EMPLOYMENT TRIBUNALS

Claimant: **Mrs L Hepworth**

Respondents: **Dr Pettit, Dr Estcourt, Dr Philips, Dr Haynes, Dr Hanslip, Dr Gillam, Dr Neale (a partnership trading as Malmesbury Medical Practice)**

Heard at: **Bristol (via video)** **On:** **2 May 2023**

Before: **Employment Judge Cuthbert**

Representation
Claimant: Mr Hepworth (lay representative)
Respondent: Mr R Fitzpatrick (counsel)

PRELIMINARY HEARING RESERVED JUDGMENT

1. The claimant **was** disabled in accordance with section 6 of the Equality Act 2010 with the physical impairments of fatigue, shortness of breath and mobility difficulties, potentially attributable to Long COVID, **from 9 September 2021 onwards**.

2. The claimant was **not** disabled **before 9 September 2021**.

3. The Tribunal does therefore have jurisdiction to consider the complaints of disability discrimination which include and post-date 9 September 2021, which will proceed to the liability hearing from 19 to 23 June 2023 and be determined along with the claimant's other complaints.

REASONS

Introduction

1. The case was listed for a public, one-day video preliminary hearing to decide the issue of disability. It was listed as such because it was convenient, this is the normal practice in the region for such hearings and the parties were content with it proceeding as such.

2. In normal circumstances, one day would have been sufficient for the Tribunal to have heard the evidence and submissions, deliberated and delivered an oral decision to the parties. Unfortunately, there were a number of technical issues involving the video hearing, which delayed the start of the hearing and caused some delays during the course of it (whilst the hearing was paused rather than during any evidence).

3. I was provided with an impact statement from the claimant and some related medical evidence, 22 pages of redacted medical records. I was also provided with a copy of the 407-page bundle which has been prepared the imminent full hearing. Both parties prepared written opening notes. I heard oral evidence from the claimant and then oral closing submissions from both representatives. The oral submissions were not heard until the afternoon, due to the earlier delays, and this left insufficient time for deliberation and an oral decision.

4. Before the start of the claimant's oral evidence, Mr Hepworth, who was representing his wife, asked for her to be allowed to refer to some additional notes, during her oral evidence, which they had prepared to assist her recall of events. I refused this request - it would have been highly unusual and there was no evidence to support such an adjustment being made. I explained that Mr Hepworth could ask the claimant further questions by way of re-examination, if he felt that any of her evidence needed to be clarified after her questioning by Mr Fitzpatrick and the Tribunal.

Issues

5. The issues on disability to be determined had identified, amongst various other issues relating other claims pursued by the claimant, at a previous case management hearing. They are set out below. Some irrelevant issues have been omitted, and some slightly refined but they are substantively the same and the impairments relied upon as are as previously defined.

    (a) Did the claimant have a disability as defined in section 6 of the Equality Act 2010 between 9 July 2021 and 9 December 2021 (the **relevant period** during which the alleged discrimination occurred, as identified in the respondent's opening note)? This entailed deciding the following sub-issues:

        i. Did the claimant have a physical impairment, identified and agreed at the previous preliminary hearing specifically as **"fatigue, difficulty breathing and mobility difficulties, attributed to Long COVID"**?
        ii. What were the effects of the impairments on her ability to carry out normal day-to-day activities?
        iii. Did the impairments have a substantial adverse effect on the claimant's ability to carry out day-to-day activities?
        iv. Were the substantial adverse effects of the impairment long-term? The Tribunal will decide:
            1. did they last at least 12 months, or
            2. were they likely to last at least 12 months?

3. if not, were they likely to recur?

Findings of Fact

6. I have set out my findings on relevant facts below.

7. As indicated, I heard oral evidence from the claimant. The claimant had been given guidance within the previous CMO (para 48) on the production of a disability impact statement and what it should set out, particularly in terms of the effects of the impairment relied upon on her normal day-to day-activities. This guidance included examples of normal day-to-day activities.

8. The claimant's three-page disability impact statement was more focused upon identifying multiple impairments and symptoms than on identifying the **effects** of the impairments on the claimant's day to day activities. She set out, on page one, a list of around 24 different symptoms/conditions, which she said she had experienced and which she attributed to Long COVID, as follows:

    a. *Reduced mobility.*
    b. *Tiredness and fatigue.*
    c. *Low mood.*
    d. *Poor concentration - Brain Fog.*
    e. *Increased susceptibility to infection.*
    f. *Low ferratin - anaemia.*
    g. *Shortness of breath.*
    h. *Loss of control of bladder and bowels*
    i. *Nausea*
    j. *Vomiting, intermittent diarrhoea*
    k. *Swelling of joints*
    l. *Sleeplessness*
    m. *Sleep Apnoea.*
    n. *Dizziness when standing up (light headedness)*
    o. *Post exertional malaise*
    p. *Change in taste and smell*
    q. *Pins and needles in feet and hands and loss of feeling in feet*
    r. *Chest pain (Costochondritis)*
    s. *Depression and anxiety.*
    t. *Rashes.*
    u. *Joint and muscle pain.*
    v. *Heartburn.*
    w. *Hiatus Hernia.*
    x. *Blood clots.*

9. This list was largely repeated on page three of the impact statement. It went substantially beyond the impairments as identified and agreed at the previous hearing. The available medical evidence in support of the claimant's impact statement was relatively limited, in terms of to the long list above: namely, 22 pages of medical notes and letters, extracted from a larger set of GP notes, and partially redacted, covering the period from September 2020 to 15 December 2021. There was little, and in many cases no meaningful medical

evidence (particularly to non-medically qualified persons) about the effects and duration of many of the symptoms/ conditions listed above.

