



## THE EMPLOYMENT TRIBUNALS

**Claimant:** Mr D Robinson  
**Respondent:** Blackberry UK Ltd  
**Heard at:** Bury St Edmunds Employment Tribunal  
**On:** 30 April 2018  
**Before:** Employment Judge M Warren (sitting alone)

### Representation

**Claimant:** Mr T Sheppard, counsel  
**Respondent:** Mr T Cordrey, counsel

## OPEN PRELIMINARY HEARING

### RESERVED JUDGMENT

The Claimant was at the material time, between 17 January and 24 May 2017, a disabled person as defined in the Equality Act 2010.

## REASONS

### Background

1. By a claim form issued on 11 August 2017, Mr Robinson has brought claims in breach of contract, that he was unfairly dismissed and that he was discriminated against by reason of disability. The claims are resisted. Mr Robinson was employed as an Account Manager by the Respondent and was dismissed on 24 May 2017. His claims arise out of the circumstances leading to his dismissal and the dismissal itself.
2. At a Closed Preliminary Hearing held on 16 February 2018, Employment Judge Vowles directed that this Open Preliminary Hearing should take place in order to determine whether, at the material time, Mr Robinson

was a disabled person as defined in the Equality Act 2010. The matter is listed for a final hearing in January 2019.

### **The Issues**

3. Mr Robinson was ordered to provide a statement setting out why he says he meets the definition of disability and a letter from his GP or other medical expert. As I understand it, his medical records had already been disclosed. The Respondent had until 23 March 2018 to inform the Tribunal and Mr Robinson whether it accepted that he met the definition of disability. By an email dated 21 March 2016, solicitors on behalf of the Respondent wrote to confirm that they do not and in particular, that in respect of the accepted physical impairments of psoriasis and psoriatic arthritis, they did not accept:
  - 3.1. That such impairments had a substantial and adverse effect on Mr Robinson's ability to carry out normal day-to-day activities at the relevant time, nor
  - 3.2. That in the event his impairments did have that effect, they were long term, in that they had lasted for 12 months or were likely to last at least 12 months at the relevant time.
4. Although in that communication, the Respondent made reference also to not accepting, if Mr Robinson was disabled, that it knew or could reasonably have been expected to know, that he was disabled, that was not an issue before me. I mention this because Mr Sheppard made reference to this issue and I cut him off, explaining that it was not an issue before me today but a matter for the final main hearing, were I to decide that Mr Robinson was disabled.
5. It is not disputed that Mr Robinson suffered at the material time from the physical impairments identified as psoriasis and psoriatic arthritis, upon which he relies as amounting to a disability.

### **Evidence**

6. I had before me today a paginated and indexed bundle of documents running to page number 242, within which was the statement prepared by Mr Robinson himself, as referred to above. I also had a witness statement from an HR Business Partner for the Respondent, Ms Marine Domarchi. Both counsel had prepared written skeleton arguments, for which I was grateful.
7. I heard oral evidence from Mr Robinson and from Ms Domarchi.

### **The Law**

8. For the purposes of the Equality Act 2010 (EqA) a person is said, at section 6, to have a disability if they meet the following definition:

*“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.*

9. The burden of proof lies with the Claimant to prove that he is a disabled person in accordance with that definition.
10. The expression ‘substantial’ is defined at Section 212 as, ‘*more than minor or trivial*’.
11. Further assistance is provided at Schedule 1, which explains at paragraph 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 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”.*

12. The word, “likely” in the context of the definition of disability in the Equality Act 2010, means, “could well happen”, or something that is a real possibility. See SCA Packaging Ltd v Boyle [2009] ICR 1056 HL. This is because we are not concerned here with weighing conflicting evidence and making findings of fact, but are in the realm of medical opinion and assessing risk or likelihood in that sense.
13. The question of how long a condition is likely to last should be assessed as at the date of the alleged discrimination, (not the date of the hearing). See Richmond Adult Community College v McDougall [2008] ICR 431 CA.
14. As to the effect of medical treatment, Schedule 1 paragraph 5 provides:

*“(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 ...”*

15. Paragraph 12 of Schedule 1 provides that a Tribunal must take into account such guidance as it thinks is relevant in determining whether a person is disabled. Such guidance which is relevant is that which is

produced by the government's office for disability issues entitled, 'Guidance on Matters to be Taken into Account in Determining Questions Relating to the Definition of Disability', (the Guidance).

