DRN-4324359

The complaint

Mr J complains that Liverpool Victoria Financial Services Limited (LV) has turned down a sickness claim he made on a personal income protection insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've simply set out a summary of what I consider to be the main events.

Mr J is insured under a 'personal sick pay' policy. The policy deferred period was four weeks.

In March 2023, Mr J was signed-off work with depression. He was prescribed medication. So he made a sickness claim on the policy.

LV assessed the available medical evidence, including Mr J's fit notes; GP records and an occupational health (OH) report. It concluded that Mr J's absence was down to work-related issues and other stressors in his personal life. So it didn't think Mr J had provided enough objective medical evidence to show that an illness prevented him from working. And therefore, it turned down Mr J's claim.

Mr J was unhappy with LV's decision and he asked us to look into his complaint. He subsequently provided LV with further medical evidence in support of his claim, including a letter from his GP, dated 28 June 2023. But LV still didn't think Mr J had shown he had a valid claim on the policy.

Our investigator didn't think LV had treated Mr J unfairly. He considered all of the medical evidence which had been available to LV at the time it assessed the claim, up to and including the doctor's letter of 28 June 2023. And he didn't think it had been unfair for LV to conclude that Mr J's absence was most likely down to work-related concerns. So he felt it had been fair for LV to turn down Mr J's claim.

Mr J disagreed. In summary, he felt that he had provided sufficient evidence, from a number of doctors, which showed he was suffering from depression. He provided us with evidence of the medication he was prescribed, which he felt would affect his ability to do his job. And he sent us further medical evidence, dated September 2023, which he thought we should take into account when deciding his complaint.

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 sorry to disappoint Mr J, I think it was fair for LV to turn down his claim and I'll explain why.

First, I'd like to reassure Mr J that while I've summarised the background to his complaint and his detailed submissions to us, I've carefully considered all he's said and sent us. In this decision though, I haven't commented on each point he's raised and nor do our rules require me to. Instead, I've focused on what I think are the key issues.

I must also make it clear that this decision will only take into account the medical evidence which was available to LV when it assessed Mr J's claim; when it issued its final response to Mr J's complaint and at the point it assessed the GP's further letter of 28 June 2023. Mr J has now provided us with a copy of a medical report dated September 2023 and he says this has also been sent to LV. I appreciate how strongly he feels that I should consider this new evidence as part of my decision. However, it wouldn't be appropriate for me to comment on new evidence before LV has had a chance to review it and provide its response. That's because we are not a claims handler and it isn't our role to assess claims. My role is to decide whether LV treated Mr J fairly based on the evidence available to it at the time it assessed the claim and investigated his complaint. If Mr J is unhappy with the outcome of LV's review of the new evidence, he may be able to make a new complaint about that issue alone.

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 Mr J's policy and the medical evidence, to decide whether I think LV treated Mr J fairly.

I've first considered the policy terms and conditions, as they form the basis of Mr J's contract with LV. Mr J made a sickness claim on the policy, as he said he was unable to work due to depression. So I think it was reasonable and appropriate for LV to decide whether Mr J met the policy terms. I've set out the applicable terms below:

'You're covered…

If you're unable to work because you're ill or have had an accident.

We'll pay you if you're too unwell to work in your own occupation (due to illness or injury only) and you aren't doing any other paid or unpaid work – for example, voluntary work.'

Unable to work is specifically defined in the contract terms. The definition says:

'Unable to work means that due to illness or injury you cannot carry out the main tasks of your occupation, and you aren't doing any other type of work whether this is paid or voluntary (unpaid) work. The main tasks are the parts of the job you do which can't reasonably be left out, or changed.'

This means that in order for LV to pay sickness benefit, it must be satisfied that a policyholder's illness prevents them from carrying out their main duties of their own occupation, for the deferred period and beyond.

