EMPLOYMENT TRIBUNALS

Claimant: **Mr Richard Rich**

Respondents: **(1) Wannops LLP**
(2) Adam Workman

PRELIMINARY HEARING

Heard at: **Bristol (by Video)** **On: 31 January 2022**

Before: Employment Judge Midgley

Representation
Claimant: Mr Julian Allsop (Counsel)
Respondent: Miss Namoi Gyane (Counsel).

RSEERVEDJUDGMENT

ON A PRELIMINARY ISSUE

The claimant was a person with a disability in the period 1 August until 23 November 2021 as a consequence of the physical impairment of myocardial infarction and aortic regurgitation.

REASONS

Claims and Parties

1. By a claim form presented on 17 January the claimant brought a complaint of discrimination on the grounds of disability against his former employer, the respondent. The first respondent is a firm of solicitors with offices in Chichester, Worthing, Littlehampton and Bognor Regis. The second respondent is a member of the First Respondent.

2. The claimant relied upon a heart condition as a physical impairment amounting to a disability for the purposes of the claim.

3. By responses presented on 21 April 2022 the respondent resisted the claim

and denied that the claimant was a person with a disability for the purposes of s.6 and Schedule 1 of the Equality Act 2010. In consequence, following a preliminary hearing before EJ Bax on 4 October 2022, the case was listed for a preliminary hearing to determine the issue of disability.

4. Through a disability impact statement prepared for the preliminary hearing and dated 25 November 2022 the claimant identified the heart condition as follows "a leaky heart valve and underlying heart disease." In medical parlance, those conditions are described as (moderate) aortic regurgitation and myocardial infarction, a form of acute coronary syndrome ("ACS").

Procedure, Hearing and Evidence

5. In preparation for the hearing the parties had agreed a bundle of 172 pages, consisting of relevant medical evidence. In addition, I had the benefit of the following before the hearing:

   5.1. A disability impact statement from the claimant

   5.2. A witness statement from the claimant

   5.3. A skeleton argument prepared by Mr Allsop for the claimant

6. Mr Allsop sought permission to ask a supplementary question to obtain further detail in relation to the medication that the claimant had referred to in his statement on the grounds that the word limit of 1000 words had prevented the claimant from detailing which medication he took when and for what condition. Mr Gyane objected on the grounds that the claimant should have applied to increase the word limit but had not, and that she should not be ambushed.

7. I permitted Mr Allsop to ask the questions as, weighing the prejudice to the parties, it was in the interests of justice to do so as (a) they were questions which I was likely to ask as they were relevant to the test I had to apply (b) there was little prejudice to the respondent as I would permit time for instructions to be taken by Ms Gyane and (c) it was difficult to see how the respondent could gainsay the evidence in any event but it had the medical evidence detailing when the medical was prescribed; lastly (d) I understood that the respondent's case was that the claimant's evidence as to his symptoms and more generally was not credible; that argument could still be deployed in relation to the medication. In the event, it appeared that Miss Gyane had prepared to question the claimant about his medication.

8. I heard evidence from the claimant by affirmation and the claimant answered questions from Miss Gyane, from me. Mr Allsop re-examined the claimant.

9. The parties had prepared skeleton arguments; Miss Gyane's was served after cross-examination. Those skeleton arguments further refined the areas of dispute between the parties. The parties agreed that the material time in respect of the claims began on 1 August 2021 and ended on the 23 November 2021 when the claimant was dismissed.

10. Prior to hearing the parties' submissions, I raised the authorities of Abedeh v British Telecommunications plc [2001] IRLR 23, EAT, Carden v Pickerings Europe Ltd [2005] IRLR 720, EAT and paragraphs B13 and B17 of the

Guidance with the parties. Specifically, I asked the parties to address me on the following - whether:

10.1. The insertion of stent should be treated as ongoing treatment because it continued to provide support, analogous to the possibility identified in Carden, and

10.2. If so, whether it was possible on the basis of the medical or other evidence to identify the deduced effect, if the treatment were to be disregarded, bearing in mind the burden rested on the claimant;

10.3. Alternatively, whether it should be treated as treatment which had cured the condition, and therefore the heart condition should be treated as a past disability in accordance with B17 of the guidance.

11. I gave Ms Gyane time to consider those points before making her submission. Mr Allsop did not request time. Having heard the parties' submissions, Ms Gyane requested permission to address me in relation to the effect of paragraph 23 of Abadeh, in essence arguing that the medical treatment in the form of a stent had created a permanent improvement and therefore the effects of the treatment should be considered when assessing whether the impairment had an adverse effect upon the claimant's day to day activities.