16. As to the meaning of 'substantial adverse effects', paragraph B1 of the Guidance assists as follows:

*"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 and ability which may exist amongst people. A substantial effect is one that is more than a minor or trivial effect".*

17. As to what amounts to a 'substantial effect', the Guidance is careful not to give prescriptive examples but sets out in the Appendix a list of examples that might be regarded as a substantial effect on day-to-day activities, as compared to what might not be regarded as such. For example, '*difficulty picking up and carrying objects of moderate weight, such as a bag of shopping or a small piece of luggage, with one hand*' which would be regarded as a substantial effect, as compared to, '*inability to move heavy objects without assistance or a mechanical aid, such as moving a large suitcase or heavy piece of furniture without a trolley*' which would not be so regarded. Also compare, '*a total inability to walk, or an ability to walk only a short distance without difficulty*' which is a substantial effect to, '*experiencing some tiredness or minor discomfort as a result of walking unaided for a distance of about 1.5 kilometres or one mile*'.
18. Also relevant in assessing substantial effect is for example the time taken to carry out normal day to day activities and the way such an activity is carried out compared to a non-disabled person, (the Guidance B2 and B3).
19. The Guidance at B4 and B5 points out that one should have regard to the cumulative effect of an impairment. There may not be a substantial adverse effect in respect of one particular activity in isolation, but when taken together with the effect on other activities, (which might also not be, "substantial") they may together amount to an overall substantial adverse effect.

20. The Guidance states at B7:

*"Account should be taken of how far a person can **reasonably** be expected to modify his or her behaviour, for example by use of a coping or avoidance strategy, to prevent or reduce the effects of an impairment on normal day to day activities. In some instances, a coping or avoidance strategy might alter the effects of the impairment to the extent that they are no longer substantial and the person would no longer meet the definition of disability. In other instances, even with the coping or avoidance strategy, there is still an adverse effect on the carrying out of normal day to day activities".*

21. Paragraph B12 explains that where the impairment is subject to treatment, the impairment is to be treated as having a substantial adverse effect if, but for the treatment or the correction, the impairment is likely to have this effect and the word 'likely' should be interpreted as meaning, 'could well happen'. In other words, one looks at the effect of the impairment as if there was no treatment.
22. A substantial effect is treated as continuing, if it is likely to recur, this is explained at paragraphs C5 and C6 by cross reference to Schedule 1, paragraph 2(2) quoted above. However, it is the substantial adverse effect on the ability to carry out day to day activities that must recur, not merely a re-manifestation of the impairment after a period or remission, but to a lesser degree.
23. Similarly, on the question of whether an impairment has lasted or is likely to last more than 12 months, it is the substantial adverse effect which must have so lasted.
24. As for what amounts to normal day-to-day activities, the Guidance at section D explains that these are the sort of things that people do on a regular or daily basis including, for example, things like shopping, reading, getting washed and dressed, preparing and eating food, carrying out household tasks, walking, travelling by various forms of transport including driving. Whilst specialised activities either to do with one's work or otherwise, are unlikely to be normal day-to-day activities, (paragraphs D8 and 9) some work related activities can be regarded as normal day-to-day activities such as sitting down, standing up, walking, running, verbal interaction, writing, driving, using computer keyboards or mobile phones, lifting and carrying (paragraph D10).
25. The indirect effects of an impairment must also be taken into account, (the Guidance at D22). For example, where the impairment causes pain or fatigue, that pain or fatigue may impact on the ability to carry out day to day activities to a degree that it becomes substantial and long term.
26. In Goodwin v Patent Office [1999] ICR 302 the EAT identified that there were four questions to ask in determining whether a person was disabled:
  1. Did the Claimant have a mental and/or physical impairment?
  2. Did the impairment effect the Claimant's ability to carry out normal day-to-day activities?
  3. Was the adverse condition substantial? and
  4. Was the adverse condition long term?

