EMPLOYMENT TRIBUNALS

BETWEEN

Claimant		**Respondent**
Miss E Sampson	AND	NHS Blood and Transplant

JUDGMENT OF THE EMPLOYMENT TRIBUNAL

HELD AT Bristol **ON** 8 November 2019

EMPLOYMENT JUDGE J Bax

Representation

For the Claimant: Ms S Anwar (Bristol Law Centre Representative)
For the Respondent: Mr C Baker (Solicitor)

JUDGMENT

At all times material to this claim, the Claimant was disabled by reason of a mental impairment, namely anxiety and depression.

REASONS

1. The Claimant presented her claim of discrimination arising from disability and a failure to make reasonable adjustments on 28 February 2019. The Claimant says that she was disabled by reason of depression and anxiety. The Respondent disputes that she was disabled at the material times.

2. Before hearing evidence, the Solicitor for the Respondent conceded that, if there was a finding of impairment and substantial adverse effect, the long-term element was established.

Background

3. On 3 September 2018 the Claimant applied for the post of Blood Production Assistant with the Respondent. She was interviewed on 19 September 2018 and was offered the position on 27 September 2018, subject to pre-employment checks. The pre-employment checks required the Claimant to provide a personal statement in relation to a gap in her employment history and the completion of an online occupational health questionnaire, including details of previous sickness absences. In its response, the Respondent says that, on 16 October 2018, Kelly Venus explained to the Claimant the reasons why the offer had been withdrawn, including that the pressure of workload could exacerbate depression and anxiety. In the letter confirming the decision, it said the Respondent was concerned about the potential impact of the role on the Claimant's health.

The evidence

4. I was provided with a joint bundle of documents of 51 pages, which included the Claimant's disability impact statement. Any reference in square brackets, within these reasons, is a reference to a page in the bundle.

5. The Claimant gave oral evidence in a straightforward fashion and made concessions where appropriate. I found her to be a credible and honest witness.

The facts

6. I found the following facts proven on the balance of probabilities after considering the whole of the evidence, both oral and documentary, and after listening to the factual and legal submissions made by and on behalf of the respective parties.

7. The Claimant said that, in about 2012, whilst at university, she was diagnosed with clinical depression and anxiety. Although I was provided with medical records, they did not extend back as far as 2012. On reviewing the medical records, it was clear that the Claimant had been taking Mirtazapine an anti-depressant drug since before February 2016. The medical report of Dr Bolam records, after reviewing the medical records, that the Claimant had been experiencing symptoms of anxiety and depression since at least 2013. The Claimant was diagnosed with anxiety and depression by her GP in about 2012 to 2013.

8. I accepted the Claimant's evidence that, whilst at university, she had difficulty focusing, her sleeping patters were severely affected and she

experienced panic attacks. She was unable to pass her exams and retook her final year. Thereafter she struggled with the same symptoms to varying degrees.

9. On 4 February 2016 [p34-35] the Claimant had not taken Mirtazapine for a month and was feeling quite tearful and low in mood. The Mirtazapine made her feel better and able to cope. She had been signed off work and it is noted that she had recently been promoted. The Mirtazapine prescription was restarted following this appointment.

10. On 29 February 2016 [p34] the Claimant attended her GP. Her anxiety and mood had improved and the Mirtazapine continued to be prescribed. The GP recorded that the Claimant said that 'work was being supportive'.

11. On 25 April 2016 [p34] the Claimant attended her GP and confirmed that if she missed Mirtazapine doses her mood would swing.

12. On 8 September 2016 [p33] the Claimant's GP recorded that she had anxiety and depression. The Claimant was struggling with untreated anxiety. There were some work-related issues and she did not get sick pay. It was recorded that she had poor sleep and surging anxiety.

13. The Claimant's condition had improved by 11 November 2016 [p32] when she next saw her GP. I accept that she felt better with an increased dose of Mirtazapine and that her mood and anxiety were better. It was recorded that she could talk to her manager at work, which helped her.

14. On 4 January 2017 [p31] the Claimant attended her GP. She had run out of Mirtazapine and had been 'up and down'. Her appetite was reduced. The Claimant had been attending CBT.