12. Given that that argument was raised at 3:30pm it necessary to reserve my Judgment as there was no prospect of promulgating it and handing it down in 30 minutes.

Factual Background

13. I make the following findings on the balance of probabilities on the basis of the evidence which I have heard and from that contained in the agreed bundle.

The claimant's evidence

14. I address the claimant's evidence separately, rather than as is more usual by simply recording those matters that I found proved on the relevant burden within my findings. I take that step because an unusual feature of this case is that the claimant's evidence hardly accords at all with the medical evidence: the symptoms and their effect upon his day-to-day activities find almost no corroboration in the medical notes and contemporaneous evidence.

15. In particular, the claimant states at paragraph 7 of his statement that his symptoms "can include" the following: shortness of breath, chest pain, fatigue, exceptional diverse bruising, excessive bleeding from pin pricks and nasal blood clots, short-term memory loss, heavy feelings in both legs, occasional pain in arms and mental health. During his evidence he clarified that he did not suffer any significant shortness of breath or chest pain after 26 August 2021.

16. He suggests the consequences of those symptoms in the period August and November 2021 was as follows:

16.1. He had stopped playing golf; he clarified in cross-examination that he had attempted to play golf once, using a buggy, but the movement of swinging a club was uncomfortable;

16.2. He could only walk short distances (although he did not state how long such walks were) and would require breaks;

16.3. He became fatigued when lifting heavy items or doing physical work and needed breaks, adapting to undertaking less strenuous task and avoiding too much physical work;

16.4. He slept upright on his couch for many months post his heart attack. He did not suggest that affected his sleep at that stage, whereas he noted that "in the past three months or so" his sleep had been "short and broken throughout the night."

16.5. He had only played in 28 of a possible 53 poker nights because of his limited ability to focus.

17. In his evidence, the claimant accepted that he had not described any of those symptoms to those treating him because (a) he was a private person and did not like to discuss personal matters, (b) he had a very high pain threshold, was not a moaner or complainer, and (c) he would only mention symptoms when he felt that they were serious and required treatment; finally, and the claimant became emotional when giving this evidence (d) he was in denial as to the seriousness of his condition.

18. The respondent argues that that explanation and the claimant's description of his symptoms is simply not credible and should be rejected.

19. In many ways I found the claimant to be an honest and credible witness, for example in his concession when asked by me that he had not experienced chest pains (save for those detailed in August) or shortness of breath, and that the main reason he had reduced activities was fatigue. I also make allowance for the fact that the claimant was distressed when his heart condition first manifested and then again upon his readmission to hospital in late August. The claimant was told that there was a one ten in chance he would die in surgery. It is understandable that the claimant would be shocked given the manner in which his life had switched from full throttle to 'hanging by a thread' as he described it.

20. However, that same shock would, I conclude, have led him to more vigilant and not less in identifying and reporting the symptoms which the treating clinicians drew to his attention as requiring immediate report to his doctors. I do not accept the claimant's argument that his knowledge of medical matters through his practice of clinical negligence and personal injury had the effect (a) that he could identify matters which could and would be treated and (b) in consequence he only reported symptoms which were consistent with that matrix. That is because the claimant did report symptoms which did not require urgent treatment: he reported a persistent cough and blood clots in his nose. Secondly, it is one thing to practice personal injury, it is quite another to identify and diagnose symptoms connected to the heart. If he was in any doubt, I am certain that the claimant would have reported symptoms to his doctors for that reason.

21. In consequence, I reject the claimant's evidence in relation to his symptoms and their effect in the period August to November 2021 save where they are corroborated by the medical evidence or where I identify them separately

below. On balance I am of the view that the claimant has conflated matters which may have occurred after the period with the symptoms he was experiencing during that period.

22. In so far as the claimant has described suffering from reduced cognitive function and short-term memory loss, I am conscious that the claimant suffered from low mood and anxiety during the period in question for which he was initially prescribed citalopram. However, he does not rely on that condition as a disability. Whilst I accept that initially the sudden onset of the heart condition may have caused anxiety, the medical evidence clearly identifies that the greater cause and contributor to the ongoing symptoms was the developing situation at work where the claimant faced the termination of his career on grounds of redundancy or gross misconduct. There is no medical evidence linking any reduction in cognitive function to the heart condition. I therefore discounted the claimant's evidence as to his short-term memory and loss of confidence for the purposes of assessing the effect of his heart condition.