10. I therefore focused, when considering the issue of disability, on those impairments which **were** identified at the previous CMO and in the agreed list of issues. These were in any event the most commonly recurring and over-arching impairments mentioned in the medical evidence and also those with the clearest potential effects, from the evidence, on the claimant's normal day-to-day activities at the relevant times. Those impairments were:

    (a) Breathing difficulties/shortness of breath
    (b) Fatigue
    (c) Mobility difficulties
    (d) Possible Long COVID (to which (a), (b) and (c) were attributed)

11. I return below to the claimant's evidence about the effects of these impairments on her normal day-to-day activities.

The GP records (in summary)

12. The following **relevant** records appeared in the GP notes (entered by GP unless otherwise indicated), summarised or set out in full in some instances:

    (a) 14 January 2021 – *"Also had covid in March 2020 and since then felt SOBOE [shortness of breath on exertion]. Had put it down to post-covid but now realises may be related to anaemia".* Compression, discomfort in lower abdomen. Unexplained anaemia.

    (b) 2 March 2021 – feels tired all the time, some gastro intestinal symptoms and reported that symptoms came on after COVID in March 2020. Felt better having altered diet.

    (c) 29 March 2021 – had Astro Zeneca vaccine (second dose)

    (d) 6 July 2021 – TATT [tired all the time] and SOB [shortness of breath]. *"not getting any better"*. Ongoing struggle to eat more healthily. Anaemia

    (e) 30 July 2021 (sic)

        "I take note of recent issues with shortness of breath, Hb was 9.1 in Jan with a low ferritin which has been investigated, Hb has gradually risen. Normal in May.
        Shortness of breath has come on gradually since this Spring, but has been worse past 2 weeks, she has come today because now struggling with the stairs here and sob in conversation.
        No wheeze, no leg oedema, no new chest pains, no cough or sputum.
        Had covid in march 20, relatively mild symptoms which she got over.
        Symptoms have been worse since double AZ vaccination.
        No calf pains, cough or haemoptysis.
        She is actively engaged with wt loss, and has lost 6lb.
        Sleep generally ok, has been sob twice at night recently.

I note normal CXR, and CT scans in Spring.
Examination: Mildly sob in conversation.
151/90mmHg
HR 80/min SaO2 97% rasps normal.
HS normal, JVP down, chest v clear. Legs nad.
Plan: ? diagnosis.
I feel long covid unlikely and this is something new, not anaemic now.
Bloods on Monday to include d-dimer and BNP, If no clues, consider referral ? via ATC.
Offered med 3 if needed and safety netted 111/999/A&E if worse over weekend.
I wonder if this is to do with her weight but other things need excluding"

(f) 5 August 2021 –

"…felt awful last Fri - more SOB than ever. Seemed a bit better on Saturday.
Had consultation with JN and further tests - nil again pointed at any significant cause. No chest pain or sharp pain on deep insp. Has tightness centrally. Has tried inhalers at home - no difference.
Noted that sx became sig worse after covid vaccines (AZ).
Suggest check ca 125 as per suggestions made by colleagues at lunchtime mtg.
Plan: If SOB worsens again ?refer medics ??consider CT chest/CTPA ?other thoughts. With current covid case numbers have to balance ref acute medics with poss exposure to infection.
Agreed I'll liaise with JN about findings/thoughts".

(g) 9 September 2021 –

"Spoke to Lisa.
Still SOB all the time.
Has developed pain underneath from breast bone to RHS. Worsens when takes deep breath.
Still SOB on exertion. TATT.
Generally still feels rubbish.

She asked about long covid service ref.
Has read about the sx from others with similar sx e g. post-vaccine.
Consultant suggested rechecking TTG after eating gluten.

Agreed sensible to check wrt TATT/gastro sx but I can't see how this accounts for her ongoing SOB.
Suggest I'll check with secs re A&G vs ?resp A&G and get back to Lisa.
She's happy to go to amb care if needed.
Plan May warrant both long covid service referral and ?resp/medics.

Referred to Long COVID clinic.

(h) 16 September 2021 – *"No PMH of asthma. Has tried her children's salbutamol to no benefit. Examination: Sats 97%. P 78. Once sitting at rest. Having arrived from her office on same level - sats were 95% and P 1 18. After walking around the surgery down and upstairs again sats 91% HR 140 V SOB. Over following 1-2 mins sats climbed back to 95% then again to 97%.*

(i) 14 October 2021 – SOB chest pain and fatigue, sleeps ok, mood ok, wiped out at home at the weekends; working long FT hours, midway through PhD at home[1], "understandably exhausted". Some days less bad than others. Pacing advised and GP suggested 4 week reduced period of hours at work. Diagnosis – shortness of breath and fatigue.

(j) ?? October 2021 – SOB and fatigue worsened in last couple of weeks

(k) 21 October 2021 – entry by physiotherapist, to whom the claimant had been referred for elbow and shoulder pain. Since long covid has been anaemic. Breathlessness. *"?Long covid since covid vaccine"*; walking – long COVID limiting; problems include long covid symptoms, reduced physical tolerance.