15. On 3 February 2017 [p31] the Claimant attended her GP and had a feeling of apathy, was not sleeping well, was anxious, had a reduced appetite and nausea. She was due to start a new job and there had been problems with her housemates. Discussion took place as to increasing the dose of Mirtazapine.

16. In April 2017 the Claimant was employed by Public Health England on a fixed term contract, at the start of which her symptoms were more manageable. I accept the Claimant's evidence that, at times, she had to take a half day off if she suffered from panic. She also suffered from a lack of motivation, overwhelming emotion and self-judgment which led to panic attacks.

17. In April 2017 the Claimant's grandmother died. Initially the Claimant was able to attend work, however her condition deteriorated.

18. The Claimant attended her GP surgery on 3 July 2017 [p29] after having been off work for a couple of weeks. She was experiencing symptoms of broken sleep, worry, exhaustion, general anxiety, low mood, panic attacks, being sick, lack of appetite, migraine, spending time in bed and feeling overwhelmed. The Claimant had moved to a new house at about this time and it was recorded that she was stressed. A sick note was issued with a diagnosis of anxiety and depression.

19. Thereafter the Claimant periodically returned to work for short periods but generally was off sick until the expiry of her fixed term contract in April 2018.

20. On 16 October 2017 [p28] the Claimant had been undergoing further therapy. She was less sociable and had not worked for the previous week. Her sleep was affected so she struggled to get up and she was having panic attacks. The condition was recorded as anxiety and depression.

21. On 9 November 2017 [p27 to 28] the Claimant reported that she had difficulty sleeping. There was ongoing anxiety and it was recorded that she had experienced erratic sleep patterns for 4 to 5 years.

22. On 29 November 2017 [p27] the Claimant was still not deemed fit to work. She continued to use Mirtazapine and was prescribed medication to help her sleep.

23. The Claimant said, which I accepted, that at the end of 2017 she received her last prescription for Mirtazapine and was weaned off the drug. She last took it at the beginning of 2018. At the beginning of 2018 the Claimant was also undergoing talking therapy treatment and had previously undergone other therapy treatments.

24. On 13 March 2018 [p27] the Claimant was not considered fit enough to return to work, although she was planning to do so.

25. The Claimant attended her GP on 18 April 2018 [p26], the GP considered that she had anxiety and depression and that she was not fit to work.

26. At some point later in April 2018 the Claimant started work as an NHS bank worker. I accepted the Claimant's evidence that her condition was much improved by this time. I also accepted the Claimant's evidence that this was in part because she was able to choose the shifts she accepted and that if she was feeling 'rough' she could cancel a day in advance.

27. Before the Claimant started the NHS bank work, her sleep was broken, she was unable to sleep and the symptoms also prevented her from

attending work. There is support for these effects in the medical records. The Claimant said that she was unable to leave the house on some occasions. She also said that before April 2018 the anxiety and depression affected her ability to attend to her care needs in that she was sometimes unable to eat or bathe. These matters were not referred to in her medical records. However, given the Claimant's general chronology is consistent with her medical records and that she was unfit to work it is more likely than not that on occasions the Claimant was unable to leave her home and there was a period when she neglected her personal hygiene. I also accept that her motivation was 'sapped' and that she suffered from a loss of appetite. The Claimant was not challenged that her pain tolerance was reduced and therefore she was able to do less, and I accept her evidence.

28. When the Claimant applied for the position with the Respondent, she said that her mental state was improved and she was coping well. This was supported by the lack of GP attendance and I accepted the Claimant's evidence.

29. I was provided with an assessment summary dated 7 September 2015 [p36 to 37]. During the appointment the Claimant completed a questionnaire. The Psychology Practitioner detailed that the Claimant's scores were assessed as her having moderate anxiety and depression. The Claimant was recommended to undertake Cognitive Behavioural Therapy. On 24 March 2016 [p38 to 39] the Claimant attended a further appointment with a Psychology Practitioner, during which a further questionnaire was completed. The Claimant's scores were assessed as her as having moderate depression and mild anxiety. In both face to face appointments the Claimant completed the questionnaires as part of an assessment process by a Psychology Practitioner.