The manifestation of the heart condition

23. Between the 2 and 6 August 2022 the claimant suffered from pains in his arms which extended into his chest. He was clammy and sweaty. His walk to work from the car park where he parks his car is an 8 minute walk. When walking the pain in his arms and chest intensified; on 2nd and 3rd August if he paused for a minute the pain would eventually pass, on 5 and 6 August he had to stop for 5 or 6 minutes before the pain reduced to a manageable level.

24. On 6 August 2022, the claimant met with a partner from his employer to discuss the future development of the personal injury department. The two men were in a beer garden in a pub. The claimant began to feel acute and sharp pain in his chest and arms. He believed he was having a heart attack but did not say or do anything until the discussion had ended.

25. He sought hospital treatment on 8 August 2021, complaining of pain in his shoulders radiating to his arms, which became worse on exertion, but improved with rest. He suggested that he felt nausea and had noticed some clumsiness. He was placed on an ECG and a diagnosis of myocardial infarction was made. He was retained for observation before being transferred to Worthing Hospital on 9 August 2021 for emergency surgery to insert a stent; it was noted that he had focal critical stenosis which was the cause of his pain in the right side of the claimant's heart and moderate mid LAD disease and mild circumflex disease in the left side of his heart.

26. Further diagnoses of hypertension and hypercholesterolaemia and early signs of pre-diabetes were made. He was prescribed a series of medications:

26.1. Aspirin for life to thin his blood and prevent clots

26.2. A 12-month prescription of Ticagelor to prevent clots forming at the site of the stent.

26.3. Ramipril (again to help his heart)

26.4. Ezetrol /Ezetimibe (to lower levels of cholesterol).

26.5. GTN spray to relieve chest pain

27. The claimant was discharged with a treatment plan involving a 7-day observation period; he was told to look out for certain symptoms and to advise his doctor immediately if they developed, namely: leg pain, leg swelling, warm or discoloured skin on his legs, new onset shortness of breath, unexplained chest pain or coughing up blood.

28. The claimant was signed off work on 13 August 2021 by his GP who cited myocardial infarction.

29. On 16 August 2021, the claimant received a follow up call from the Western Sussex Hospitals; he informed the caller that he was 'feeling good' and 'had no further symptoms' and that he was managing with his medication without difficulty. He expressed a desire to attend an assessment clinic within the next few weeks. An appointment was scheduled to that end on 23 August 2023.

30. The appointment occurred as scheduled on 23 August 2021; the claimant's risk factors were discussed, and a further echocardiogram was to be scheduled after a further 6-8 weeks to assess the claimant's left ventricular function.

<u>Readmission to A & E</u>

31. Between 24 and 26 August 2021, the claimant suffered sharp pains in his chest. He did not use the GTN spray he had been prescribed. On 26 August 2021, having suffered pains in his chest while playing poker, he was readmitted to A & E for further medical review and treatment. A form, entitled 'Acute Admissions Record', records that the claimant reported no fever, vomiting, nausea, night sweats or loss of appetite or shortness of breath; aside from the pain he described himself as "feeling well in himself" when questioned by a consultant. It was found that the ramipril he had been prescribed had affected his kidneys, causing pain, and he was directed to halve the dose to 1.25mg daily.

32. An echocardiogram revealed moderate aortic regurgitation and mildly impaired diastolic function. In short, the claimant's aortic valve was not closing tightly, allowing blood to flow back into the heart. The resulting reduced blood pressure can cause fatigue (particularly during exercise), shortness of breath when exercising or lying down, chest pain, irregular pulse and swollen ankles and feet.

33. On discharge from A&E the claimant was scheduled for a further cardiac rehabilitation for 31 August 2021. Again he was advised, through the discharge note, to look out for the symptoms previously described which might indicate a blood clot.

34. His GP therefore provided him with a further fit note signing him off work to 7 November 2021.

35. Thereafter, on 6 September, the claimant endeavoured to return to work, but that was unsuccessful. There was no evidence beyond the reference to the fact of the attempt in the particulars of claim which indicated the reason why.

36. In any event, as a consequence of the ongoing medical treatment, and possibly

because of the failed attempt to return to work, on 8 September 2021 the claimant's GP provided him with a further fit note covering the period until 7 November 2021.

37. On 28 September 2021, the claimant was scheduled to have a further echocardiogram. On 2 October 2021, a consultant cardiologist noted that there was no significant valve abnormality and the claimant had had a good response to the surgery to insert a stent.