(l) 11 Nov 2021 – Long COVID assessment on Monday

(m) 15 November 2021 – entry by occupational therapist:

General symptoms: can fall asleep, falls asleep when home from work, can't do anything in the house, weekends watches TV downstairs napping in the day.
…
Lives with H and 4 children, 3 young adults and one 15 years
Attends works Monday to Friday
…
SOB – some days worse than others
Stairs stops two to 3 steps and stops.
Out of breath walking to car - 3 metres.
At work people can hear me coming because of my breathing.
Sits down for ten mins back to normal.
[D]Cardiovascular system symptoms (R05..)
Heart racing - on exertion
Plus goes up and sats go down below 90 on walking up one flight of stair.
At rest back up to 93
…
Works in the same GP surgery as she is registered to, no extended sick leave. Reports GP advised against time off work as concerned she would become depressed. Therefore, working 3/4 of her day in work and 1/4 at home.
…
Joints ache all the time, wrists, elbows, shoulders
…

[1] The claimant was asked about the PhD in cross examination and said this was wrong and she was **not** undertaking a PhD over this period in 2021.

Covid unconfirmed March 2020, then in March 2021 had 2nd astrazeneca, main long covid symptoms following this.
…
Lacking iron, tablets for over a year, then infusion, helped for 2 weeks, fatigue improved. GP monitoring/reviewing as Lisa appears be unable to store iron.
…
Does not like to read about long covid symptoms as she feels she would convince herself she has them all.
…
Has agreed to consider reduced working hours or sometime off on sick leave.
Described the concept of body battery and she is not giving herself any time to re charge and recuperate.
Work at present consumes all her energy.
…
Identifying personal goals - Being alive next year
…
Standing for long periods such as 30 minutes?: Severe
Taking care of your household responsibilities?: Extreme or cannot do
…
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?: Severe
How much have you been emotionally affected by your health problems?: Extreme or cannot do
Concentrating on doing something for ten minutes?: Moderate
Walking a long distance such as half a mile?: Extreme or cannot do
Washing your whole body?: Extreme or cannot do
Getting dressed?: Extreme or cannot do
…
Your day-to-day work?: Moderate
….
Daughter helps with washing/bath- washes hair and helps with transfers.
Teenage sons will lay out clothes and help undress at night.
Due to tiredness can lift arms, joint pain = difficulty with bra.
Since March 21 after 2nd vaccine
Family attending to chores.
Family make dinner, walk dog, cook & clean.
…
USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities): I have severe problems doing my usual activities
…
SELF-CARE: I have moderate problems washing or dressing myself
…
PAIN / DISCOMFORT; I have moderate pain or discomfort

(n) 15 November 2021 – GP entry – *"Chest no change remains breathless but no different"*.

(o) 2 December 2021 – physiotherapist entry. *"Recent investigations clear so advised likely long covid cause for majority of symptoms ?from*

vaccination - Has been seen in the long covid clinic - has a plan in place and follow up".

(p) 7 December 2021 - waking up in night feeling breathless. Becoming more achy in joints

13. Within the GP notes was an extract of a letter from a Specialist Registrar in respiratory medicine. The first two pages of the letter were missing (it was not apparent why) but it was evidently prepared at some point whilst the claimant was working for the respondent, as her employment there is mentioned. The letter refers to breathlessness symptoms, for which there was no clear cause apparent. It included the following statement: *"Over this last year Lisa has been very tired and has been thoroughly investigated."* In short, the available extract from the letter discussed various possible causes and contributory factors and ruled some causes out and recommended further tests. It did not mention Long COVID.

14. There was also a letter dated 8 December 2021 from an Occupational Therapist at the Long COVID clinic (to which the claimant had previously been referred by the GP), the same individual who created the entry above dated 15 November 2021. The letter stated:

> *Thank you for your referral to the BSW Long Covid Assessment Hub. Lisa Hepworth has received a 60 minute telephone assessment and been provided with resources and advice relevant to their symptoms and the impact long covid has had on their function.*
>
> *All critical information regarding the Long Covid assessments is available on System One records.*
>
> *Lisa Hepworth has now been transferred to the Wiltshire Health and Care Long Covid Rehab Team and registered to receive one to one intervention with our team of Allied Health professionals. They are aware they will be sent details on this in due course.*

15. There was no detail of further Long COVID treatment undertaken by the claimant after that, although even if there were, it would have been after the end of the relevant period.

16. Finally, in the medical notes, there was a referral form, seemingly from the GP to the Community Respiratory Team, dated 17 January 2022. The author was not identified. This recorded: *"confirmed diagnosis: Dysfunctional breathing post-Covid".* The claimant was to be referred for pulmonary physiotherapy and pulmonary rehabilitation. Her oxygen saturation was recorded as 98% on 29 December (2021 presumably). It was also noted: *"Patient has post covid shortness of breath and dysfunctional breathing"*.

17. There were also two Med 3 forms from the GP in the main bundle, dated 14 October 2021 and 6 January 2022. Each said: *"May be fit" "Shortness of breath and fatigue – awaiting respiratory input"* – recommended 75% of hours for next 4 weeks to pace activities.