## **Facts**

### ***Credibility***

27. I found no reason to disbelieve the evidence of Mr Robinson and I accept that he was a credible witness.

28. The Respondent sought to undermine Mr Robinson's credibility by referring to the medical records and suggesting that these do not support his claim that his illness affected his ability to walk, to climb stairs and so on. I did not find that a convincing argument, because I would not necessarily have expected to see his GP notes recording in detail the manifestation or effect of his physical conditions. Indeed, as I shall explain below, my view of the medical records is that they corroborate his description of the impact of his illness.
29. It is suggested that Mr Robinson's evidence as to the effect of his illness is exaggerated because he took little time off work, he was never late and he did not mention his illness in HR meetings. In a letter dated 25 April 2018, Mr Robinson's GP expresses her amazement that he had continued to work throughout his illness, describes him as a, "coper" and expresses the view that other people with similar symptoms would have stayed at home on sick leave. In my view, this stoicism explains such matters and the GPs remarks add considerable weight to the credibility of Mr Robinson's evidence.
30. It is also suggested that Mr Robinson's evidence is undermined by Ms Domarchi's evidence that, in summary, he did not appear to be exhibiting the difficulties he refers to, in their meetings during the relevant period. I bear that in mind. However, I refer again to his GP's reference to his stoicism and his own evidence that his attitude was to, "crack on", to get on with his work. He struck me as one disinclined to be overly demonstrative. Ms Domarchi is not a medical expert and she cannot have known what discomfort Mr Robinson was actually experiencing.

### ***Findings of Fact***

31. I have not seen the list of issues, but I am told by Mr Cordrey without demur, that the relevant time is from 17 January 2017, when performance management targets were set and 24 May 2017, when Mr Robinson was dismissed.
32. Mr Robinson has psoriasis and psoriatic arthritis. He experienced a flare up in May 2016; he felt tired during the day, his knees and hands began to hurt, he was stiff after one hour of driving or after being in one position for such a length of time.
33. When this started is potentially very important. GP notes of 1 June 2016, (page 49) refer to symptoms starting over last 3 to 4 weeks, which would make the start as 11 to 18 May 2016. I do note that the GP's note also suggests at that time he was able to walk with a normal gait. By 9 June the problem had become more serious, (page 50). In a referral to "Early Arthritis Fastrack" dated 10 June, his GP refers to a 5 week history of rapidly progressing joint pain" which would put the commencement of the difficulties as about 6 May 2016.

34. The symptoms gradually became worse. By mid-June 2016, Mr Robinson's walking became so impaired he likened it to more like a shuffle. The pain in his hands was severe, his fingers, knees and ankles were swollen. Sitting was uncomfortable. Driving was agony. He was experiencing breathlessness, in particular in climbing stairs.
35. On 20 June 2016, Mr Robinson was admitted to hospital, where he remained for 3 days being treated with pain killers and creams on his skin.
36. On 1 and 8 July 2016, a consultant rheumatologist prescribed Methotrexate and folic acid. Mr Robinson's condition was described as fairly aggressive. Methotrexate is, (says the Respondent's medical expert, Dr Axon) a powerful immune suppressant treatment. He was also prescribed Hydroxychloroquine, a mild immune suppressant often used in conjunction with Methotrexate. He also took the maximum dosage of ibuprofen 4 or 5 times a day.
37. Through July and August 2016, the impact on Mr Robinson of his conditions continued. He regarded walking and using stairs as very painful and a major achievement. He was losing strength, suffering muscle wastage, through lack of movement. He was unable to shower and so took baths instead. Getting in and out of the bath, "took all of" his strength. Turning on taps and shaking hands was painful. He told me he could lift a kettle, but it was painful. He could not put out the bins. His wife and children would lift things for him. He would get up an hour early to allow for the extra time everything took him, so that he could get to work on time.
38. In a letter dated 9 August 2016 the consultant rheumatologist, in respect of a consultation on 8 July, described Mr Robinson as, "*very symptomatic at present with significant joint pains*".
39. The psoriasis on Mr Robinson's bottom made it painful for him to sit and difficult to concentrate. He became fatigued.
40. In August 2016, a dermatologist prescribed Lymecline, an antibiotic with immune suppressant properties.
41. During September and October 2016, there was minor improvement. As Mr Robinson put it, "things were not really improving dramatically", but they were improving.
42. Following a consultation on 2 November 2016, a consultant dermatologist wrote, (on 17 November):

*"His joints and skin are now fine and his only problem now is his perianal and scrotal skin eruption. He has some nodules on his scrotum and some scaling on his perianal region. He also has some pustules on his thighs"*
43. Mr Robinson denied that this meant that everything was fine in November 2016. He says, (and I accept what he says) that there was an

improvement compared to June, but he certainly was not fine. This account, following a consultation in early November, is consistent with his acknowledgement that there was some improvement in the autumn. He was clear though, that whilst there had been some improvement, the problem was still there and that it flared up again, became worse, in December 2016. He described how he felt as if the medication was beginning to wear off.