38. On 14 October 2021, the clamant had a 7-day heart monitor fitted. A proforma detailing activities and symptoms was completed. The form recorded, "*overall no problems, just very mild early morning arm pain 2 or 3 times… generally active all week with non-strenuous DIY jobs.*"

39. On 8 November 2021, the claimant's GP provided him with a further fit note again citing myocardial infarction and ongoing medical assessments as the cause, covering the period until 7 January 2022. The claimant had requested that fit note because of his scheduled cardiac catherisation.

40. On 9 November 2021 the claimant was discharged from the cardiac rehabilitation class. He emailed the respondent on the same day. Within the email he made the following comments,

    "*I never exaggerated my symptoms and as everyone said I seemed much healthier post heart attack and physically that is how I felt…*

    I have made a very good physical recovery as far as I am aware

    I propose requesting my GP revokes the majority of the sick certificate and condones my return to work on the Monday 29 November 2021 initially on a phased 3 day return ."

41. On 11 November 2021 the respondent sent the claimant a series of letters which included allegations of gross misconduct and which put him on notice of risk of redundancy. On the same day the consultant cardiologist noted that the claimant should maintain the 12-month prescription of Ticagrelor, and that he would have "a very low threshold for maintaining him on a lower dose for 3 years from 10 August 2022."

<u>The cardiac catheterisation</u>

42. On 15 November 2021 the claimant also underwent a cardiac catheterisation procedure. The purpose of that procedure was to investigate through x-ray the condition of the claimant's heart and supporting blood supplies. Following that procedure the consultant cardiologist wrote to the claimant's GP on 15 November 2021. He made the following observations which are relevant to the issues I have to determine; first that the claimant had bystander LAD disease, and beyond that

    "*he has been completely asymptomatic since his ACS presentation in August 2021…*

    The LAD disease [is] very much borderline… with somewhat diffuse disease in the mid vessel which would be non-prognostic. Given that he has been

asymptomatic we felt it inappropriate to proceed to PCI on that disease today.

The circumflex disease looks unlikely to be causing symptoms and is mild to moderate. The right coronary was imaged again and the stent is widely patent. There is some mild ectasia and in view of this… I strongly advise keeping him on lifelong Aspirin, the complete the initial 12 months of Ticagrelor [sic] … and then I strongly advise a further 3 years of Ticagrelor…

I think we can exercise him in 12 months from now to ensure that he is not getting exertional symptoms. If he were to develop clear stable exertional angina in the future, then I think even with this borderline pressure wire we may have some mandate to consider an LAD angioplasty in the future..

43. On 16 November 2021, the claimant again wrote to his employer repeating his view that 'physically my position is good.' He repeated that view in a further email to the respondent on 17 November 2021, adding "*(other than the stress related effects upon me.")*

44. On 23 November 2021 the claimant was dismissed by the respondent on the grounds of gross misconduct.

<u>The consultation in December 2021</u>

45. On 6 December 2021 the claimant attended a telephone consultation. He described that he was,

    "…feeling good from a physical perspective. He is not being troubled by any chest pain or symptoms suggestive of angina. He is back to walking his dog and doing DIY."

46. The claimant reported that he had blood clots in his nose in the morning, and a dry cough. He referred to his dismissal and stated that he was feeling very stressed in consequence and had been prescribed citalopram. The claimant did not however make any reference to chest pain, fatigue when walking, lifting or playing golf or undertaking DIY; he made no reference to sleeping upright or to heavy or achy legs or to difficulties with memory or confidence.

47. The consultant cardiologist noted, however, that the claimant had a significant cardiovascular disease, moderate aortic regurgitation and bystander coronary disease. He advised that an exercise tolerance test should be scheduled for November 2022 to assess for progression of the latter condition. A further echocardiogram was scheduled for a year's time.

48. In the event, the procedure occurred on 12 April 2022. The consultant noted that the claimant's left and right ventricles were of normal size and systolic function; there was an impression of "at least mild to moderate eccentric aortic regurgitation…" and "mid mitral regurgitation." There was no progression of the aortic valve disease and a further echocardiogram was scheduled for 2 years' time.

<u>Continuing medication</u>

49. The claimant continues to take aspirin, ticagrelor and candesartim for his heart

condition.

The Issues

50. The relevant issues were as follows

50.1. Did the claimant have a disability as defined in section 6 of the Equality Act 2010 at the time of the events the claim is about? In particular:

50.1.1. Did the claimant have a physical or mental impairment. The claimant argues that he had a physical impairment, namely a heart condition.

50.1.2. Did that impairment have a substantial adverse effect on the claimant's ability to carry out day-to-day activities?

50.1.3. If not, did the claimant have medical treatment, including medication, or take other measures to treat or correct the impairments?

