DRN-4337483

The complaint

Miss S complains that Legal & General Assurance Society Limited (L&G) has turned down an incapacity claim she made on a group income protection insurance policy.

Miss S is represented by Mr K, although for ease of reading, I'll refer to Miss S throughout.

What happened

Miss S is a member of her employer's group income protection insurance policy. The policy provides cover if a member is unable to work due to accident or illness. The policy provides cover for Miss S' own occupation and includes a deferred period of 26 weeks.

In February 2022, Miss S was signed-off from work. On her claim form, she stated that she was absent due to work-related stress; hypertension; sleep apnoea; anxiety with depression; panic disorder; fatigue; Covid recovery and recurring anaemia. In April 2022, Miss S' employer made an incapacity claim on her behalf. The deferred period ran from February to August 2022.

L&G looked into Miss S' claim and assessed the available medical evidence. It noted that an occupational health (OH) physician had found that Miss S was fit for work with adjustments. And following a telephone call with Miss S, L&G's vocational clinical specialist (VCS), concluded that the trigger for Miss S' absence had been work-related stress. The VCS considered that Miss S was medically fit for work, again with adjustments. On that basis, L&G decided that Miss S hadn't met the policy definition of incapacity and it turned down her claim.

Miss S asked us to consider a complaint about L&G's decision to decline her claim.

Ultimately, an ombudsman issued a final decision on that complaint in January 2023. They felt it had been reasonable for L&G to conclude that Miss S didn't meet the policy definition of incapacity for the entirety of the deferred period. While they acknowledged Miss S had physical conditions; they didn't think Miss S had demonstrated that these conditions prevented her from working. Instead, they felt the medical evidence indicated that Miss S would be unable to return to work until workplace issues had been resolved. Therefore, the ombudsman decided it had been fair for L&G to turn down Miss S' claim.

Subsequently, Miss S provided L&G with further evidence which she considered demonstrated that she'd met the policy definition of incapacity throughout the entirety of the deferred period. That evidence included the following:

- A tribunal decision, dated 17 October 2022, which stated that Miss S was entitled to Personal Independence Payments (PIP), backdated to October 2021;
- A letter from a cognitive behavioural therapy (CBT) practitioner, dated 2 October 2022; which stated that Miss S had been seen for sessions of CBT. She'd been experiencing symptoms of panic disorder, depression and anxiety. The letter said that the treating clinician had advised that a return to work wasn't recommended at that time; due to co-presentation of some physical concerns;

- A letter from a consultant rheumatologist, dated 14 November 2022, which stated that Miss S had been diagnosed with fibromyalgia. The consultant referred to a number of other symptoms and diagnoses Miss S had received over the previous two years, which had been getting worse;
- A letter from a consultant ear, nose and throat (ENT) surgeon, dated 6 October 2022, which stated that Miss S had presented with a three-year history of variable hoarseness and intermittent vertigo. The consultant referred to a diagnosis of muscle tension dysphonia. They felt that alongside treatment for Miss S' mental health conditions; a course of voice therapy would reduce the frequency and severity of Miss S' symptoms.

L&G considered the new evidence Miss S had provided, together with its chief medical officer (CMO). The new evidence didn't change the CMO's opinion of Miss S' claim and they remained satisfied that the major barrier to Miss S' return to work was workplace stress. The CMO still felt that Miss S was fit to return to work with adjustments. On that basis, L&G maintained that Miss S still hadn't shown she met the policy definition of incapacity.

Miss S therefore asked us to look into a new complaint about the way L&G had assessed the further information she'd provided. She provided evidence that she'd been awarded Employment Support Allowance (ESA) in the 'support group' category in November 2022. While this complaint was ongoing, Miss S raised a third complaint about L&G, which related broadly to the service she'd received from it. She felt she'd been blocked from providing L&G with new OH reports.