44. On 21 December 2016, Mr Robinson wrote to Human Resources asking for advice. His email reads as follows:

*"I was diagnosed with psychiatric [sic] arthritis back in June, spent 3 days in hospital because I could not walk, gradually over a period of 4 or 5 weeks I was back to relative normality (frustrating not normal). During this time I carried on working on voice and mail, couldn't drive for a while but okay now.*

*Anyway, my query is how do I go about ensuring the company is aware of this on my records, just recently it has flared up again but hasn't stopped me working at all, just very uncomfortable and frustrating"*

45. Of this, I accept Mr Robinson's evidence that when he speaks of being back to relative normality, his words in brackets were intended to indicate that it was frustrating that his, "normal" given his condition, was not really what one would ordinarily call, "normal". This email confirms that the initial impact of his symptoms was that he could not walk and that he was experiencing a flare-up in early December 2016.
46. During December 2016, Mr Robinson was struggling to walk. During a GP consultation in December, it was noticed that although he had been prescribed Hydrochloroquine, he had not been given it and he was not taking it. He was told to start taking it immediately. At this point he was in agony and his walking was again as he would describe it, a shuffle.
47. On 17 January 2017, a GP, (Dr Geatch) wrote a letter, "to whom it may concern" in which she explained Mr Robinson's diagnosis and she went on to write:

*"Although symptoms can be quiescent for significant periods, patients can equally suffer from relapse. This can manifest with joint pain, deterioration in the condition of his skin sometimes associated with secondary skin infection. Significant flares can cause fatigue and general feeling of malaise. Mr Robinson is under the care of both the dermatologist and rheumatologist for his ongoing problems, but at present unfortunately his symptoms are not well-controlled"*

48. On 10 February 2017, Mr Robinson was given a steroid injection. In a letter dated 14 February 2017, the rheumatologist wrote to his GP:



*“In clinic today he is struggling with painful knees and ankles and his hands have flared up as well now. His psoriasis has been an active [sic] but he feels that this is just starting to settle down and he is struggling with fatigue and managing his activities of daily living”*

49. Although it has been suggested to me that the last part of that quote is ambiguous, it seems to me that in the context of the letter, the rheumatologist meant that Mr Robinson was struggling with managing his activities of daily living. This letter refers to Mr Robinson having five tender joints, 10 swollen joints, his left wrist being very swollen and tender, his left ankle very swollen and tender, joints on both hands mildly swollen.

50. On 24 February 2017, Mr Robinson’s GP wrote to a consultant dermatologist in which she commented:

*“He is currently keeping on top of his psoriasis but his joints are still troubling him and he has been in contact recently with the rheumatology specialist nurse. His arthritis is not well-controlled at present which is causing difficulty for him...”*

51. Mr Robinson confirmed that the steroid injection at that time and the hydroxychloroquine made walking easier, but that he still suffered with inflammation of many joints, such that during March and April 2017 walking, sitting, driving, lifting, turning keys and taps and shaking hands was painful and draining. In a letter dated 6 March 2017, a consultant dermatologist wrote to Mr Robinson’s GP to say that his psoriatic arthritis was causing him significant problems.

52. By July 2017, Mr Robinson was feeling a bit, but not much, better. In a letter dated 10 July 2017, a consultant rheumatologist wrote to his GP and said:

*“Unfortunately he has not felt much better in terms of his joints. He has ongoing pain symptoms and swelling in his right elbow as well as his right middle finger where there are signs of fixed flexion. He also has ankle swelling and in addition he feels very lethargic and tired with early-morning stiffness that can last all morning.... He currently has at least eight tender joints with three swollen joints.”*

53. In the period June to September 2017, Mr Robinson describes gradually feeling better, inflammation to his wrists and elbows gradually going, although still having to stop and stretch after 45 minutes of driving.

