DRN-4709149

The complaint

The estate of Mr R complains that Liverpool Victoria Financial Services Limited (LV) refused to pay a claim and cancelled Mr R's flexible protection plan.

The estate is represented by Ms N.

What happened

In summary, in March 2013, Mr R took out insurance with LV, through a broker. The plan included life and critical illness cover, as well as total permanent disability benefit and income protection.

Very sadly, in December 2021, Mr R died. Ms N subsequently claimed on the policy. But LV declined the claim, saying Mr R hadn't given full and accurate information during the application process. LV thought Mr R should've answered differently to questions about recreational drug use and mental health.

LV considered there'd been a qualifying misrepresentation. It said that, had Mr R answered correctly, it would not have offered him cover at all. LV treated the misrepresentation as deliberate, refused to pay the claim and cancelled Mr R's cover.

Ms N complained and asked for an appeal, but LV maintained its position, so on behalf of the estate, Ms N brought the complaint to the Financial Ombudsman Service. Our investigator upheld the complaint and recommended LV reinstate the policy and pay the claim.

LV didn't accept our investigator's opinion and asked for an ombudsman to review the complaint and issue a final decision. LV relied on disclosures to health professionals indicating long-term recreational use of ketamine, pre-dating Mr R's application for cover.

In February 2024, I issued a provisional decision. In it I referred to The Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA). I've since noted that Mr R's policy was taken out the month before CIDRA came into force. This doesn't make a difference to my provisional findings. In considering what's fair and reasonable, I need to have regard to the relevant law and regulations, regulators' rules, guidance and standards, codes of practice and (where appropriate) what I consider to have been good industry practice at the time. The relevant law in this case is the Marine Insurance Act 1906. This required Mr R to act with utmost good faith when applying for the policy and to tell LV about anything that would be material to it. If he didn't provide the correct information then, provided LV would have offered the policy on different terms or not at all if the correct information had been provided, LV would be entitled to avoid his policy. And when assessing the claim, LV needed to follow the good industry practice set out in the ABI Code of Practice – Managing Claims for Individual and Group Life, Critical Illness and Income Protection Insurance Products September 2019 (the code). The code reflects this service's well-established approach to what's fair and reasonable for policies taken out before CIDRA.

So in my provisional decision I said:

> ‘LV raised concerns about answers Mr R gave to questions about drug use and mental health. But it’s confirmed that it would still have offered cover on the same terms in relation to the mental health question. So I’ve focused on the question relevant to LV’s claims decision.
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> ‘LV says Mr R failed to take reasonable care not to make a misrepresentation when he answered *‘no’* to the following question:
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> > *‘Have you ever used recreational drugs (e.g. cannabis, cocaine, heroin)?’*
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> ‘LV says Mr R should’ve answered yes to this question, based on evidence in his psychiatric and other medical records, indicating a long-standing history of drug use - significantly, ketamine - pre-dating his application for the policy. I’ve reviewed the medical evidence provided.
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> ‘LV accepts there’s no evidence of drug use noted in Mr R’s GP record before 2020. I can see that in May 2021, Mr R saw a private psychiatrist, Dr D. This was an online consultation, due to Covid-19 disruption. Dr D subsequently sent a summary of the consultation to Mr R’s GP.
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> ‘The presenting conditions are recorded as, *‘recurrent depression, ADHD, drug-induced psychosis.’* Under the ‘history’ section, Dr D records the issues Mr R spoke about, including:
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> > *‘…the fact that he had been ‘self-medicating’ with cannabis, MDMA and ketamine since the age of 18. We reviewed how he became psychotic a year ago, due to taking ketamine every hour. Hence the recent concerns about him taking it more regularly.’*
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> ‘A further online consultation took place in June 2021. In the follow-up summary to Mr R’s GP, Dr D records the presenting conditions as, *‘recurrent depression, ADHD, drug-induced psychosis, ketamine dependency.’*
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> ‘Under the ‘care plan’ section, Dr D says:
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> > *‘[Mr R’s] mood has improved, but partly due to him taking additional ketamine which is unsafe and unsustainable despite his views of feeling entitled to it. He thinks he will be ok as he has been using ketamine in a similar way for a very long time.’*
>
> ‘Ms N says this evidence is unreliable as it was given at a time when Mr R may have been under the influence of drugs and medication during a period of severe mental illness. I accept that Mr R was a man with addiction and mental health problems. But I don’t agree this means nothing he said can be relied upon.
>
> ‘Prior to the May consultation, Mr R had been referred to a community home treatment team (HTT). This was after police took him to A&E following concerns about a deterioration in his mental health after continuous abuse of ketamine over the weekend. Mr R was assessed and discharged from A&E with HTT follow up requested. The HTT discharged him after ten days *‘without any outstanding concerns’*, two days before his consultation with Dr D.
>
> ‘I also note that under ‘examination’ for the May consultation, Dr D records:

‘[Mr R] gave a good account of himself. He had sufficient insight and was able to consent to treatment.’

‘And for the June consultation:

‘[Mr R] was calm his affect was euthymic. He gave a good account of himself. He had partial insight into his condition and tends to minimise his addiction on ketamine.’

‘I’ve not seen anything to indicate Dr D had concerns about Mr R’s ability to engage in the consultation process or that he doubted the truthfulness of Mr R’s disclosed history.

‘Between July and September 2021, Mr R was in hospital, receiving psychiatric care. Following his discharge from hospital he received care from the HTT for approximately ten days. A discharge summary was completed by registered mental health nurse L in October 2021. In the summary, under ‘presenting situation’, nurse L records:

‘Taking ketamine daily, started since 2006.’