Our investigator didn't recommend that Miss S' complaints should be upheld. Briefly, she thought the evidence indicated that Miss S had been experiencing symptoms of voice hoarseness for a period of three years, which meant she'd been able to work with those symptoms previously. She accepted that Miss S had been awarded PIP at tribunal, but she noted that a PIP claimant didn't need to be out of work to claim this benefit. She didn't think the CBT practitioner's letter explained why Miss S' physical symptoms would prevent her from working. And as the ESA award letter was dated November 2022, she didn't think it was evidence of what had happened during the deferred period. So the investigator still didn't think it had been unfair for L&G to conclude that Miss S hadn't met the policy definition of incapacity. She didn't think either that there was evidence to show L&G had blocked Miss S from providing new OH reports to it.

Miss S disagreed with our investigator. She provided additional evidence in support of her complaint and I've summarised this evidence below:

- A copy of Miss S' job description, which showed that she was required to hold face-to-face meetings with clients; social occasions etc;
- A GP's letter dated 23 March 2023, which set out Miss S' symptoms and diagnoses and which stated that Miss S remained unfit for work;
- Miss S set out a list of a number of worrying symptoms and conditions she suffers from;
- A psychiatrist's report, dated 23 February 2023, which provided a diagnosis of mixed anxiety and depressed mood, with panic disorder; together with strong features of ADD;
- A report from another OH physician, dated 13 April 2023, which stated that Miss S' symptoms were not compatible with a return to work;
- A further letter from the ENT consultant surgeon, dated 15 May 2023, which stated that by February 2022, severe muscle tension dysphonia was apparent and as a consequence, Miss S would be unable to work effectively. The consultant also said that Miss S had been experiencing episodes of vertigo on a monthly basis – including

during the deferred period - which would have further affected her ability to work and fulfil her role;
- A further letter from the consultant rheumatologist, dated 20 May 2023, which stated that Miss S' symptoms of fibromyalgia had become considerably worse in 2022.

The new medical evidence was sent to L&G for its CMO comments. Based on those comments, L&G maintained its stance.

I issued a provisional decision on 6 July 2023, which explained the reasons why I didn't think L&G had treated Miss S unfairly. I said:

'First, I must make it clear that this decision will only consider whether L&G fairly and reasonably assessed the new medical evidence Miss S sent it following its original decline of the claim. I will not be reconsidering any of the issues which were decided by my colleague in January 2023.

It's clear that Miss S has been through a very difficult time and I'm sorry to hear about the impact this has had on her. I would stress though that I am not a medical expert and therefore, my decision must necessarily be based on an assessment of the medical evidence provided by experts in their field, including L&G's CMO.

I'd also like to reassure Miss S that while I've summarised her detailed submissions to us, I've carefully considered all she's said and all that's been sent to us. Within my decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of this group insurance policy and the available medical evidence, to decide whether I think L&G has handled Miss S' claim fairly.

I've first considered the terms and conditions of this policy, as they form the basis of Miss S' employer's contract with L&G. As Miss S' claim was for incapacity benefit, I think it was fair and reasonable for L&G to assess whether it considered that the new medical evidence showed Miss S' claim met the policy definition of incapacity. I've turned then to look at L&G's definition of 'incapacity'. This says incapacity:

'Means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.'

In order for L&G to pay Miss S benefit then, it needs to be satisfied that it's an illness which prevented her from carrying out the essential duties of her role. It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Miss S' responsibility to provide L&G with enough new evidence to demonstrate that her illness had led to her being unable to carry out the essential duties of her role. And the policy says that L&G will pay incapacity benefit the day immediately after the last day of the deferred period. As such, Miss S needed to provide L&G with enough evidence to show that she was incapacitated for the entirety of the deferred period – between February and August 2022 – and afterwards.

L&G assessed the new evidence Miss S provided in support of her claim, including with its CMO and concluded that it still didn't show that she met the policy definition of incapacity. So I've next looked at the available medical evidence to assess whether I think this was a fair conclusion for L&G to draw.