### **Medical Reports**

54. The Respondent produced a medical report from a Dr Axon, consultant in rheumatology and rehabilitation medicine. Remarkably, Dr Axon did not see Mr Robinson. He set out a review of the medical history and of Mr Robinson’s impact statement and reached the conclusion that Mr Robinson was not a disabled person as defined in the Equality Act 2010, which is of course a legal question, not a medical question.

55. Also remarkably, given the issues before me, Dr Axon does not give information or opinion on the likelihood of re-occurrence as at the relevant time, the likely duration of the described symptoms nor the extent to which medication alleviated the impairment as described.
56. I have quoted above excerpts from relevant medical records and correspondence passing between Mr Robinson's medical advisers, none of which had been prepared with a view to these proceedings.
57. For these proceedings, Mr Robinson has produced a letter from his GP Dr Rookledge, dated 25 April 2018, referred to above. In my view, it is a significant and helpful document, (although it is a shame it does not help me with the effect of medication or the anticipated duration of the impairment as at the relevant time). I will quote excerpts from that letter:

*"This 50 year old gentleman was diagnosed with inflammatory arthritis in June 2016. This followed a period of severe symptoms including stiffness and loss of function of most of his joints. This was so severe that he was unable to walk or use his hands..."*

*This flare lasted from 10/05/2016 until 5/12/17 and necessitated treatment with methotrexate (which is a very strong potentially toxic medicine) from 8/7/16 until 14/09/17. From when his symptoms started in early May 2016 until they started to settle in September 2017 he had a very torrid time. I was frankly flabbergasted when he told me that he had continued to work through this. I have been a GP for over 20 years and in my considerable experience it is most unusual for someone to work through a condition like this....*

*Psoriatic arthropathy is a chronic condition that may remain quiescent for months or even years but then it can cause severe flare ups. The joints affected are very sore and swollen and can be difficult to use. It can affect any joint in the body. There can be resulting muscle wastage, causing disability, which Mr Robinson has. This makes normal activities very difficult or impossible.*

*I have known Mr Robinson for 10 years or so now. He is a capable man who never comes into the surgery unnecessarily. He is a coper. He has coped with this chronic disability extremely well, and has continued to struggle into work with disability, when the vast majority of people with similar symptoms would stay at home on sick leave".*

58. Of course, I take Dr Rookledge's reference to, "disability" in the colloquial, rather than the legal, sense.

### **Respondents Submissions**

59. Mr Cordrey submits that this is not a case of a prolonged period of substantial adverse effect. He says that there was one acute episode in June 2016, (during which period the effect was not substantial in any

event) which then subsided until a minor flare-up in January 2017. Even if I were to find that the impairment in June 2016 was substantial, that was only for a brief period and it has never recurred again as a substantial effect.

60. As to the effect of medication, Mr Cordrey points to Mr Robinson's comment in his impact statement, (page 41) that the effect of the medication wore off. Actually, that is not what Mr Robinson said. He referred to his symptoms becoming worse, "almost as if the medication was beginning to wear off". That is not the same as the effect of the medication actually wearing off; it might be that the symptoms were becoming worse and so the medication was becoming less effective. I do not know, I do not have any medical evidence on that.
61. In a similar vein, Mr Cordrey points to a remark in a letter from a rheumatology nurse dated 19 September 2017, (page 209) in which she comments, "*he was unsure if the methotrexate has been beneficial for him in terms of his joints and he still has felt no benefit*". This is not medical evidence as to the ineffectiveness of methotrexate, it is a reference to Mr Robinson continuing to experience unpleasant symptoms and as a consequence, he is unsure as to the effectiveness of methotrexate. Finally on this point, Mr Cordrey refers to the consultant dermatologist's comment in her letter of 7 November 2017, "*he has been off methotrexate for a few months now and his joints feel the same and have not deteriorated*". This is not evidence that the methotrexate was ineffective; it may simply be that the symptoms have abated.
62. It is suggested that there is no evidence that if one took away the 4 or 5 doses of ibuprofen per day, there would be a transition to a substantial adverse effect. About that I would comment, Mr Robinson was clear that when the symptoms were bad he longed for the few hours to pass until he would be next be permitted to take ibuprofen.
63. Mr Cordrey suggests that because Mr Robinson did not start taking hydroxychloroquine until January 2017 and one can see that Mr Robertson's state of health between June 2016 and January 2017 was not such that he met the definition of disability, one can therefore see the effect of the medication was not such as to prevent the symptoms amounting to a disability. Further, he says that we know that Mr Robinson came off the hydroxychloroquine towards the end of 2017 and since that time there have been no obvious joint problems, which therefore indicates that the effect of the medication was not masking a substantial adverse effect of the illness. Again, I do not think I can reach such a conclusion; there is no medical evidence to that effect.
64. In answer to Mr Sheppard's submission that I should look at the cumulative effects of the impairment, which should be taken together to conclude that there is a substantial adverse effect, Mr Cordrey submits that Mr Robinson's impact statement, "majors" on the difficulty he had in walking. I do not agree; Mr Robinson clearly makes references to other difficulties, as I have set them out in my findings of fact.

