DRN-4387933

The complaint

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

What happened

The background to this complaint is well-known to both parties. So I haven't set it out in detail here. Instead, I've set out a summary of what I think are the key events.

Miss D is insured under her employer's group income protection policy. The policy provides cover in the event that Miss D is unable to work in her own occupation, as a result of illness or injury. The policy deferred period is 26 weeks.

In February 2023, Miss D's employer made an incapacity claim on her behalf. Between May 2022 and February 2023, Miss D had been signed-off from work on four occasions, suffering from symptoms of depression.

L&G looked into Miss D's claim and it linked the four periods of absence. It organised a call with one of its vocational clinical specialists and it asked for copies of Miss D's GP records, which it asked its Chief Medical Officer (CMO) to review. Overall, L&G concluded that Miss D hadn't shown she met the policy definition of incapacity throughout the deferred period and it turned down her claim.

Miss D was unhappy with L&G's decision and she asked us to look into her complaint.

Our investigator didn't think Miss D's complaint should be upheld. Based on the available evidence, he didn't think it had been unfair for L&G to conclude that Miss D hadn't provided enough evidence to show she'd been incapacitated in line with the policy terms.

Miss D disagreed and so the complaint's been passed to me to decide.

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 D, I don't think it was unfair for L&G to turn down her claim and I'll explain why.

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 policy and the available medical evidence, to decide whether L&G handled Miss D's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Miss D's employer's contract with L&G. Miss D's employer made a claim on her behalf for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate

for L&G to consider whether Miss D claim met the policy definition of incapacity. This is defined as follows:

'*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.*

The insured member's capacity to perform the essential duties of his own occupation will be determined whether or not that occupation remains available to him.'

This means that in order for L&G to pay Miss D incapacity benefit, it must be satisfied that she had an illness or injury which prevented her from carrying out the essential duties of her own occupation. And in order for benefit to be paid, Miss D needed to have been incapacitated in line with the policy terms for the entire deferred period and afterwards.

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 D's responsibility to provide L&G with enough medical evidence to demonstrate that an illness had led to her being unable to carry out the duties of her own occupation for the full 26-week deferred period between May and December 2022.

L&G assessed the available evidence, including seeking the opinion of its clinical staff. While it acknowledged that Miss D had been through a difficult time, it concluded that there wasn't enough objective medical evidence to show that Miss D had been totally incapacitated throughout the whole deferred period. So I've next looked at the available medical and other evidence to assess whether I think this was a fair conclusion for L&G to draw.

Miss D and her employer didn't send in a claim form until February 2023 – which was over six weeks after the deferred period ended. And it's unfortunate that by the time Miss D spoke to the vocational clinical specialist - in April 2023 - her symptoms were sufficiently recovered to allow Miss D to have returned to work – initially on a phased basis. So at the time of the discussion between Miss D and the vocational clinical specialist, it was found that Miss D was fit for work.

Given the lack of contemporaneous evidence about Miss D's health and symptoms during the deferred period, I think it was reasonable and appropriate for L&G to ask her GP for copies of Miss D's medical records. I've looked carefully at this evidence.

In May 2022, Miss D saw a GP who noted that Miss D had experienced a low mood and lack of motivation the previous week but was '*euthymic*' on the date of consultation. I can see that the GP practice (including nurses) continued to issue Miss D with fit notes which stated that she was unfit to work due to 'symptoms of depression'. And, in late 2022, she was prescribed an anti-depressant. I can also see that Miss D was referred for talking therapy, although she was discharged from that service due to non-attendance. There is little evidence of Miss D being physically reviewed by her GP practice for much of that period and the fit notes appear to have been issued based on Miss D's self-reported symptoms, rather than a GP's observation of her presentation.

Subsequently, in November and December 2022, Miss D attended A&E on a few occasions, as she'd self-harmed. And Miss D was referred to a community mental health team at that point.

As there was little objective evidence of Miss D's health between May and December 2022, L&G asked its CMO to review the available evidence. I've set out below what I think were the CMO's key conclusions:

‘Based on my review of the evidence, there is insufficient objective evidence to support total incapacity during the period… in my opinion. There were no clinical interventions during the majority of the absence, with (an anti-depressant) *only briefly trialled in late 2022 and no therapy prior to that whatsoever, which is inconsistent with mental illness of sufficient severity to totally preclude work, in my opinion. The insurer was also unable to assess the member during 2022 due to lack of engagement.’*

I’ve thought very carefully about all of the evidence that’s been provided. It’s important I make it clear that I’m not a medical expert. In reaching a decision, I must consider the evidence provided by both medical professionals and other experts to decide what evidence I find most persuasive. It isn’t my role to interpret medical evidence to reach a clinical finding.

It’s clear that Miss D was suffering from symptoms which can also be indicative of a significant mental health condition. It’s also clear that she’s been through a difficult and upsetting time. But, I have to bear in mind the contemporaneous medical evidence which was available to L&G when it assessed the claim. I appreciate Miss D says she didn’t engage much with medical professionals during the deferred period because she was so unwell.

However, I don’t think it was unreasonable for L&G to conclude that there was very little objective evidence to show that Miss D was incapacitated in line with the policy definition of incapacity between May and December 2022. I say that because as I’ve set out above, there is little evidence that Miss D was physically reviewed by a doctor after May 2022 and the fit notes appear to have been issued based on Miss D’s self-reporting of her symptoms. Miss D wasn’t prescribed medication until late into the deferred period and neither was she referred for psychological treatment after she’d been discharged from talking therapy due to non-attendance. This means there is no available medical evidence from a psychological specialist to indicate the severity of Miss D’s symptoms during the deferred period or how her symptoms would have affected her ability to carry out the essential duties of her role. I was sorry to read about Miss D’s episodes of self-harm. But again, these took place several months after the deferred period began.

I note Miss D is unhappy that L&G didn’t organise an occupational health assessment or support her in returning to work. However, by the time L&G assessed the claim, Miss D had already gone back to work and so I think there was little L&G could reasonably do to offer rehabilitation support.

Overall, taking into account the totality of the medical and other evidence available to L&G, I think it was reasonably entitled to rely on the clinical opinion of its CMO when deciding whether or not to accept this claim. And I don’t think it was unfair for L&G to conclude that Miss D hadn’t provided enough objective medical evidence to show she met the policy definition of incapacity throughout the whole of the 26-week deferred period.

I’d like to reassure Miss D that I’m not suggesting that she was fit for work. I appreciate she was medically signed-off. And I understand she’s been through a very difficult time. But I need to decide whether I think she’s shown she met the policy definition of incapacity for the whole of the 26-week deferred period. As I’ve explained, I don’t think she has. This means that despite my natural sympathy with Miss D’s position, I don’t think it was unfair or unreasonable for L&G to turn down her claim.

My final decision

For the reasons I’ve given above, 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 D to accept

or reject my decision before 6 December 2023.

Lisa Barham
Ombudsman