Medical evidence provided to L&G

First, I've looked carefully at the medical and other evidence Miss S provided to L&G when she appealed.

It's clear that a tribunal judge ruled that Miss S was entitled to PIP and that this was backdated to October 2021. However, as the investigator said, PIP can be awarded even if a claimant is working. So I don't think it was unfair for L&G to conclude that this wasn't evidence that Miss S was incapacitated during the deferred period.

On 6 October 2022, Miss S' ENT consultant stated:

'Miss S presented with a three-year history of variable hoarseness, significantly worse during stressful episodes…Loss of voice can occasionally last 30 minutes, or occasionally, the whole day.'

They stated that Miss S' other main complaint was intermittent episodes of vertigo. They found no evidence of an abnormality in Miss S' larynx and referred her for voice therapy with a speech and language therapist, as they thought 'it would significantly reduce the frequency and severity of her voice problems.'

Later in October 2022, a CBT practitioner stated: 'Miss S was experiencing symptoms of anxiety, depression and panic disorder and at the time, the treating clinician advised a return to work was not recommended due to co-presentation of physical concerns.'

Later in October 2022, Miss S' consultant rheumatologist stated: 'We discussed in detail a lot of your symptoms which have been getting worse over the last two years…You have previous issues with anxiety and depression…your symptoms and certainly clinical signs on examination would suggest you have fibromyalgia…It is my view that most of these symptoms would fall under the bucket of fibromyalgia and treating the triggers…may help, but more importantly, you need some information on fibromyalgia…in addition to asking you to be referred through your GP to the local fibromyalgia management service.

L&G's CMO considered this evidence. They concluded that Miss S' voice therapy could take place alongside a resumption of work. They felt that there was no evidence of serious illness in relation to fibromyalgia in Miss S' case. They said fibromyalgia was a long-term condition and could be managed in the workplace, as per current legislation and best practice. So they remained persuaded by the OH physician's conclusion previously that Miss S was fit to return to work with adjustments.

I've considered this evidence very carefully. It's clear that Miss S was suffering from symptoms which can sometimes be indicative of an impairing health condition. But I don't think that L&G was unreasonable in concluding that this evidence didn't indicate that Miss S was incapacitated in line with the policy terms. I find the CMO's conclusions on the evidence persuasive. That's because neither consultant suggested that Miss S was unfit for work and both of the consultant's letters indicated that not only had Miss S been experiencing these symptoms for some time, she'd previously managed to work with them. It isn't clear how or why those symptoms went on to prevent Miss S from working during the deferred period. I accept that the CBT practitioner indicated that Miss S' clinician had felt she was unfit for work. But the letter doesn't specify what timeframe this applied to and neither does it indicate what physical concerns would've caused Miss S to be incapacitated during the deferred period.

In the round then, I'm currently satisfied it was fair and reasonable for L&G to conclude that

this evidence didn't indicate that Miss S had met the policy definition of incapacity.

Further medical evidence

As I've explained, following the investigator's assessment, Miss S provided further medical evidence in support of her claim, which L&G has had the opportunity to see and comment on. It's maintained its position though and so I've gone on to consider the evidence to decide whether I think it was fair for it to do so.

In April 2023, another OH physician carried out an assessment ahead of a grievance procedure meeting. The report stated:

'The level of symptoms which continue to be reported are not compatible with a return to work at this stage. Thoughts of work and the issues surrounding the grievance continue to result in anxiety.'

And the OH also stated: 'I cannot provide you with a timescale for returning to work. However I would conclude it will be very difficult for a return to take place before the grievance is investigated… I believe the current absence will be ongoing and future absence will be dependent on levels of anxiety, particularly those related to work.'