65. It is submitted that in some 200 pages of medical evidence, there is no reference to a substantial effect on walking.
66. Mr Cordrey points out that Mr Robinson did not have to resort to any form of physical aid such as a walking stick, a wheelchair or a stairlift, no adjustments were necessary to his vehicle, he was not referred to a physiotherapist or an occupational health therapist by his medical advisers.
67. It is suggested that Mr Robinson complained that he was not able to walk any more than a mile and a parallel is drawn to the Guidance, which gives as an example of something not amounting to a substantial adverse effect, the experience of tiredness or minor discomfort as a result of walking unaided for a distance of about 1.5 km or one mile, whereas what would amount to such an effect would be a total inability to walk or an ability to walk only a short distance without difficulty, for example because of physical restrictions, pain or fatigue.
68. On the ability to lift, reference is made to the Guidance. It is acknowledged that inability to lift a moderate weight might amount to a substantial adverse effect, but Mr Cordrey says there is no evidence of that. I do not agree, the evidence which I have is the evidence of Mr Robinson, which I accept.
69. In respect of ability to drive, Mr Cordrey refers to the Guidance and suggests that the example of discomfort as a result of travelling for more than two hours is on a parallel with the case of Mr Robinson. Actually, the evidence was that at its worst, Mr Robinson would have to stop after 45 minutes and that at other times, after an hour. It was suggested that Mr Robinson's driving difficulties are no greater than or are within the variation experienced in the general population.
70. With regard to coping strategies, it is said that those described by Mr Robinson such as not giving as firm a handshake as he would do otherwise, or lifting a kettle with his left hand and tilting himself over, show that whilst he suffered some effect, it was not a substantial effect.
71. Finally, on the question of long-term effect, Mr Cordrey reminds me that it is the substantial effect that must be long-term, not just the impairment itself. Similarly, if there is to be a recurring effect, that too must be substantial.
72. As to the medical reports, Mr Cordrey suggests that I should attribute little weight to the GP's letter of 25 April 2018 because it is vague, the assertions are not supported by the contemporaneous medical records and the letter requesting the report has not been produced. He acknowledges that limited weight can be attached to Dr Axon's report because he was not here to be cross examined and he did not personally see Mr Robinson. However, it is suggested that his evidence corroborates the respondent's submissions.

**Claimant's Submissions**

73. Mr Sheppard submits that Mr Robinson's impairment was substantial, lasted as such from May 2016 to late 2017 and was likely to recur. He presses me to have regard to the cumulative effect of the impairment and argues that it is plainly substantial, when one has regard to the impact statement. He points in particular to the difficulties in walking, in climbing and coming down stairs, in lifting, in Mr Robinson looking to his wife and children for help about the house, that he takes an extra hour to get up and out in the morning and that he would have to take a break from driving after 45 minutes. He stresses that one should not overlook the impact of pain, constant pain, on one's abilities and the consequent, constant, feelings of tiredness.
74. Mr Sheppard dismisses the evidence of Ms Domarchi, pointing out that she is no medical expert and merely had some minimal interactions with Mr Robinson over a limited period when he was on medication, (of which she was unaware).
75. With regard to the evidence of Dr Axon, Mr Sheppard makes the point that he did not meet Mr Robinson, does not address the impact of his medication, does not give reasons for his conclusions and was not here to answer questions.
76. Mr Sheppard answers the Respondent's emphasis on the medical records and the suggestion that they do not corroborate Mr Robinson's account of the impact of his illness, by pointing out that such notes are merely a snapshot of what the GP needs to record, are not prepared with a view to recording the impact of the illness with a view to what might be looked at in seeking to decide if Mr Robinson meets the definition of disability in some future court case. I have already indicated that I agree with that submission and indeed, take the view that the records do in fact corroborate Mr Robinson's account. Mr Sheppard places great emphasis on the GP's letter of 25 April 2018 for an overview.
77. Mr Sheppard stresses that Mr Robinson was under treatment for a period of 16 months from June 2015 to September 2017, which straddles the relevant period, during which he was taking hydroxychloroquine, methotrexate, folic acid and Ibuprofen 4 or 5 times a day and had a steroid injection. The deduced effect, he says, is very much a live issue. He points out that without medication in June 2016, Mr Robinson was hospitalised. With the benefit of medication, his illness was brought under control and he was discharged. At the end of 2016, the effects were becoming worse again, Mr Robinson had been prescribed but had not taken, hydroxychloroquine and once he started taking it, the condition was brought under control again.
78. I am reminded that the GP's letter of 25 April 2018 explains that this is a condition which is likely to flare up in the future.