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 Mr J's responsibility to provide LV with enough evidence to demonstrate that his illness led to him being unable to work in line with the policy terms, for the entire deferred period of four weeks and afterwards. And he also needed to show that his illness would prevent him from carrying out his own occupation for any employer – not just his current one.

LV assessed the evidence Mr J provided in support of his claim and concluded that it didn't

indicate that that he'd shown he met the policy definition of unable to work and that instead, his absence was likely down to workplace issues. So I've next looked at the available medical evidence to assess whether I think this was a fair conclusion for LV to draw.

First, I've considered Mr J's GP records, which set out details of Mr J's consultations. The first entry is dated 30 March 2023. A mental health nurse noted:

'(Mr J) is now under investigation…(Mr J) is feeling depressed in mood and feels like he needs support at this time…(Mr J) has requested a sick note…as he does not feel medically fit to attend meetings for the investigation.'

The nurse noted a diagnosis of 'depressive disorder' and provided Mr J with a fit note signing him off work. He was also prescribed an anti-depressant medication, along with sleeping medication.

On 24 April, a GP noted:

'Review of medication…still struggle with low mood. Some unresolved sentiments with work and colleagues…still reporting not fit to return'

The GP's records refer to a situation at work, which had ended, but stated that Mr J still had trouble with his colleagues. A further fit note was issued which gave Mr J's cause of absence as depression.

Mr J saw his employer's OH in May 2023 and I've looked carefully at their report. Following an earlier absence in September 2022, the OH report noted that Mr J:

'*informed me that he experienced several workplace stressors upon his return to work. He cited concerns around high demands, a lack of control and a perception that he was not being supported in work.*

(Mr J) explained he started to experience difficulty sleeping, loss of appetite, feeling hopeless and worrying about a personal concern that has impacted him financially. He described (a workplace incident) and stated his health further declined. He engaged with his GP and was signed off from work and prescribed suitable medication. He has engaged with your EAP for counselling support…

(Mr J) reported he has had no meetings with the workplace to discuss the concerns. He expressed he feels unable to attend such a meeting until he has completed his current episode of sick leave. I advised that unless the workplace concerns are addressed, it may take him longer to recover and impact his eventual return to work.

(Mr J) was engaged with the assessment and provided a thorough history. However, he is doing very little at present and seldom leaves his home. He appeared resistant to my suggestions about self-managing his recovery and addressing the workplace matters.'

The OH concluded that Mr J was temporarily unfit for work and noted that Mr J had been signed-off for a further three months. They added:

'To address the workplace perceptions, I recommend a workplace meeting is arranged to help support (Mr J) when he is then ready to return to work, and to enable him to keep in touch with work regarding the present situation, in around 3-4 weeks to allow for any adjustments to his medication and for (Mr J) to access some more counselling.'

LV assessed the available medical and other evidence. While it sympathised with Mr J's

position, it concluded that the evidence didn't indicate he was suffering from a mental illness which prevented him from carrying out his role. Instead, it felt that Mr J was suffering with a reaction to his circumstances, It didn't think there was objective medical evidence to suggest that Mr J was suffering with a significant mental health condition of a severity which would result in him being unable to work.

I've thought very carefully about this. I must make it clear that I'm not a medical expert and therefore, my decision must necessarily be based on an assessment of the available medical evidence. It's clear that Mr J was suffering from symptoms which can also be indicative of a significant mental health condition. But at the point Mrs G was signed-off in March 2023, the evidence indicates that the reason he wasn't fit for work was because he wasn't coping with a potential investigation at work, rather than because of a significant, impairing mental health condition. And the OH report concluded that Mr J had experienced several work-place stressors, including an incident which appears to have resulted in the planned investigation. While I appreciate Mr J's fit notes stated depression at this time, the notes don't indicate how Mr J was precluded from work in March or April 2023 and nor do they show, objectively, why or how he was functionally impaired when the deferred period began.