The ENT consultant has provided a letter dated 15 May 2023. I've set out what I think are the salient points:

'I have been asked to provide a summary of Miss S' ENT conditions which have been affecting her health over the last few years, in order to provide support for a medical insurance claim…I first reviewed Miss S in September 2022 and diagnosed severe muscle tension dysphonia of the larynx, which is a defined clinical condition where the larynx becomes intermittently hoarse and strained…Miss S had intensive voice use in her job, but also a history of stress and anxiety which can exacerbate the severity of muscle tension dysphonia…

(Miss S) tells me that…by the time she left work in February 2022, she was having problems with her voice every other day and this prevented her from carrying out her role…It is quite clear to me that severe muscle tension dysphonia was apparent by February 2022 and as a consequence Miss S would be unable to work effectively…

In addition to voice problems, Miss S also suffered from vestibular (balance) disturbances…Between February and August 2022 the episodes of vertigo were occurring on a monthly basis on average…Intermittent vertigo…is a further factor that will reduce Miss S' ability to work and fulfil her role.'

The consultant rheumatologist stated, on 20 May 2023, that Miss S 'had symptoms of fibromyalgia for nearly two years prior to her clinic attendance however these symptoms became considerably worse in early 2022 with her being symptomatically affected since then, to the extent that it started impacting her day-to-day life and activities of daily living…We would normally recommend that a thorough occupational health assessment should be carried out in the first instance to determine the level of function and suitability for any given role.'

Miss S' GP provided a letter confirming Miss S' conditions and stating that she had been unfit for work.

As I've set out above, L&G's CMO has reviewed the new evidence. I've set out their key findings below:

‘This report from April 2023 builds on those suggestions (from the January 2022 report), in my view, and indicates the breakdown in employer-employee relationship precludes a return to work and that work-related stress will continue to be a driver for ongoing absence. These issues are not within the income protection policy definition, including an ‘own occupation’ policy for this client, and the previous OHP made valid suggestions to move forward, in my view.’

They felt that the ENT consultant’s letter was based on subjective reporting, as they’d previously stated that they’d only seen Miss S once, in September 2022, when voice therapy had been recommended. The CMO also stated that the report of Miss S’ vocal symptoms ‘didn’t align with any recognised medical pathology pattern’ and were in contrast to the ENT consultant’s earlier report that Miss S’ symptoms were intermittent and occasional.

In response to the ENT’s consultant’s comments regarding Miss S’ vertigo, the CMO said: ‘I am unclear how a first attack in a few months noted in September 2022 can be logically compatible with monthly vertigo episodes, on average, between February 2022 and August 2022 and this remark is inconsistent with the formal clinic letter to the member’s GP and history taken at the time by (the consultant), in my view, which would be assumed to be more contemporaneous and accurate, from a medico-legal perspective, relative to a ‘to whom it may concern’ letter ‘FAO Medical Sickness Insurer’ written several months later for the purpose of the income protection claim.’

With regard to the rheumatologist’s letter, the CMO said:

Again, (the consultant) only reviewed the member on one occasion (12/11/2022), which is outside the deferred period. The contents of this letter mostly mirror his previous comments in the clinic letter dated 14/11/2022, which I have already commented on in my email dated 03/01/2023.

I take particular exception to the second comment around her symptoms becoming worse in early 2022, as there is no objective basis for this remark by this doctor. The main objective evidence from early 2022 is from the Occupational Health Physician, who, as I remarked in my email dated 19/08/2022, stated in January 2022 that Miss S is fit for work with adjustments, in his opinion. He stated there is a ‘small chance of sickness absence if her perceptions of work do not change’. (The consultant) has placed emphasis on the view of Occupational Health in his current report. I therefore disregard the other subjective remarks around symptoms that significantly predate his first interaction with the member, given an Occupational Health Physician review took place in early 2022 and the recommendations are clear.’