79. Mr Sheppard argues with regard to the various points put by Mr Cordrey that Mr Robinson did not need any form of physical aid, was not referred to an occupational health therapist or physiotherapist, that he did not have a day off work, that he was never late, that he appeared well to Ms Domanchi, by pointing out that his GP has explained in strident terms that he is a coper and that she is, “flabbergasted” that he carried on. As I have already indicated, I regard that as a point well made.

### **Conclusions**

#### ***Did the Claimant have a mental and /or physical impairment?***

80. It is accepted that Mr Robinson had the physical impairments relied upon; psoriasis and psoriatic arthritis.

#### ***Did the impairment effect the Claimant's ability to carry out normal day to day activities?***

81. The impairment effected the Claimant's ability to carry out the following normal day-to-day activities:

- 81.1. Walking;
- 81.2. Climbing and descending stairs;
- 81.3. Driving;
- 81.4. Sitting down;
- 81.5. Taking a shower or taking a bath;
- 81.6. Turning on taps and turning keys;
- 81.7. Shaking hands;
- 81.8. Lifting a kettle or shopping;
- 81.9. Putting out the bins;
- 81.10. Other household activities, and
- 81.11. Getting ready for work.

#### ***Was the adverse condition substantial?***

82. One can see from the medical records, repeated references throughout to Mr Robinson having swollen joints. Not one or two, but a significant number. For example, I have quoted in the findings of fact that on 14 February 2017, (during the relevant period) he was said to have 5 tender joints and 10 swollen joints. This can but have had a significant impact on

Mr Robinson's mobility and dexterity. The pain must have had a significant impact on his quality-of-life and must have contributed significantly to his feeling tired and lethargic. To my mind it renders utterly credible, his account.

83. There were times when Mr Robinson could barely walk at all, there were times when his walk was more akin to a shuffle and there were times when he could walk up to a mile in a day, but in discomfort. On those occasions when his mobility was limited to barely being able to walk at all or merely shuffle, the effect was substantial.
84. Not being able to climb or descend stairs without pain and difficulty and without becoming breathless, is substantial. Similarly, there will have been times when the impairment was less serious.
85. When the impairment was at its worst, Mr Robinson was unable to drive for any more than 45 minutes without a break and stretch. At best, he could drive for no more than an hour. That is a greater difficulty than as experienced by the general population and in my judgment, amounts to a substantial impairment.
86. The psoriasis made it very uncomfortable for Mr Robinson to sit down. When one bears in mind the wearing effect of constant pain and not being able to sit down and rest in comfort or work pain free, I find this too a substantial impairment.
87. Not being able to take a shower but being able to take a bath, albeit that getting into and out of the bath saps one's strength is, I find on balance, a substantial impairment because it is not an impairment that I would describe as, "trivial".
88. Turning on taps, turning keys and shaking hands are all impairments caused by arthritis in the fingers and hands of Mr Robinson which were painful. He got by and found ways around these difficulties and any single one might be regarded as trivial, but taken together are much more than trivial and therefore in my view, are substantial.
89. I would say the same in respect of being able to lift a kettle, lift a bag of shopping, put out the dustbins and other undertake other household activities.
90. Taking an extra hour to get ready to go to work in the morning because of the global effect of the impairments in my view, amounts to something that is more than trivial and is therefore a substantial effect.
91. For the avoidance of doubt, where I have concluded that an effect is substantial, I have concluded that it is more than trivial and that it is beyond the differences in ability that may exist amongst people in the general population.

