episodes of depression, an absence from a previous position of four months, and a diagnosis of clinical depression. Whilst therefore the EAT did draw a distinction between clinical depression and simply a reaction to adverse life events, it held that the proper analysis in the circumstances was the former.

65. I have concluded that there is sufficient evidence to find that the mental impairment was the cause of the adverse effects that I shall come to, to a sufficient extent. I do not therefore consider that there is an insufficiency of evidence as occurred in ***Morris.***

(b) Adverse

66. The claimant gave clear evidence of the difficulties her condition created for her, in particular a lack of motivation, the difficulty of getting up in the morning, or of going to bed on return to work, a lack of concentration, high levels of anxiety and stress, and lack of sleep. She spoke about her ability to engage in

normal social interactions with family and friends being impaired. Those interactions did not cease, but they were affected detrimentally. She attended about half of the meetings arranged with friends she had from before the depression, for example. I consider that there is sufficient evidence of these effects being adverse.

(c) Substantial.

67. The claimant did attend work, and did so to a good standard. That is one factor that supports the respondent's argument, as does the absence of reports to her line manager of personal or other difficulties. But that does not mean of itself that she is not someone who falls within the terms of section 6. Not telling someone at work of difficulties is not uncommon.

68. The claimant gave evidence that she coped with the work, notwithstanding her impairment. In general terms this is a matter referred to in ***Goodwin,*** where this was said

> "What the Act is concerned with is an impairment on the person's ability to carry out activities. The fact that a person can carry out such activities does not mean that his ability to carry them out has not been impaired. Thus, for example, a person may be able to cook, but only with the greatest difficulty. In order to constitute an adverse effect, it is not the doing of the acts which is the focus of attention but rather the ability to do (or not do) the acts. Experience shows that disabled persons often adjust their lives and circumstances to enable them to cope for themselves."

69. There were a number of entries in the GP records relating to stress at work. She was absent from work from 30 October 2017 to 8 December 2017 and that was a not insignificant period of time.

(d) Conclusion on effect

70. The pattern that emerged from all the evidence as a whole is of the claimant being a person with an underlying condition of a depressive and anxiety disorder, that lasted for at least the periods September 2014 to about July 2016, and then from 10 November 2017 up to dismissal on 15 October 2018 and beyond. It was treated by anti-depressant medication in those periods, and medication to reduce anxiety and for hypertension. The mental impairment I consider caused the adverse effects described above. Those effects were substantial, in the sense of not minor or trivial under the statutory test.

(iii) Long term

71. I consider that the effects were long term as, at the date of dismissal, they had lasted in total over 12 months by that date, even if there were periods within the period from about July 2016 to November 2017 when the claimant did not have anti-depressant medication.

72. In any event if that were not the case I consider that the claimant's condition at the date of dismissal was likely to last for at least 12 months continuously from November 2017 onwards, in that her condition was then likely to continue for a material period thereafter, well beyond twelve months. That indeed has been what has occurred, in that the claimant is still being treated for depression and anxiety with anti-depressant and other medication.

Conclusion

73. The claimant is a disabled person under section 6 of the Equality Act 2010.

5 **Further procedure**

74. Having so determined, I consider that a case management Preliminary Hearing should be fixed. It can be conducted by telephone. Agents should write to the Tribunal within three working days of receipt of this Judgment to confirm dates to avoid for that Preliminary Hearing in the period October to December 2019.

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Employment Judge:	**Alexander Kemp**
Date of Judgment:	**04 October 2019**
Date sent to parties:	**08 October 2019**