50.1.4. Would the impairments have had a substantial adverse effect on his ability to carry out day-to-day activities without the treatment or other measures?

50.1.5. Were the effects of the impairments long-term? In particular:

50.1.5.1. did they last at least 12 months, or were they likely to last at least 12 months?

50.1.5.2. if not, were they likely to recur?

The Relevant Law

51. Section 6 of the Equality Act 2010 provides as follows:

6 Disability

(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.

(3)…

(4) This Act (except Part 12 and section 190) applies in relation to a person who has had a disability as it applies in relation to a person who has the disability; accordingly (except in that Part and that section)—
(a) a reference (however expressed) to a person who has a disability includes a reference to a person who has had the disability, and
(b) a reference (however expressed) to a person who does not have a disability includes a reference to a person who has not had the disability.

(5) A Minister of the Crown may issue guidance about matters to be taken into account in deciding any question for the purposes of subsection (1).

(6) Schedule 1 (disability: supplementary provision) has effect.

52. Section 212 (1) EQA 2010 defines “substantial” as meaning “more than minor or trivial”.

53. The relevant sections of Schedule 1 are as follows:

> *Long-term effects*
> **2** (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.
>
> *Effect of medical treatment*
> **5** (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.
>
> (3) Sub-paragraph (1) does not apply—
>
> (a) in relation to the impairment of a person's sight, to the extent that the impairment is, in the person's case, correctable by spectacles or contact lenses or in such other ways as may be prescribed;
>
> (b) in relation to such other impairments as may be prescribed, in such circumstances as are prescribed.

54. The Equality and Human Rights Commission Guidance (“the Guidance”) was issued in accordance with s.6(5) EQA and by virtue of section 12(1) to Schedule 1 a Tribunal must take it into account when determining whether a person is a disabled person.

55. When dealing with the effects of treatment, the 2010 Guidance on the definition of disability at para B13 states:

> "This provision applies even if the measures result in the effects being completely under control or not at all apparent. Where treatment is continuing it may be having the effect of masking or ameliorating a disability so that it does not have a substantial adverse effect. If the final outcome of such treatment cannot be determined or if it is known that removal of the medical treatment would result in either a relapse or a worsened condition, it would be reasonable to disregard the medical treatment in accordance with paragraph 5 of Schedule 1."

56. Para B17 of the Guidance says:

    "However, if a person receives treatment which cures a condition that would otherwise meet the definition of a disability, the person would be protected by the Act as a person who had a disability in the past."

57. Thus, if treatment for an impairment has ceased by the relevant time, the claimant's abilities must be assessed as he or she is after that treatment. So, if the result of completed treatment is that an improvement has occurred then the individual should be assessed in that improved state. This is the case because paragraph 5 of Schedule 1 applies only to continuing medical treatment, ie to measures that 'are being taken' (Abadeh v British Telecommunications plc [2001] IRLR 23, EAT at paras 31-32).

58. In Carden v Pickerings Europe Ltd [2005] IRLR 720, EAT at para 32. The EAT (Burton P presiding) considered whether a metal plate inserted into the claimant's ankle some 20 years before the material period was 'past treatment' or could be described as 'measures which are being taken.' The EAT held that it depended on whether or not, on the balance of probabilities, the plates that remained in the ankle continued to give support or assistance to the functioning of the ankle. If that was the case, then it could be said that the plates were a 'measure' being taken to treat the impairment whether or not they were correctly described as a 'prosthesis'

59. The additional issues in this case therefore are whether:

    59.1. The stent had cured the condition of ACS and

    59.1.1. if so, whether the condition amounted to a disability so the claimant could or should be treated as a person who had a disability in the past

    59.1.2. if not, whether the insertion of a stent had brought the effects completely under control or, applying Abedeh, had created a permanent improvement

    59.1.3. and, if so, whether it could be treated as ongoing treatment, applying Carden

    59.1.4. if so, whether the claimant had adduced sufficient evidence to show that the deduced effect, absent such treatment, was one which was likely (in the sense of could well happen) to have more than a trivial impact on his day to day activities.

60. In order to determine whether a claimant has a disability the tribunal should consider four questions (see Goodwin v Patent Office [1999] ICR 302, EAT):-

    60.1. did the claimant have a mental and/or physical impairment? (the 'impairment condition')

    60.2. did the impairment affect the claimant's ability to carry out normal day-to-day activities? (the 'adverse effect condition')

    60.3. was the adverse condition substantial? (the 'substantial condition'), and

    60.4. was the adverse condition long term? (the 'long-term condition').