The claimant's own evidence

18. In her impact statement, on the second page, the claimant described the effects upon her as follows:

> *On occasions I was too tired to drive the mile home and my husband had to collect me. Prior to Covid I could walk the mile home. Post Covid, walking to the car was a challenge. At the end of each day I would collapse into a chair exhausted and fall asleep. I had no social life due to my fatigue. I had mobility and flexibility issues, that were made much worse by my breathing difficulties. I could not walk easily and negotiating stairs was a serious challenge, that took time and frequent breaks to catch my breath. My low mood was the outcome of suffering consistent pain and discomfort…*
>
> *My inability to assimilate and retain iron has had an enormous impact upon me. The transfusions themselves, of which I have had four to date, have a significant impact on my whole body and result in three to four days of all over pain. Then towards the point where my iron levels fall dangerously low, I am consistently exhausted and even the slightest of movements becomes an enormous effort. I could physically feel my iron running out. My sleep quality was variable and usually had an adverse influence on me during the following day. …Lack of energy and physical flexibility meant that I relied heavily on my family to help me with the simplest of tasks. I was unable to manage personal hygiene, personal administration, my home and the simplest of tasks and again I relied on the things I should have done being completed in total by other family members. All these impairments are still my day-to-day experiences now.*

19. The above paragraphs are evidently somewhat vague in places; the impact statement was focused more on medical conditions and symptoms than on describing effects on normal day-to-day activities. There were further details and evidence relating to normal day-to-day activities within the contemporaneous GP notes, upon which the claimant also relied, but they did not cover all of the details summarised in the extracts from the impact statement set out above. So, I asked the claimant to expand on what she meant in the above paragraphs, in several respects:

    (a) She explained that the shortness of breath had affected her from around January 2021 to the date of the hearing. The symptoms became progressively worse, particularly from around July 2021.

    (b) I asked about social activities mentioned in the same paragraph. She said she had stopped going out with friends from around February or March 2021.

    (c) Before the onset of her symptoms she had walked her dog about 10 miles a day but by around the middle of 2021, June or July, things were getting worse and from around September or October she could "do nothing".

(d) I asked what tasks her family helped with. She said she could not do housework – making dinner, cooking, cleaning. She could not wash herself or get dressed without assistance. She could not do shopping. Family members had to carry out or assist with these activities. I asked over what period these effects were the case. She said she got progressively worse after the second vaccine (March 2021) and by July 2021, she was the worst she had been and could not finish sentences because of her breathlessness.

20. The claimant was challenged in cross examination about the extent of the disability which she described in the entry in the medical notes of 15 November 2021, set out above. It was suggested that the inability which she described (at the "severe" or "extreme" end of the scale in several responses), which was put to her as painting a *"picture of someone quite profoundly disabled"* was inconsistent with her being able to remain at work and only considering reduced hours. The claimant said that she hadn't felt able to take time off work because of what was happening at that time. I note that there are places in the GP records which record the claimant's work as consuming all her energy, or words to that effect, and in her impact statement, she said *"The long hours I was forced to work exhausted me… At the end of each day, I would collapse into a chair and fall asleep"*. I do not find that there was any material inconsistency.

21. Whilst it was suggested during cross examination that the claimant was exaggerating her self-reporting of her symptoms, there was **no** medical or other evidence which indicated that what she was reporting to those who were attempting to treat and diagnose her was materially inaccurate or significantly over-stated. It seems likely that there was some *mild* over-statement in the self-reporting of 15 November 2021 to the occupational therapist, in that the *"extreme"* and *"severe"* labels which were self-applied during a diagnostic test did not seem to be wholly consistent with someone who was still able to attend work at that time; perhaps a classification of the effects as *"moderate"* or *"moderate to severe"* would have been more accurate. I did accept the claimant's account, essentially that she did not want to take time off work and that attending work consumed most of her available energy – that was consistent with what was noted in the contemporaneous records from 2021. Those records also indicated that a GP had offered to sign the clamant off work in the entry of 30 July 2021 but evidently the claimant did not agree to this suggestion as the first Med 3 was not until October 2021.

22. I therefore largely accept the claimant's account of breathlessness, fatigue and impaired mobility and of the effects that these impairments had on her normal day-to-day activities, set out above (walking, driving, social activities, housework, shopping, personal care), increasingly during the course of 2021. It was broadly consistent with the GP records. For example, the GP note of 14 October 2021 gives a *"diagnosis"* of *"shortness of breath and fatigue"* and contains reference to the claimant being heavily fatigued at home; the earlier entry of 30 July refers to shortness of breath issues being connected to a difficulty climbing the stairs.

23. The claimant was cross examined about various different oxygen saturation readings which were contained in the GP records. There was no medical or

other evidence which materially assisted the Tribunal in interpreting what those readings meant, in terms of the claimant's shortness of breath issues. For instance, it was not clear whether or not there was a direct correlation between such readings and the extent or severity of shortness of breath symptoms which might be expected at that point in time, or whether there may be other factors relevant to shortness of breath which may not be reflected in those particular readings. It was put to the claimant during cross-examination her that there was a discrepancy between readings she took herself and reported to the GP, which appeared to be lower than readings taken by the GP or other medical professionals. There was no medical or other evidence which showed that the readings taken by the claimant were false/over-stated, so as to displace her evidence in response to this line of questioning, to the effect that the readings simply reflected the circumstances in which the reading was taken at a given time. She referred to one oxygen reading being taken by the GP after she had been sat down waiting for an hour for her appointment, and so her symptoms of breathlessness were not significant at that specific point in time when the reading was taken. She had also reported to the GP that the shortness of breath fluctuated.