92. Had I decided differently and taken the view that some or all of the above did not quite cross the threshold into what could be said to be a substantial impairment, there cannot be any doubt at all that the combined effect of these difficulties amounted to a substantial impairment on Mr Robinson's ability to undertake day-to-day activities as a consequence of his psoriasis and psoriatic arthritis.
93. I find that this is so throughout the period from May 2016 through to June 2017, after which Mr Robinson gradually began to feel better.
94. Given these conclusions, the effect of medication does not enter into the equation. It is unfortunate that I had no direct medical evidence on the point and perhaps fortunate that it is not crucial to the conclusion which I reach. It is a shame that the tribunal was not provided with a joint medical report that answered all the usual questions in a case such as this, following an examination of the Claimant, as one would expect.
95. That said, given the very poor state that Mr Robinson was in when he was hospitalised in June 2016 and what he went through over the coming year, notwithstanding that he was taking methotrexate, hydroxychloroquine, folic acid and ibuprofen 4 or 5 times a day and has had a steroid injection, I would have found on the balance of probability that this treatment must have alleviated what would otherwise have been an even more profoundly debilitating episode of illness, meeting the definition of substantial impairment on Mr Robinson's ability to undertake day-to-day activities. If the lower SCA Packaging test were applied, it certainly could well happen, that without the medication, the impairment would have been significantly greater.

***Was the adverse condition long term?***

96. The period of substantial adverse effect on Mr Robinson's ability to undertake day-to-day activities began in May 2016. The end of the relevant period is 24 May 2017. When the impairment started, 6 or 13 May 2016, it would not have immediately have had a substantial effect, but by the time Mr Robinson went to his GP on 1 June 2016, it had. On the balance of probability, doing the best I can with the evidence before me, I find that the impairment became substantial half way between 13 May and 1 June, which is 24 May 2016. I therefore find that by the end of the relevant period, the substantial impairment had lasted 12 months.
97. However, I have gone on to consider the remaining provisions of Schedule 1 Paragraph 2 in order to set out what I would have decided had I not decided that the impairment had lasted 12 months and to consider the status of Mr Robinson as a disabled person or otherwise, which may be relevant to any acts of potential discrimination prior to 24 May 2017.
98. I have no medical evidence before me on which I could conclude that at the relevant time, it could be said that the impairment then being experienced would last 12 months. On the other hand, from 17 January 2017 onwards, it would only a matter of a few weeks or days away from



the anniversary of the substantial effect commencing, at which time Mr Robinson was still suffering. With that in mind, one could say that on the balance of probability, given the substantial effect had already lasted 10 or 11 months, it was likely to last 12 months. Applying SCA Packaging, the lower threshold of, "could well happen", certainly it could have been said at the time to be likely to last 12 months.

- 99. I do know that the substantial impairment was not likely to last the rest of Mr Robinson's life, because there would be periods of quiescence, (see below).
- 100. Finally considering the likelihood of the substantial impairment reoccurring, I thankfully do have the evidence of Dr Rookledge, in her letter of 28 April 2018, which is that the condition can remain quiescent for months and then it can cause severe flare-ups. She describes what that is: very sore and swollen joints, which become difficult to use and possible muscle wastage. Dr Geatch said something similar in her open letter of 17 January 2017, (paragraph 47 above). I find that it is likely, in the sense that it could well happen, that the impairment, to the extent of it being a substantial impairment, could well recur.
- 101. For these reasons, I find that Mr Robinson was a disabled person at the relevant time.

Dated: 3 May 2018

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Employment Judge M Warren

ORDERS SENT TO THE PARTIES ON

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.....  
FOR THE TRIBUNAL OFFICE

**NOTES: (1) Any person who without reasonable excuse fails to comply with an Order to which section 7(4) of the Employment Tribunals Act 1996 applies shall be liable on summary conviction to a fine of £1,000.00.**

**(2) Under rule 6, if this Order is not complied with, the Tribunal may take such action as it considers just which may include (a) waiving or varying the requirement; (b) striking out the claim or the response, in whole or in part, in accordance with rule 37; (c) barring or restricting a party's participation in the proceedings; and/or (d) awarding costs in accordance with rule 74-84.**

**(3) You may apply under rule 29 for this Order to be varied, suspended or set aside.**