Impairment

61. The time at which to assess the disability (whether there is an impairment which has a substantial adverse effect on normal day-to-day activities) is the date of the alleged discriminatory act (Cruickshank v VAW Motorcast Ltd [2002] ICR 729, EAT). The date of the discriminatory act is also the material time when determining whether the impairment has or is likely to have a long-term effect (All Answers Ltd v W [2021] EWCA Civ 606, CA).

62. The meaning of impairment is dealt with at A3 of the Guidance which provides: "*the term mental or physical impairment should be given its ordinary meaning. It is not necessary for the cause of the impairment to be established, nor does the impairment have to be the result of an illness."*

63. Thus 'Impairment' in s.6 EQA 2010 bears 'its ordinary and natural meaning… It is left to the good sense of the tribunal to make a decision in each case on whether the evidence available establishes that the applicant has a physical or mental impairment with the stated effects' (McNicol v Balfour Beatty Rail Maintenance Ltd [2002] ICR 1498, CA) The term is meant to have a broad application.

64. In Rugamer v Sony Music Entertainment UK Ltd [2002] ICR 381, EAT, the Employment Appeal Tribunal suggested the following definition of physical or mental impairment under the DDA: 'some damage, defect, disorder or disease compared with a person having a full set of physical and mental equipment in normal condition'.

65. Appendix 1 to the EHRC Employment Code 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, not the cause' — para 7. This endorses the decision in Ministry of Defence v Hay [2008] ICR 1247, EAT, where the EAT held that an 'impairment' under S.1(1) DDA could be an illness or the result of an illness, and that it was not necessary to determine its precise medical cause. That line of authority was endorsed in Patel v Metropolitan Borough Council [2010] IRLR 280 (see Slade J at §14) and further adopted in Nissa v Waverly Education Foundation Ltd UKEAT/0135/18 (19 November 2018) the EAT held it was wrong to focus on the question of diagnosis rather than the impairment (§26). It was noted that, whilst the existence of a diagnosis may be evidentially relevant, the absence of a diagnosis is not necessarily determinative (§25). The correct approach is to consider what the effects of the impairments were at the material time, and to consider whether there is information before the Tribunal which shows that, viewed at that time, it could well happen that the effects of the impairments would last for more than 12 months (§25).

66. It will not always be essential for a tribunal to identify a specific 'impairment' if the existence of one can be established from the evidence of an adverse effect on the claimant's abilities (see J v DLA Piper UK LLP [2010] ICR 1052, EAT. Similarly, it is not always necessary to identify an underlying disease or trauma where a claimant's symptoms clearly indicate that he or she is suffering a physical impairment (see College of Ripon and York St John v Hobbs [2002] IRLR 185, EAT.)

Substantial adverse effect

67. The meaning of 'substantial adverse effect' is considered at section 212(2) EQA 2010 and paragraph B1 of the Guidance which provides "a substantial effect is one that is more than a minor or trivial effect".

68. The Guidance provides, in its Appendix, examples 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 (p53-55):
    68.1. Difficulty in getting dressed
    68.2. Difficulty using transport
    68.3. Difficulty in going up or down steps, stairs or gradients
    68.4. A total inability to walk, or an ability to walk only a short distance without difficulty
    68.5. Difficulty picking up and carrying objects of moderate weight with one hand
    68.6. Persistent distractibility or difficulty concentrating

69. D3 of the 2011 Guidance (p34) provides: "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."

70. Sleeping is a normal day-to-day activity. D16 of the 2011 Guidance (p39) provides:

    "Normal day-to-day activities also include activities that are required to maintain personal well-being or to ensure personal safety, or the safety of other people. Account should be taken of whether the effects of an impairment have an impact on whether the person is inclined to carry out or neglect basic functions such as eating, drinking, sleeping, keeping warm or personal hygiene; or to exhibit behaviour which puts the person or other people at risk."

71. B4 of the 2011 Guidance (p16) provides that it is important to consider whether the effect of an impairment on more than one activity, when taken together, could result in an overall substantial adverse effect. It provides the following example:

    "a person whose impairment causes breathing difficulties may, as a result, experience minor effects on the ability to carry out a number of activities such as getting washed and dressed, going for a walk or travelling on public transport. But taken together, the cumulative result would amount to a substantial adverse effect on his or her ability to carry out these normal day-to-day activities."

72. The Tribunal's focus, when considering adverse effects upon day-to-day activities, must necessarily be upon that which claimant maintains he cannot do as a result of his physical or mental impairment" (see Aderimi v London and South Eastern Railway Ltd UKEAT/0316/12, [2013] ICR 591).