24. Finally, there were a number of references to Long COVID and to various tests and assessments in the available GP notes, and the claimant was referred to the Long COVID clinic in September 2021. There was, however, no clear or definitive medical diagnosis of Long COVID, during the relevant period ending in December 2021. As such, there was also no clear view on prognosis in the medical documents. By the end of the relevant period, Long COVID was still seemingly on the table as a real possibility in terms of causing the claimant's symptoms, with some treatment proposed (by way of COVID rehabilitation) according to the letter from the occupational therapist, dated 8 December 2021. I have considered this further when applying the legal tests further below, particularly on the issue of "long term" and "likely".

The law

Statutory definition of disability

25. Section 6 of the Equality Act 2010 states:

6(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**…*

A reference to a disabled person is a reference to a person who has a disability.

26. Section 212 of the Equality Act 2010 defines "substantial" as being **more than minor or trivial.**

27. Paragraph 5 of Schedule 1 to the Equality Act 2010 says:

(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 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.

28. Para. 12 of Schedule 1 of the Equality Act 2010 provides that when determining whether a person is disabled, the Tribunal *"must take account of such guidance as it thinks is relevant."* The "Equality Act 2010 Guidance: Guidance on matters to be taken into account in determining questions relating to the definition of disability" (May 2011) (the "Guidance") was issued by the Secretary of State pursuant to section 6(5) of the Equality Act 2010.

The Overall Approach to Deciding the Issue

36. Unless it is agreed by the respondent that the claimant was at the relevant time a disabled person then the responsibility is on the claimant to show that he or she was a disabled person.

29. The relevant point in time to be looked at by the Tribunal when evaluating whether the claimant is disabled under section 6 is not the date of the hearing, but the time of the alleged discriminatory act: *Cruickshank v Vaw Motorcast Ltd* [2002] I.C.R. 729.

30. In *Goodwin v Patent Office* [1999] I.C.R. 302, Morison J (President), provided some guidance on the proper approach for the Tribunal to adopt when applying the provisions of the Disability Discrimination Act 1995 (precursor to the Equality Act 2010 disability provisions). Morison J set out four questions to be answered by the Tribunal in order. This four-stage approach was approved more recently by the Court of Appeal in *Sullivan v Bury Street Capital Limited* [2021] EWCA Civ 1694, where Singh LJ listed the questions as:

(a) Was there an impairment? (the 'impairment condition');

(b) What were its adverse effects [on normal day-to-day activities]? (the 'adverse effect condition');

(c) Were they more than minor or trivial? (the 'substantial condition');

(d) Was there a real possibility that they would continue for more than 12 months? (the 'long-term condition').

31. Singh LJ emphasised that these are questions for the Tribunal; although it may be assisted by medical evidence, it is not bound by any opinion expressed.

32. In *Goodwin,* Morison J warned of the risk of "disaggregating" the 4 questions – i.e. whilst they can be addressed separately, it is important not to forget the purpose of the legislation, and to look at the overall picture. This warning was emphasised by HHJ Tayler more recently in *Mr A Elliot v Dorset County Council*, UKEAT/0197/20/LA.

"Impairment"

33. Underhill J (President) in *J v DLA Piper UK LLP* 2010 WL 2131720 suggested (para [40]) that although it was still good practice for the Tribunal to state a conclusion separately on the question of impairment, as recommended in *Goodwin*, there will generally be no need to actually consider the 'impairment condition' in detail:

> *"In many or most cases it will be easier (and is entirely legitimate) for the tribunal to ask first whether the claimant's ability to carry out normal day-to-day activities has been adversely affected 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 an impairment which has produced that adverse effect. If that inference can be drawn, it will be unnecessary for the tribunal to try to resolve the difficult medical issues."*

34. Para 7 of Appendix 1 to the EHRC's Employment Code of Practice (the Code) states: *'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'*. This was confirmed by Langstaff P in *Walker v Sita Information Networking Computing Limited* [2012] UKEAT 0097/12: *'The purpose of the definition of disability was not to confine an impairment to that which could be shown to be given a medical label which was either a recognised physical or mental condition; it was, rather, to describe the nature of the impairment. The Act did not require a focus upon the cause of that impairment'*

35. There is no statutory definition of a physical impairment. In *College of Ripon and York St John v Hobbs* [2002] IRLR 185 it was held that a person has a physical impairment if he or she has "*something wrong with them physically*".

36. In the case of *Millar v HMRC* [2006] IRLR 112, the Court of Session held that a physical impairment can be established **without** establishing causation and, in particular, without the impairment being shown to have its origins in any particular illness.

Adverse effect on normal day-to-day activities

37. "Day to day activities" encompass activities which are relevant to participation in professional life as well as participation in personal life, and that the Tribunal should focus on what the claimant cannot do, not what they can do.

38. In *Elliot v Dorset County Council* HHJ Tayler pointed out that it is difficult to look at this question in isolation – for example, how is it possible to decide whether there is a "substantial adverse effect" on normal day to day activities without first identifying which "normal day to day activities" are affected?

39. The Guidance provides the following examples of what is meant by "normal day to day activities" (note this is a selection of the examples given and reference should be made to the Guidance itself – paragraph numbers are in square brackets):

    (a) 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. [D3]
    (b) Normal day-to-day activities can also include general work-related activities such as interacting with colleagues. [D3]
    (c) The term 'normal day-to-day activities' is not intended to include activities which are normal only for a particular person, or a small group of people[2]. In deciding whether an activity is a normal day-to- day activity, account should be taken of how far it is carried out by people on a daily or frequent basis. In this context, 'normal' should be given its ordinary, everyday meaning. [D4] It is not necessary, however, that "most people" carry out the activity – the example of breast feeding is given.
    (d) Normal day-to-day activities also include activities that are required to maintain personal well-being. 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 and sleeping. [D16]
    (e) Some impairments may have an adverse impact on the ability of a person to carry out normal day-to-day communication activities. [D17]

37. There needs to be evidence that the relevant impairment **caused** the adverse impact on the claimant's ability to carry out normal day to day activities – see *Primaz v Carl Room Restaurants Ltd* [2021] WL 05510289.