30. I was also provided with a report from the Claimant's GP, Dr Bolam, in which she confirmed that the Claimant suffered from anxiety and depression. Dr Bolam had only seen the Claimant once, but had access to her medical records. The Claimant's condition was described as a mixed picture and was intermittent since 2013. Mirtazapine had been used to treat the Claimant's depression. From her personal observations, Dr Bolam was unable to say whether the impact on the Claimant was substantial.

The Law

31. Section 6 and Schedule 1 of the Equality Act 2010 define disability for the purposes of the Act. A person has a disability if he or she has a physical or mental impairment that has a substantial and long-term adverse effect on their ability to carry out normal day to day activities. A substantial

adverse effect is one that is more than minor or trivial, and a long-term effect is one that has lasted or is likely to last for at least 12 months, or is likely to last the rest of the life of the person, or if it has ceased to have a substantial adverse effect it is to be treated as continuing to have that effect if it is likely to recur.

32. In addition, I considered the 'Guidance on the Definition of Disability' as required under Schedule 1, Part 1, paragraph 12.

33. The time at which to assess the disability is the date of the alleged discriminatory act (Richmond Adult Community College v McDougall [2008] ICR 431 (para 24) and Cruickshank v VAW Motorcast Ltd 2002 ICR 729, EAT).

34. In Goodwin-v-Patent Office [1999] IRLR 4, the EAT gave detailed guidance as to the approach which ought to be taken in determining the issue of disability. A purposive approach to the legislation should be taken. A tribunal ought to remember that, just because a person can undertake day-to-day activities with difficulty, that does not mean that there was not a substantial impairment. The focus ought to be on what the Claimant cannot do or could only do with difficulty and the effect of medication ought to be ignored for the purposes of the assessment.

35. The step approach in Goodwin was approved in J v DLA Piper UK LLP [2010] ICR 1052 (paragraph 40). It was said at paragraph 38,

"*There are indeed sometimes cases where identifying the nature of the impairment from which a Claimant may be suffering involves difficult medical questions; and we agree that in many or most such cases it will be easier – and is entirely legitimate – for the tribunal to park that issue and to ask first whether the Claimant's ability to carry out normal day-to-day activities has been adversely affected – one might indeed say "impaired" – on a long-term basis. If it finds that it has been, it will in many or most cases follow as a matter of common-sense inference that the Claimant is suffering from a condition which has produced that adverse effect — in other words, an "impairment". If that inference can be drawn, it will be unnecessary for the tribunal to try to resolve difficult medical issues of the kind to which we have referred."*

36. The EAT also said at paragraph 42 and 43

"*42. The first point concerns the legitimacy in principle of the kind of distinction made by the tribunal, as summarised at para 33(3) above, between two states of affairs which can produce broadly similar symptoms: those symptoms can be described in various ways, but we will be sufficiently understood if we refer to them as symptoms of low mood*

and anxiety. The first state of affairs is a mental illness—or, if you prefer, a mental condition—which is conveniently referred to as "clinical depression" and is unquestionably an impairment within the meaning of the Act. The second is not characterised as a mental condition at all but simply as a reaction to adverse circumstances (such as problems at work) or—if the jargon may be forgiven—"adverse life events". We dare say that the value or validity of that distinction could be questioned at the level of deep theory; and even if it is accepted in principle the borderline between the two states of affairs is bound often to be very blurred in practice. But we are equally clear that it reflects a distinction which is routinely made by clinicians—it is implicit or explicit in the evidence of each of Dr Brener, Dr MacLeod and Dr Gill in this case—and which should in principle be recognised for the purposes of the Act. We accept that it may be a difficult distinction to apply in a particular case; and the difficulty can be exacerbated by the looseness with which some medical professionals, and most lay people, use such terms as "depression" ("clinical" or otherwise), "anxiety" and "stress". Fortunately, however, we would not expect those difficulties often to cause a real problem in the context of a claim under the Act. This is because of the long-term effect requirement. If, as we recommend at para 40(2) above, a tribunal starts by considering the adverse effect issue and finds that the Claimant's ability to carry out normal day-to-day activities has been substantially impaired by symptoms characteristic of depression for 12 months or more, it would in most cases be likely to conclude that he or she was indeed suffering "clinical depression" rather than simply a reaction to adverse circumstances: it is a common sense observation that such reactions are not normally long-lived.