‘I’ve also seen a Mental Health Tribunal Decision Notice, issued in August 2021, to which Mr R’s has added multiple comments, making observations and giving explanations about events. He also questions and challenges statements he considers factually inaccurate, including dates. Under the six paragraphs making up the ‘history’ section, Mr R makes 13 comments. From what I’ve seen, Mr R went to considerable lengths to record his views on the decision notice. But I note he does not challenge the statement, *‘the medical report suggests that he has been taking [ketamine] since the age of 18’.*

‘I accept there are some inconsistencies regarding the date Mr R first started taking ketamine. But overall, I think there is consistency in him reporting long-term use of ketamine which pre-dated application for the policy.

‘I appreciate the strength of feeling Ms N has about the unreliability of this evidence, coupled with her own testimony that she was unaware of any drug use prior to 2020/2021. But there are other possible explanations, such as Mr R having been able to hide his drug use until his usage became so frequent that it led to involvement with mental health services. I’m also conscious that Mr R’s first presentation to mental health services was 2020, shortly after the onset of the Covid-19 pandemic and a restrictive lockdown, when hiding addictive behaviours would’ve been more difficult.

‘I’m aware our investigator suggested Mr R might’ve lied to his psychiatrist about his drug use for fear his private prescriptions would be stopped. Of course this is possible, but I’ve not seen any evidence to suggest this was Mr R’s motivation for disclosing long-standing usage to his psychiatrist and other treating medics. Overall, I’m more persuaded that the medical evidence reflects Mr R speaking frankly about his history of drug use.

‘Mr R was responsible for answering questions correctly and accurately. LV said he was sent a copy of the application form with his answers on the day of application and told to let LV know if any of the answers were incorrect. Mr R made no

corrections. So I'm satisfied Mr R failed to take reasonable care when answering LV's question.

'LV has provided information about its underwriting criteria to show what would have happened, had Mr R answered the drugs question accurately. I've reviewed this information carefully and can see the non-disclosure would've made a difference. Ultimately, LV would not have offered any cover to Mr R. So I'm satisfied Mr R's misrepresentation was a qualifying one.

'LV has treated Mr R's misrepresentation as deliberate. The Association of British Insurers' Code of Practice – Misrepresentation and Treating Customers Fairly, says that for a misrepresentation to be deliberate or reckless, on the balance of probabilities, the customer knew, or must have known, that the information given was both incorrect and relevant to the insurer, or the customer acted without any care as to whether it was either correct or relevant to the insurer. Relying on the evidence, I think this was a fair categorisation.'

Overall, I was satisfied that the action LV had taken was fair and in line with the relevant code of practice. I also noted that Mr R had received a sizeable benefit under the income protection element of his plan. LV would have been entitled to seek recovery of these payments from Mr R's estate. However, it had confirmed it would not be doing so. So in light of all the circumstances, I didn't think LV needed to do anything more in respect of the complaint.

LV accepted my provisional decision. Ms N made further representations, following a discussion she'd had with Dr D. In summary, Ms N argued that LV didn't show due consideration in interpreting the medical records and questioned whether LV should've contacted Dr D as part of the assessment process. Again in summary, she said Dr D had made the following points:

- His notes were not reliable evidence of prior drug use. The purpose of the consultations was not to confirm drug use at specific times, so LV shouldn't be using the notes in that way.
- Given Mr R's mental health and substance misuse disorder his comments cannot be considered reliable. LV should not use unreliable statements as evidence.
- In the medical world, statements alone cannot determine drug use. Testing is required for confirmation. The statements are uncorroborated.

Through our investigator, I've already explained to Ms N that I'm satisfied I can reach a fair decision without, as she invited me to, speaking to Dr D. Our investigator also reminded Ms N that my decision centres on whether or not LV acted fairly in declining the claim, based on the evidence available at the time. I would, however, like to make it clear I don't dispute Ms N's account of Dr D's points as an accurate reflection of their conversation.

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, I'm not upholding this complaint. I appreciate this isn't the answer Ms N was hoping for and I'm sorry about that. I'll explain further.

I've thought carefully about the points Ms N put forward following my provisional decision. Firstly, all insurers work with medical professionals who, where necessary, are able to assist

in the interpretation of medical records. I can see that LV initially sought information from Mr R's GP, later seeking more specific information from mental health services. Having obtained documentary evidence, I'd only expect an insurer to make contact with a medic where further clarification was needed. I've not seen evidence to suggest that was the case when LV made its claims decision.

I accept that the purpose of Dr D's notes wasn't to confirm drug use at specific times. But I don't agree this means the notes cannot be used at all as evidence of historic drug use. As a matter of fact, Dr D's contemporaneous notes are part of Mr R's medical records. Dr D is noting what Mr R said to him during the consultations. Self-report is an established part of medical recording, and in respect of noting medical history, may be the only form of evidence available.

I've already explained in my provisional decision that I accept Mr R was a man with addiction and mental health problems. But I still don't think this means nothing he said can be relied upon. Dr D's notes do not indicate any concerns about the accuracy of Mr R's reporting. There's been speculation about Mr R's motivation for his disclosures, but no corroborative evidence as to whether any of the reasons put forward is likely true in Mr R's case. I accept it's possible he wasn't telling the truth. But I've not seen evidence to suggest it was probable.

I'm therefore satisfied LV was entitled to take the medical evidence at face value and rely on it to show that, on balance, Mr R should've answered yes to the question about recreational drug use when he took out the policy.

Overall, given the reasons set out above, I find that LV acted fairly in making its claim decision. It doesn't need to do anything more in respect of this complaint.

My final decision

For the reasons given above, I do not uphold this complaint.

Under the rules of the Financial Ombudsman Service, I'm required to ask the estate of Mr R to accept or reject my decision before 24 April 2024.

Jo Chilvers
Ombudsman