"Substantial"

38. Section 212(1) defines "substantial" as meaning "more than minor or trivial."

39. In *Rayner v Turning Point* [2010] 11 WLUK 156, HHJ McMullen QC held, at [22], that although the question of whether there is a *"substantial"* adverse effect is a matter of fact for the Tribunal to determine, in circumstances where a claimant was diagnosed with anxiety by his GP and his GP advises him to refrain from work, that is "in itself" evidence of a substantial effect on day-to-day activities, because were it not for the

[2] But see the section about European disability law, below

anxiety the claimant would have been at work, and his day-to-day activities include going to work.

40. The Guidance includes the following:

    a. The requirement that an adverse effect on normal day-to-day activities should be a substantial one reflects the general understanding of disability as a limitation going beyond the normal differences in ability which may exist among people [B1]. This has been seen as a problematic aspect of the Guidance – see *Elliot v Dorset County Council* UKEAT/0197/20/LA paragraphs 36 – 51. Any inconsistency **must** be resolved in favour of the statute.

    b. The **cumulative** effects of an impairment should be taken into account when working out whether it is substantial. An impairment might not have a substantial adverse effect on a person's ability to undertake a particular day-to-day activity in isolation. However, it is important to consider whether its effects on more than one activity, taken together, could result in an overall substantial adverse effect [B4]. For example: *"A man with depression experiences a range of symptoms that include a loss of energy and motivation that makes even the simplest of tasks or decisions seem quite difficult. He finds it difficult to get up in the morning, get washed and dressed, and prepare breakfast. He is forgetful and cannot plan ahead. As a result he has often run out of food before he thinks of going shopping again. Household tasks are frequently left undone, or take much longer to complete than normal. Together, the effects amount to the impairment having a substantial adverse effect on carrying out normal day-to-day activities."*

    c. The effects of some impairments may become substantial depending on environmental conditions – for example, a mild hearing impairment may become substantial in noisy working conditions. It will depend on the circumstances whether the frequency/ regularity of the effect is sufficient to substantial – [D20/21].

41. Appendix 1 to the EHRC Employment Code also provides guidance on the meaning of "substantial"[3]: "Account should… be taken of where a person avoids doing things which, for example, causes pain, fatigue or substantial social embarrassment; or because of a loss of energy and motivation."

42. Whether an impairment has a substantial effect is for the Tribunal to decide, taking account of the relevant Guidance. The Guidance sets out a number of factors to consider including: the time taken by the person to carry out an activity [paragraph B2]; the way a person carries out an activity [B3]; the cumulative effects of an impairment [B4]; the cumulative effects of a number of impairments [B5/6]; the effect of behaviour [B7]; the effect of environment [B11] and the effect of treatment [B12].

[3] Paragraph 9, Appendix 1

"Long term"

43. In *McKechnie Plastic Components v Grant* UKEAT/0284/08 it was said:

> *"… the Appellant does have a valid ground on one aspect of the judgment; namely the approach the Tribunal adopted in relation to the question of whether the mental impairment was long term. It is not clear why the Tribunal decided at paragraph 6 that the mental impairment had started in January 2007 nor is it clear whether the Tribunal had in mind the full statutory test which has* ***three categories*** *concerning the impairment; namely that it* ***has lasted*** *for 12 months; the period for which it lasts is* ***likely to be*** *at least 12 months or it is* ***likely to last for the rest of the person's life****. Paragraph 9 of the decision refers only to the 12 month test. However the Tribunal do not appear to have considered whether the 12 month test was satisfied at the time of the alleged discriminatory acts as opposed to the date of the hearing. Moreover the Tribunal has made no findings of fact to justify whether the conditions of either of the other categories have been met".[emphasis added]*

44. Likely' has been held to mean it is a "real possibility" and '**could well happen'** rather than something that is probable or more likely than not. *(SCA Packaging Ltd v Boyle* [2009] ICR 1056)**.** Here the Supreme Court upheld Girvan LJ in the Court of Appeal (para 19):

> *"The prediction of medical outcomes is something which is frequently difficult. There are many quiescent conditions which are subject to medical treatment or drug regimes and which can give rise to serious consequences if the treatment or the drugs are stopped. These serious consequences may not inevitably happen and in any given case it may be impossible to say whether it is more probable than not that this will occur. This being so, it seems highly likely that in the context of paragraph 6(1) in the disability legislation the word "likely" is used in the sense of "could well happen"."*

45. The relevant date for assessing whether or not an impairment had lasted, or was likely to last, for 12 months is at the date(s) of alleged discrimination: *Tesco Stores Ltd v Tennant* [2020] IRLR 363.