43. We should make it clear that the distinction discussed in the preceding paragraph does not involve the restoration of the requirement previously imposed by paragraph 1(1) of Schedule 1 that the Claimant prove that he or she is suffering from a "clinically well recognised illness";…"

37. In cases involving mental impairments, it has been held that the use of terms such as 'anxiety', 'stress' or 'depression', even by GPs, would not necessarily amount to proof of an impairment, even if such terms, or similar, had been referred to as part of one of the World Health Organisation International Classification of Diseases (Morgan-v-Staffordshire University [2002] IRLR 190 and J-v-DLA Piper UK LLP [2010] IRLR 936). Counsel for the Respondent referred me to paragraph 20 in Morgan, in particular the following section:

"*Whilst the words 'anxiety', 'stress' and 'depression' could be dug at intervals out of the copies of the medical notes put before the tribunal, it is not the case that their occasional use, even by medical men, will without*

further explanation, amount to proof of a mental impairment within the Act, still less as proof as at some particular time. Even GPs, we suspect, sometimes use such terms without having a technical meaning in mind and none of the notes, without further explanation, can be read as intending to indicate the presence of a classified or classifiable mental illness…"

38. The EAT in Morgan underlined the need for a Claimant to prove his or her case on disability; tribunals were not expected to have anything more than a layman's rudimentary familiarity with mental impairments or psychiatric classifications. The use of labels such as 'anxiety', 'stress' or 'depression' would not normally suffice unless there was credible and informed evidence that, in the particular circumstances, so loose a description nevertheless identified an illness or condition which caused the substantial impairment required under the statute. The EAT recognised that there were significant dangers of a tribunal forming a view on the presence of a mental impairment solely from the manner in which a Claimant gives evidence on the day of the hearing.

39. I was also referred to paragraph 55 in Royal Bank of Scotland plc v Morris UKEAT/0436/10

"*The burden of proving disability lies on the Claimant. There is no rule of law that that burden can only be discharged by adducing first-hand expert evidence, but difficult questions frequently arise in relation to mental impairment, and in* ***Morgan v Staffordshire University*** *[2002] ICR 475 this Tribunal, Lindsay P presiding, observed that "the existence or not of a mental impairment is very much a matter for qualified and informed medical opinion" (see para. 20 (5), at p. 485 A-B); and it was held in that case that reference to the applicant's GP notes was insufficient to establish that she was suffering from a disabling depression (see in particular paras. 18-20, at pp. 482-4). (We should acknowledge that at the time that* ***Morgan*** *was decided paragraph 1 of Schedule 1 contained a provision relevant to mental impairment which has since been repealed; but it does not seem to us that Lindsay P's observations were specifically related to that point.)*"

40. Nevertheless, it is not always possible or necessary to label a condition, or collection of conditions. The statutory language always had to be borne in mind; if the condition caused an impairment which was more than minor or trivial, however it had been labelled, that would ordinarily suffice. In the case of mental impairments, however, the value of informed medical evidence should not be underestimated.

41. Appendix 1 to the EHRC Code of Practice of Employment states that there is no need for a person to establish a medically diagnosed cause for their

impairment. What is important to consider is the effect of the impairment and not the cause. This endorsed the decision in Ministry of Defence v Hay [2008] ICR 1247.

42. Normal day-to-day activities included those which were normal for the particular Claimant as long as they were not specialised activities, as defined in paragraphs D8 and 9 of the *Guidance.* The correct approach involved a consideration of all matters, but particular attention had to be paid to those activities that the Claimant could not do (Leonard-v-Southern Derbyshire Chamber of Commerce [2000] All ER (D) 1327).

43. It was clear from paragraph 2 of Schedule 1 of the Act that an impairment was long term if it had lasted for 12 months or more, or was likely to have lasted that long of the rest of the life of the Claimant. 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 having that effect id it is likely to recur. As to the question of likelihood, I had to ask whether it could well happen (*Guidance*, paragraph C3 and SCA Packaging Ltd v Boyle [2009] IRLR 746). In terms of likelihood of reoccurrence all of the circumstances of the case should be taken into account and this should include what the person could reasonably be expected to do to prevent the recurrence. It is also possible that the way in which a person can control or cope with the effects of an impairment may not always be successful (*Guidance* C9 and C10).