73. In that context, the appendix to Schedule 1 of the Equality Act 2010 includes examples of factors which it would be reasonable to regard as having a substantial adverse effect on normal day-to-day activities. These include "a total inability to walk, or inability to walk only a short distance without difficulty; for example because of physical restrictions, pain or fatigue, and persistent distractibility or difficulty concentrating."

74. Conversely the guidance indicates that the following factors would not reasonably be regarded as having such an effect: "experiencing some tiredness or minor discomfort as a result of walking unaided from a distance of about 1.5 kilometres or 1 mile; inability to concentrate on a task requiring application of several hours."

75. The Guidance addresses recurring or fluctuating effects at C5. Examples of how to address episodes of such conditions as depression, or conditions which result in fluctuating symptoms are given at paragraphs C6, C7 and C 11; they provide:

> *C6. If the substantial adverse effects are likely to recur, they are to be treated as if they were continuing. If the effects are likely to recur beyond 12 months after the first occurrence, they are to be treated as long term.*
>
> *C7. It is not necessary for the effect to be the same throughout the period which is being considered in relation to determining whether the "long-term" element of the definition is met. A person may still satisfy the long-term element of the definition even if the effect is not the same throughout the period. It may change: for example activities which are initially very difficult may become possible to a much greater extent. The effect might even disappear temporarily. Or other effects on the ability to carry out normal day-to-day activities may develop and the initial effect may disappear altogether.*
>
> *C11. If medical or other treatment is likely to permanently cure condition and therefore remove impairment so the recurrence of its effects would then be unlikely even if there were no further treatment, this should be taken into consideration when looking at the likelihood of recurrence of those are facts. However, if the treatment simply delays or prevents a recurrence, and a recurrence would be likely if the treatment stops, as is the case with most medication, then the treatment is to be ignored and the effect is to be regarded as likely to recur.*

76. In all four contexts the Guidance stipulates that an event is likely to happen if it 'could well happen' (see para C3). This definition of the word 'likely' reflects the House of Lords' decision in Boyle v SCA Packaging Ltd (Equality and Human Rights Commission intervening) 2009 ICR 1056, HL.

Deduced effect

77. In Royal Bank of Scotland v Morris [2016] EWCA Civ 981 and in particular the observations at paragraphs 62 and 63 in relation to 'deduced effect.' In that case the President Mr Justice Underhill observed:

> "The fact is that while in the case of other kinds of impairment the contemporary medical notes or reports may, even if they are not specifically

addressing the issues arising under the Act, give a Tribunal a sufficient *evidential* basis to make common sense findings, in cases where the disability alleged takes the form of depression or a cognate mental impairment the issues will often be too subtle to allow it to make proper findings without expert assistance. It may be a pity that that is so, but it is inescapable given the real difficulties of assessing in the case of mental impairment issues such as life duration, deduced effect and risk of recurrence which arise directly from the way in which the statute is drafted."

78. I observe, first that that passage does not enunciate any principle of general application, it is clear that it is a question of fact and degree depending on the facts of the case. The extent to which the Court of Appeal were required to set out the evidence in relation to disability in the case before it prior to expressing this view emphasises that point.

79. Morris was approved in the case of Morgan v Abertawe Bro Morgannwg Universities Hospital Trust [2020] ICR 1043. Paragraph 55 of Morgan addresses the decision in the Royal Bank of Scotland v Morris. It reads as follows:

> *"While there is no rule of law that an issue of this type can only ever be properly decided with the benefit of expert medical advice, as the EAT put it in Royal Bank of Scotland v Morris, particularly in relation to matters to do with mental health, the issues will often be too subtle for the Tribunal to be able to properly resolve, even if there are contemporaneous medical records, without the benefit of specific expert medical evidence prepared for the purposes of litigation."*

80. I observe that in the case of Morgan the nature of the medical evidence in question was that of a particular doctor whose evidence was inconsistent with that of other doctors which had been provided at the time, and there a was conflict within the medical opinion as to the likely duration and the precise symptoms of the condition. That was of particular importance given claims for future loss (see paragraphs 57 and 58 of the Judgment).

81. Having carefully reviewed Morgan and Morris, I conclude that there is no legal principle that a claimant must place an expert medical report before the Tribunal addressing the question of deduced effect in order to prove that a condition of constitutes a disability. Paragraph 55 of Morgan identifies that such a course may be necessary, but it creates no rule of law to that effect.