I’ve weighed-up the new evidence very carefully, as I appreciate it’s supportive of Miss S’ position. But having considered everything, I currently find the CMO’s evidence more persuasive. The consultants’ letters were both written some months after the end of the deferred period and some months after they’d originally reviewed Miss S. Both letters do suggest subjective reporting of her symptoms by Miss S. And I agree that that it’s reasonable for L&G to place more weight on the contemporaneous evidence provided by Miss S’ treating doctors, than letters which were written some time after the end of the deferred period with the aim of supporting the claim.

It's clear that OH physician who reviewed Miss S in April 2023 did think she was unfit for work. But it seems to me that they concluded much of Miss S’ fitness or otherwise to work was dependent on her relationship with her employer. On this basis then, I don’t think it was unfair for L&G to place weight on this evidence to conclude that Miss M’s absence was at least partly due to her work-related stress and a grievance with her employer. Generally,

work-related stress isn't considered to be an illness in and of itself.

I appreciate Miss S' GP felt she was unfit for work. But their evidence is a record of Miss S' diagnoses, rather than a detailed explanation of how she met the definition of incapacity during the deferred period. And while Miss S was awarded ESA in the support group category, it appears that this award post-dated the deferred period. So I don't think this is persuasive evidence that Miss S met the definition of incapacity during the relevant period.

Overall then, based on the totality of the evidence, I don't think it was unfair for L&G to conclude that Miss S' new evidence wasn't enough to show she met the policy definition of incapacity between February and August 2022. So whilst I sympathise with Miss S' position, I currently find it was fair for L&G to maintain its decision to decline her claim.'

I asked both parties to send me any additional evidence or comments they wanted me to consider.

Miss S has provided me with a number of additional submissions, which I've summarised below:

- L&G had previously wrongly assessed the claim on the understanding that Miss S' role was sedentary. This wasn't the case;
- Initially, Miss S' symptoms were attributed to workplace stress, which were only diagnosed following onward review by her GP;
- She'd understood that usually, L&G would write to consultants to ask for evidence it considered necessary to assess a claim. L&G hadn't done so during the deferred period. Any medical evidence Miss S had paid for her consultants to provide after the end of the deferred period had then been dismissed as having been provided too late;
- Miss S has recently been diagnosed with a new medical condition. She now has around 12 co-morbid medical conditions – but it takes some time to assess and diagnose conditions. She queried what reassurance she could have that both L&G and I had taken her co-morbidities and the difficulties she faced into account;
- She'd repeatedly asked L&G for an up-to-date health assessment, but it had denied her this opportunity. She felt this showed that L&G had failed in its duty of care;
- Miss S had made a subject access request, but she felt L&G had failed to provide her with some of her data and she couldn't access calls it had sent her on a CD. She felt that it was important that I listen to all of the calls between her and L&G to ensure I had all of the relevant information on file to reach a fair outcome;
- Miss S and her family had been severely adversely impacted by the situation and the additional stress L&G's actions have placed on them. The handling of the claim has also affected Miss S' recovery;
- The backdated court order for Miss S' ESA award showed that she was entitled to payment from October 2021 – prior to the deferred period;
- Miss S disagreed with the CMO's comments on the ENT surgeon's later letter and also felt that the CMO was relying on an outdated OH report;
- Covid-19 had hampered Miss S' ability to be assessed and Miss S queried why the deferred period hadn't been adjusted to reflect this;
- She believed the CMO was selective in the information they relied upon, given the OH physician's conclusion in April 2023 that Miss S wasn't fit to return to work. The OH physician had also concluded that anxiety and stress were not the only conditions preventing Miss S from working;
- Voice therapy had been taking place, but this hadn't removed the occurrences of Miss S' hoarseness. She accepted the fibromyalgia can be managed in the

workplace, but given the non-sedentary nature of Miss S' role, they didn't agree that it could be here;
- Miss S maintained that she met the policy definition of incapacity.

L&G considered the medical report Miss S had provided setting out her new diagnosis, but it didn't change its position.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, whilst I'm very sorry to disappoint Miss S, I still find that L&G has treated her fairly and I'll explain why.