Conclusions

Was there an effect on the Claimant's ability to carry out normal day to day activities?

44. The Claimant had symptoms of poor sleep, reduced appetite, was sometimes unable to leave the house and suffered panic attacks. These affected her ability to work either necessitating absence or leaving work early. Being able to sleep, go to work, eat and socialise are normal day to activities and these were affected. These problems existed before the death of her grandmother in April 2017 but became much more pronounced after that time, in particular from around June or July 2017 to about April 2018. The Claimant's social interaction was also affected. There was therefore an effect on the Claimant's ability to carry out normal day to day activities.

Were such effects substantial?

45. Substantial means, more than minor or trivial. The symptoms were sufficient to mean that the Claimant was unable to work for a lengthy period of time. The medical records also detail that there was a significant

history of sleep disturbance. The symptoms necessitated the prescription of anti-depressant drugs in order to manage the condition alongside other therapies. These effects were therefore more than minor or trivial and were therefore substantial within the meaning of the Act.

Are such effects long term/did they cease to have effect?

46. It was conceded by the Respondent that there was a long-term element to the Claimant's problems. The Respondent submitted that, from April 2018, there were no significant problems for the Claimant and she was not using anti-depressant medication or receiving therapy. The Respondent submitted that, at the time of the withdrawal of the job offer, there were no substantial effects. In relation to whether there was a risk of reoccurrence of the symptoms, Counsel for the Respondent said that it was not possible to say that it could well happen again because she was coping without medication or therapy from at least December 2017.

47. I took into account the type of illness from which the Claimant had suffered and that she had suffered from symptoms, albeit intermittently, since 2012. The medical expert, Dr Bolam, confirmed that the Claimant suffered from intermittent symptoms. The Claimant was prescribed anti-depressant drugs for prolonged periods of time and had undergone various courses of therapy. I also took into account that the Claimant was signed off work until April 2018 and that the withdrawal of the job offer was only 6 months later and that this was in the context of problems spanning 5 to 6 years. I was therefore satisfied on the evidence that the Claimant's condition could well recur and therefore the long-term requirement under the Act was met.

Does the Claimant have an impairment which is either physical or mental?

48. The Respondent submitted that I was unable to rely upon the references in the GP records and relied upon the EAT decision in Morgan. In the present case, the Claimant's GP records consistently record her as having long term mental health problems and anxiety and depression; this was by more than one doctor. This is not a case where there was simply occasional use of such words. Further, the Claimant had been assessed on 2 occasions by Psychology Practitioners [p36 to 39] and it had been concluded that she had moderate depression and anxiety. The Respondent said that these assessments were based on questionnaires completed by the Claimant, however with psychiatric conditions the practitioner is largely reliant on what they are told. I also note that the Claimant attended appointments with the practitioners and discussions took place with them. The Respondent submits the letters [p36 to 39] are not objective evidence, however the discussions with the Claimant during the appointments would have formed part of the practitioners' assessments. I am satisfied that the practitioners, at the time, considered

that the Claimant suffered from anxiety and depression and there was an objective element to those assessments. Further, Dr Bolam considered the medical records and also formed an opinion from her discussion with the Claimant that she had been suffering from depression and anxiety.

49. The Respondent submits that the matters referred to in the medical notes are simply reactions to adverse life events. I took into account the prolonged nature of the problems from which the Claimant had suffered, the need for medical assistance, prescribed drugs and therapy sessions. The Respondent also accepted that the problems had been present for more than 12 months. I also took into account the nature of the GP records, that the Psychology Practitioners in 2015 and 2016 diagnosed that there was depression and anxiety and that Dr Bolam was of the opinion that the Claimant suffered from an anxiety disorder with depression. On considering the evidence as a whole and taking into account the guidance in J v DLA Piper UK LLP, I reject the Respondent's submission and am satisfied that the Claimant had a mental impairment within the meaning of the Act.

50. Accordingly, at the material time, the Claimant was disabled by reason of depression and anxiety.

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Employment Judge J Bax

Dated 12 November 2019