Submissions

46. I heard oral submissions, summarised below, on top of opening written notes from both representatives.

47. Mr Firzpatrick on behalf of the respondent submitted:

a. The headline point was that the claimant had failed to discharge the burden of proof.
b. He accepted that there was a physical impairment – the rest was less clear
c. On the first question of "long term", I should consider both the issue of "causation" and the issue of whether the effects "could well last"

as these aspects feed into each other and I should not lose sight of that.

d. Whilst a Tribunal is concerned with whether *effects* are long term rather than the *condition*, where cause of the effects is unclear, it is difficult to make any informed speculation as to whether effects may well last longer.
e. We are limited to matters as they were at the time and what was known at that time.
f. In her evidence, the claimant had said something along the lines of Long COVID being a new condition and more information becoming available. She referred to iron deficiency and breathlessness. There was not good evidence of the medical view which had been taken at the time.
g. As the caselaw makes clear – *Tennant* at paragraph 26 – the long-term question is fixed in time so that a sensible and reasonable employer who assessed the likelihood of a condition lasting is not penalised on the basis of information subsequently available. This informs the strict approach on this aspect of the test.
h. His second general point on the issue of "long term" was that "severity" is a general matter – all that is relevant is what amounts to "substantial". The [12 month] clock - starts to run once that threshold is reached.
i. In terms of "adverse effect", the language is of impairment and adversity. It makes clear there is some limit placed on an individual by the impairment which is not otherwise there. Fatigue and breathlessness are similar to issues like stress. Where there is a particular effect as opposed to an ordinary effect is the key – an ordinary effect does not give rise to a disability. All individuals have fatigue and shortness of breath and the issue is if it goes beyond what is usual.
j. On the question of substantial adverse effect, the claimant self-reported, at the time, a stark and profound effect. The problem was that did not accord with an objective examination and assessment. There was a disparity in what was reported and what the case was. For example, at page 82 [the OT note dated 15 November 2021] there was a disparity between the stark description by claimant and the position of her attending work at that time.
k. Bar the letter at page 88 [the undated extract from the Specialist Registrar letter] and short form evidence at page 90 [the referral form of 17 January 2022] there was little of useful detail in the medical notes to form a view as to the cause and effect of the impairment and how long the effects may well last.
l. There was clearly a live issue of reliability and exaggeration on the issue of oxygen level reporting. That was the main focus of the cross examination on that issue was not on what could be interpreted from the medical results. There was no need for medical expertise to interpret a consistent disparity between what was being told to the doctors and what was observed.
m. There may be various reasons for this. There was reference in the medical notes to the claimant fearing convincing herself that she had COVID.
n. There were Med 3s but the problem with treating them as medical evidence is that they are based on self-reporting. It was

questionable as to how much weight, if any, can be placed on a Med 3.

o. In terms of causation, the [undated] letter from the Specialist Registrar was the best evidence on this point and suggested multiple reasons why the claimant was experiencing breathlessness. It does not refer to COVID or Long COVID. There was a real issue in this case on the interplay of causation with the issues of "long term" and whether the impairment was "likely to last". At page 76 [July 2021 note] the GP had ruled out COVID as a likely cause.
p. He suggested that a second Specialist Registrar did mention post-COVID [with reference to the notes on the 17 January 2022 referral form] but added that the same document doesn't opine as to causation or make out matters other than shortness of breath or fatigue.
q. The claimant's impact statement set out 22 symptoms experienced by the claimant which were not extrapolated and made out. There may be other causes afoot which informed the position as to long term – for instance anaemia and the possible impact of that on exhaustion.
r. The problems of causation are real – unless something sensible could be said about what was going on and why it was too difficult to say that the effects were "likely" to last 12 months.
s. If the Tribunal was not with him on the above, he submitted that the clamant should only be regarded as disabled from December 2021 or from the 17 January 2022 referral form.

48. I then heard from Mr Hepworth on behalf of the claimant. He submitted, in summary:

a. The respondent didn't "examine" issues of substantiality or longevity – it had focused on symptoms and the provision of medical evidence.
b. Three areas had been put together but there was no real credibility to the respondent's submissions.
c. He referred to the *Goodwin* tests and suggested the claimant was disabled from February 2021 until December 2021.
d. In May 2021, the condition of Long COVID became known to the respondent within its GP practice.
e. The "impairment condition" position of the respondent omitted a diagnosis of a hiatus hernia and of an iron deficiency in January 2021.
f. Fatigue and shortness of breath was from February 2021. The claimant was resilient but as the year wore on, her resilience wore out and impacted on her in the workplace.
g. She needed significant medical interventions by way of iron infusions [NB there were some references to an iron infusion in the redacted GP notes but no medical evidence had been adduced to explain to the Tribunal what that process meant or entailed for the claimant or her health]. Her iron reserves ran out.
h. The Tribunal should focus on what normal activities cannot be done by the claimant. She shared the wider impacts during questioning. There was an inability to control urination.

i. The impact on her was life changing.
j. Shortness of breath alone didn't consider a wider variety of other symptoms. The claimant had difficulties with normal things like using stairs.
k. The volume and variety of appointments in 2021 was relevant. It made elimination the only operation.
l. There was a Long COVID diagnosis in September 2021 and a worsening of her condition.
m. The Med 3s indicated her condition was worsening.
n. The physical conditions restrained her and substantially impacted her conducting activities.
o. Removing one symptom did not take away the rest and the case should be looked at as a whole

Discussion and Conclusions

49. I have considered whether the claimant had established the various elements of the definition, as outlined in *Goodwin* and looked at the overall picture. The relevant period was between 9 July and 9 December 2021.