First, I'd like to thank Miss S for the further submissions and evidence she sent to me following my provisional decision. I've read all she's said and sent me and I've thought carefully about everything she's provided. However, as I explained in my provisional decision, our rules don't require me to address each point a consumer or business has raised. And I won't be commenting on each of Miss S' points individually in this decision. I'll be focusing on what I think are the key arguments.

It remains the case that it's for a policyholder to provide enough evidence to show that they have a valid claim on their policy. So it's Miss S' responsibility to provide L&G with medical evidence which demonstrates that she was incapacitated for the whole of the deferred period and afterwards. While Miss S may have liked L&G to write to her treating consultants to ask for information, I think it had enough medical evidence available in order to make a decision on her claim. And I'm satisfied that when Miss S did provide further information, it has appropriately considered whether that new evidence has any impact on its overall claims decision. I don't think it's unreasonable though for L&G to place more weight on contemporaneous evidence than new evidence dated some months after the deferred period ended. I'd add too that I'm satisfied the evidence shows that L&G considered Miss S' job role in line with the job description provided to it.

I appreciate that Miss S has been diagnosed with a number of co-morbidities and I'm sorry to hear about the impact this has had on her on and her family. I find L&G's records indicate that it is aware of her diagnoses and that these have been considered when L&G assessed the claim. I must reiterate that I am not a medical professional and so it wouldn't be appropriate for me to make any finding on whether Miss S is incapacitated by her medical conditions.

Instead, I've reconsidered the totality of the medical evidence that's been provided. And while I sympathise with Miss S' position, I still find L&G's CMO's findings persuasive evidence that Miss S hasn't shown she met the policy definition of incapacity throughout the deferred period – for the same reasons I set out above. I haven't seen compelling evidence to suggest that the CMO didn't weigh-up all of the medical evidence when providing their opinion. I'd add too that L&G isn't obliged to arrange an independent medical examination for Miss S – and in this case, I think it had enough evidence to make a claims decision without such an independent assessment. I accept Miss S may not have been fit to work – and I acknowledge that she was awarded backdated benefit. But being signed-off from work doesn't mean that a policyholder will necessarily meet an insurer's definition of incapacity.

Miss S has provided me with a copy of a report showing that she's been diagnosed with a new medical condition. This was also sent to L&G for its comments. L&G has maintained its claims decision – and I don't think it was unfair for it to do so. L&G noted that Miss S had

experienced and worked with traits of this condition for some years. And the diagnosing professional didn't suggest that Miss S wasn't fit for work – they simply suggested that she share her diagnosis with her employer. So I don't find L&G acted unreasonably when it concluded that this wasn't sufficient evidence to show Miss S met the policy definition of incapacity either.

It's clear Miss S would have liked me to obtain and listen to the calls between her and L&G. But as the investigator explained, it's for me to decide what evidence I need to consider what's fair and reasonable in all the circumstances. I'm satisfied that the evidence provided by both parties was and is already sufficient for me to do so and that I don't need to listen to the calls. I say that because I think the key evidence here is the medical evidence and L&G's assessment of it. Miss S has told us that L&G didn't fully comply with a data subject access request she made to L&G. However, that point doesn't appear to have been addressed by L&G as part of this complaint and so it wouldn't be appropriate for me to comment on it further here. Miss S may be able to complain to the Information Commissioner's Office though if she feels L&G has failed to comply with data protection law.

Overall, I do sympathise with Miss S' position and I appreciate how disappointed she will be with my final decision. But for the reasons I've set out above, I still don't think it was unfair for L&G to conclude that Miss S didn't meet the policy definition of incapacity. And so I still find it was fair for L&G to turn down her claim.

My final decision

For the reasons I've given above and in my provisional decision, my final decision is that I don't uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask Miss S to accept or reject my decision before 13 October 2023.

Lisa Barham
Ombudsman