Discussions and conclusions

82. I address to the questions set out in Goodwin.

Did the claimant have a mental or physical impairment?

83. There is no dispute in this case that the claimant had physical impairment, namely a heart conditions described in medical terms as 'myorcardial infarction' and 'aortic regurgitation.' The latter condition appears from the medical evidence to have become more pronounced from a diagnostic perspective between October and December 2021

Did the impairment affect the claimant's ability to carry out normal day-to-day

activities?

84. I first address the question of whether the stent should be treated as having created a permanent improvement in the claimant's condition. I am satisfied that it did: without it, the claimant's right radial artery would have become blocked which would likely have resulted in the claimant's death. However, that is not to say that it cured the claimant's heart condition; he still has myocardial infarction and aortic regurgitation. The permanent improvement was in the radial artery only, not in the aortic or mitral valve.

85. Furthermore, applying Carden, I am persuaded that the stent provided and continues to provide support to the claimant. The medical evidence, specifically the consultant's letter of 15 November 2021, records that the stent is 'widely patent.' Thus the e stent has the effect of masking or ameliorating the condition. In my Judgment therefore (a) the insertion of the stent is to be treated as measures that 'are being taken' for the purpose of paragraph 6 of Schedule 1 and (b) in consequence the effects of the stent should stripped out to determine the deduced effect of the condition upon the claimant's ability to undertake day to day activities.

86. I therefore reject Miss Gyane's argument that the impairment should be assessed on the basis of the claimant's actual abilities; the insertion of a stent is not analogous to physiotherapy, which was considered in Abedeh. The issue of the claimant's credibility in relation to that effect, whilst I have decided it, is irrelevant; I must consider the deduced effect not the actual effect.

87. However, in my judgment, the measures which are being taken include the prescription of aspirin (for life), and of ticagrelor (for 3 years at varying strengths) and ramipril. The effects of those medications must also be discounted when assessing the effect of the heart conditions upon the claimant's ability to perform day to day activities.

88. What then would the effects on the claimant's day to day activities have been if he did not have a stent and was not prescribed medication? In my judgment, it is unnecessary for me to have specific expert medical evidence to identify the deduced effect; the effect is obvious: the claimant would have continued to struggle to walk distances without significant pain and requiring breaks to allow the pain to pass, and the likelihood is that he would inevitably have died were the condition to have been left untreated. That is obvious from the fact of the emergency surgery and that the claimant was told there was a 10% chance of mortality through the surgery itself.

89. Moreover, the medications were prescribed to prevent blood clots forming around the stent, because of the risk of cardiac arrest were that to occur, and the forming of blood clots more generally creating a risk of stroke. Thus, if I am wrong as to how the stent is to be treated for the purposes of schedule 1, I would still have concluded that the heart condition would have had an adverse impact on the claimant's ability to undertake day to day activities, because he would be likely to suffer a cardiac arrest or stroke; on the balance of probabilities I have no hesitation in concluding that either event could well have happened. Moreover, the medical professionals clearly perceived the risk as being one that could well happen given their prescription of medication to prevent it.

Was the adverse effect substantial?

90. It is trite that living is a day to day activity. Dying through stroke or cardiac arrest would have more than a trivial impact on that activity. Similarly, any risk of stroke or cardiac arrest would have such an effect.

91. For the avoidance of doubt, in addition, for the reasons I have given, if the stent were not inserted, there would have been a substantial adverse effect on the claimant's ability to walk distances of more than 1.5 km without significant pain and without requiring breaks, and on his ability toundertake physical activity such as lifting heavy objects.

Was the adverse effect long term?

92. It is clear that the medical professionals believed that the risk of blood clots forming around the stent and more generally would last longer than 12 months: Aspirin was prescribed for life, and ticagrelor for 12 months with a reduced prescription for a period of 3 years from the 8 August 2021. Similarly, the risk of the right radial artery becoming blocked would have lasted 12 months; the stent was inserted to prevent the blockage that was developing, and there was no intention to remove it at all, let alone within 12 months.

93. I therefore conclude that during the material period the adverse effect was likely to last more than 12 months.

Conclusion on disability

94. It follows from those matters that I have concluded that the claimant was a disabled person for the purposes of Section 6 EQA 2010 at the material times for the purposes of this claim, namely 1 August and 23 November 2021 due to 'myorcardial infarction' and 'aortic regurgitation.'

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Employment Judge Midgley
Date: 1 February 2023

JUDGMENT & REASONS SENT TO THE PARTIES ON
16th February 2023 by Miss J Hopes

FOR THE TRIBUNAL OFFICE