So I think it was reasonable for LV to conclude that the evidence showed Mr J was suffering from an understandable reaction to the very difficult situation in which he found himself, as opposed to a mental health condition which met the definition of 'unable to work' for the whole of the deferred period. This means I don't think it was unfair for LV to consider that Mr J hadn't met the policy definition of incapacity for the entirety of the deferred period when it initially assessed the claim.

Mr J provided LV with further evidence from an online GP and two letters from his GP surgery. The first GP's letter is dated 8 June 2023 and says:

'*Mr J is…a gentleman with a diagnosis of Depression and currently on medications for his mental illness.*

Due to his condition, he has been unable to work and has been given a sick note for 3 months which may be extended if required.'

The online GP's letter is dated 20 June 2023. This letter stated that due to Mr J's depression, he had been unable to fulfil the duties of his work and explained how some of Mr J's symptoms could affect his ability to do his job.

A further GP letter was dated 28 June 2023 and stated:

'(Mr J) has requested a letter from us. I confirm he has depression and has been signed off with this. He states he lacks the ability to concentrate, and his depression affects his ability to focus and maintain attention on tasks at work. He lacks focus which could be dangerous in his work.

He lacks energy and is constantly fatigued and suffers sleep disturbance and insomnia which impacts negatively on his mood energy levels and ability to concentrate at work.

He has ongoing panic attacks and anxiety which makes it hard to cope with stressful situations at work and his depression affects his decision making leading to self-doubts and fears about work.

He continues to feel very negative about life in general. He continues to take medication from us for these problems but feels unable to work at this time.'

LV reviewed the new evidence and following the GP's letter of 28 June 2023, it asked the GP for more information, which was provided to LV. I think this was a fair and appropriate step for LV to take. The GP's response included the following note dated 6 June 2023:

'*Known mild depression…Patient said he noticed improvement in his mood with (anti-depressant medication) and would be happy to continue…Would like a letter from GP to submit to pay protection insurance mentioning his diagnosis and medication for this.'*

Having assessed the new medical evidence, LV maintained its position. It said that the majority of the consultations point to a depressed low mood, which isn't depression and it said the later entry referred to 'mild depression'. It stated that a depression diagnosis and medication doesn't mean that a person is unable to work. It pointed to the fact that much of the evidence referred to Mr J's issues with work and the potential workplace investigation. So it still felt there was no objective medical evidence which supported a claim.

Again, I've considered this evidence carefully. But I don't think LV has reached an unreasonable conclusion. The GPs' letters seem to be based on Mr J's self-reporting of his symptoms. The online GP didn't examine Mr J in person. And there remains reference to Mr J's fears about work. I agree too that the GP's records suggest that Mr J had 'mild depression' and don't indicate that Mr J was significantly functionally impaired. So I don't think LV acted unfairly when it concluded that this evidence didn't show Mr J was unable to work in line with the policy terms.

I appreciate Mr J says his medication could affect his ability to do his job. But the GPs' letters don't state that Mr J couldn't do his job because of the medication he was taking. And the medication information leaflet he sent us only says that the medication could influence a patient's ability to do certain things (such as driving) and that a person should wait to find out how the medication affected them before attempting to undertake those activities.

Overall then, I don't think it was unfair for LV to conclude that the June 2023 evidence didn't change its position and to maintain its decision that Mr J hadn't shown he met the policy definition of 'unable to work' during the full deferred period and afterwards.

I sympathise with Mr J's position and I accept that medical professionals have found that he is unable to work. But that isn't enough to show that a claim meets an insurer's policy terms. And based on all I've seen, I've decided that LV didn't act unfairly when it relied on the medical evidence up to and including 28 June 2023, to conclude that Mr J's claim wasn't covered. So I find it was fair for LV to turn down Mr J's claim.

As I've set out above, Mr J indicated he's sent LV a copy of the new medical evidence he's obtained, which is dated September 2023. If he's unhappy with the outcome of any assessment of that evidence by LV, he may be able to make a new complaint about that issue alone.

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 Mr J to accept or reject my decision before 26 October 2023.

Lisa Barham
Ombudsman