Was there an impairment? (the 'impairment condition')

50. I am satisfied that the claimant was physically impaired during this period by way of symptoms of breathlessness, fatigue and impaired mobility, whether or not these individual impairments fall under the umbrella of Long COVID. They are potentially attributable to that condition but there was no definitive diagnosis in the available medical evidence from 2021. *Millar* makes it clear that a physical impairment can be established without the impairment being due to any specific physical illness.

51. The respondent did not dispute the fact that the claimant was physically impaired, but disputed the other elements of the definition – adverse effects/causation, substantial and long term.

What were the adverse effects caused by the impairments on normal day-to-day activities? (the 'adverse effect condition')

52. I am satisfied, from the claimant's impact statement, from her oral evidence and from the available contemporaneous medical evidence, as set out above, that the combined effects of the above impairments, namely her breathing difficulties, her fatigue and her impaired mobility, impacted upon the claimant's normal day to day activities at the relevant times (9 July to 9 December 2021) and caused the following adverse effects on her normal day-to-day activities (focusing on what the claimant could **not** do rather than on what she could do):

a. Difficulty climbing stairs
b. Difficulty walking short distances
c. Difficulty dressing
d. Difficulty washing
e. Unable to cook at home
f. Unable to clean at home
g. Difficulty speaking (particularly due to breathlessness)

h. Limited social engagement – the claimant stopped going out with friends. This was supported by medical evidence which referred to her falling asleep when arriving home from work and at weekends lying on the sofa, watching TV and napping.

Were the adverse effects more than minor or trivial? (the 'substantial condition');

50. I am satisfied that the effects of the shortness of breath, fatigue and mobility issues which were described by the claimant and in various places observed and recorded between July and December 2021 by the GPs, occupational therapist and physiotherapist, were more than trivial. They affected her increasingly as the relevant period progressed, with the referral to the Long COVID service being made in September 2021. They were plainly more than trivial and in combination were having a profound effect on her home life.

51. The fact that she was able to remain at work for much of that period, in a desk-based job and evidently not without difficulty, does not change my view that the effects of the impairments were substantial. The focus of the statutory test is on what the claimant **cannot do** and not on what she can do and I have accepted her account of what she cannot do over the relevant period.

Was there a real possibility that the substantial adverse effects would continue for more than 12 months? (the 'long-term condition').

52. This is probably the most difficult issue in the present case, in the absence of a clear diagnosis and consequently the lack of any view on prognosis being expressed within the available medical records.

53. I have found that the adverse effects of the impairments (shortness of breath, fatigue and impaired mobility) were substantial from July 2021. So they had not lasted for 12 months during any of the relevant period. In that case, the next question to be considered is whether it be said that they were "likely" to last for 12 months at any stage during that period, and if so, from when could that be said?

54. The effects of the conditions on the claimant became more pronounced after the claimant had her second dose of the COVID vaccine (in March 2021) and by July 2021 I have found that the adverse effects became substantial i.e. more than trivial (as referenced in the claimant's oral evidence and supported by the GP entries of 6 and 30 July 2021). However, at that point in time, it could not be said that it was "likely" that the effects would last for 12 months. Long COVID initially appeared to have been considered and ruled out in the July 2021 GP entries.

55. As 2021 continued, the claimant's symptoms of breathlessness, fatigue and mobility issues became more chronic in nature, by 9 September 2021 the GP referred the claimant to the Long COVID clinic for further investigation. This is as a clear indication that her symptoms were regarded by those treating her as more persistent (so as to warrant such a referral). There must have been some likelihood or a real possibility that the claimant may have Long COVID by that point. There is no indication in the records that the referral was tentative one, or was simply being made to appease the claimant.

56. From 9 September 2021 onwards, the evidence and records indicate that the claimant's symptoms and the adverse effects of them upon her at the very least continued at the same level, which I have found to be substantial. She was being investigated for Long COVID and those investigations were still ongoing at the end of the relevant period, and the letter of 8 December 2021 referred to possible future treatment for Long COVID. That overarching/umbrella condition was clearly still on the table at that time as a possible explanation for her various ongoing symptoms. She was also provided with Med 3s during that period which referred more specifically to shortness of breath and fatigue. There was no suggestion in the medical records of there being any recovery or material improvement in terms of the effects of the impairments on the claimant by the end of the relevant period.

57. Based on the available evidence at the time, summarised in the previous paragraph I have to answer to the question: "were the substantial adverse effects upon the claimant likely to last for 12 months" applied to the period between 9 September to 9 December 2021? I find that the answer for the duration of that period is *"yes, that could well happen"*, applying the test in *SCA v Boyle.* The long-term condition is therefore met from 9 September 2021 onwards.

Conclusion

58. I find that the clamant was **not** disabled prior to 9 September 2021, as until that point in time, when she was referred by her GP to the Long COVID clinic, it cannot be said the substantial adverse effects of her impairments (shortness of breath, fatigue and mobility difficulties, potentially attributable to Long COVID) upon her were likely to last for 12 months, from their onset in around July 2021.

59. From 9 September 2021 onwards, I **am** satisfied that the substantial adverse effects of the same impairments upon the claimant **were** likely to last for 12 months and so she **was** disabled. Looking at the overall picture, as is also suggested by *Goodwin,* I am satisfied with this conclusion.

Employment Judge Cuthbert

4 May 2023

RESERVED JUDGMENT & REASONS SENT TO THE PARTIES ON
05 May 2023 By Mr J McCormick

FOR EMPLOYMENT TRIBUNALS