DRN-4431386

The complaint

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

Mr D's represented by Mr G.

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 focused on what I think are the key events.

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

In December 2022, Mr D was signed-off work with anxiety and depression. And he subsequently suffered a fractured ankle. In March 2023, his employer made an incapacity claim on his behalf.

L&G looked into Mr D's claim to determine whether it felt he'd shown he met the policy definition of incapacity throughout the deferred period. One of L&G's clinical vocational specialist's (VCS) carried out a telephone interview with Mr D. The VCS concluded that Mr D was fit to undertake a suited sedentary role. And they felt Mr D's absences were linked to stress triggers.

On that basis, L&G didn't think there was enough medical evidence to show that Mr D was clinically limited or functionally restricted from performing his own or any suited occupation. So it didn't think Mr D had met the policy definition of incapacity and it turned down his claim.

Mr D was unhappy with L&G's decision and Mr G asked us to look into his complaint.

Our investigator didn't recommend that Mr D's complaint should be upheld. Briefly, he considered the available evidence. And he felt it had been fair for L&G to conclude that Mr D hadn't shown he met the policy definition of incapacity during the deferred period. Therefore, he thought it had been reasonable for L&G to turn down Mr D's claim.

Mr G disagreed on Mr D's behalf 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 Mr D, I don't think it was unfair for L&G to turn down his claim and I'll explain why.

First, I'd like to reassure Mr D that while I've summarised the background to his complaint

and his submissions to us, I've carefully considered all that's been said and sent. I'm very sorry to hear about the circumstances that led to Mr D needing to make a claim and I don't doubt what a worrying and upsetting time this has been for him.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And 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 Mr D's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mr D's employer's contract with L&G. Mr D's employer made a claim on his behalf for incapacity benefit, given he'd been signed-off work. So I think it was reasonable and appropriate for L&G to consider whether Mr D's claim met its definition of incapacity throughout the 26-week deferred period. I've turned then to look at L&G's 'suited occupation' definition of incapacity. This says:

'Suited occupation means the insured member is incapacitated by an illness or injury so that he is unable to undertake all occupations which we consider appropriate to his experience, training or education.'

This means that in order for L&G to pay incapacity benefit, it must be satisfied that it's a policyholder's illness or injury which results in them being unable to undertake all occupations which it considers appropriate to their experience, training or education. So in Mr D's case, L&G needs to be satisfied that it was an illness which prevented him from undertaking his own or a suited occupation throughout the entire 26-week 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 Mr D's responsibility to provide L&G with enough evidence to demonstrate that an illness had led to him being incapacitated in line with the policy terms.

L&G assessed the evidence Mr D provided in support of his claim and concluded that it didn't indicate he had a functionally impairing mental health condition or that he met the relevant policy definition of incapacity. 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.

When Mr D's employer first made a claim on his behalf, a member statement and questionnaire was submitted to L&G. I've looked closely at the questionnaire, to understand what Mr D understood to be the cause of his illness. He stated that he'd first experienced symptoms of the condition in November 2021 and he stated that the following symptoms were stopping him from working:

'*Anxiety and depression endured symptoms including chronic sleep problems, low mood, panicy [sic] state, always feeling tired but unable to sleep, issues concentrating.'*

Mr D added that he'd previously suffered from symptoms of the condition, stating:

'Issues first started to occur after a work related event where the first time I started to receive treatment for anxiety and depression being in November 2021, the anxiety and depression has gone up and down levels over this time until my most recent absence where my symptoms have become much worse.'

Mr D had undergone self-CBT and he was prescribed anti-depressant medication. He'd been signed-off work by a mental health nurse, who'd stated that he was unfit for work due

to anxiety and depression.

Subsequently, Mr D underwent a telephone interview with L&G's VCS. I don't think it was unreasonable for L&G to ask a VCS to try and gain a wider understanding of how Mr D's diagnosis and symptoms would affect his ability to work and whether they restricted his functional impairment. I've set out what I think are the VCS' key findings below:

'*The member explained that his anxiety started around November 2021 due to an issue at work.*

He has had several short stints of work due to his mental health since then. These were triggered by both work and life stressors at the time… Two life stressors impacted on the members [sic] mental health. Prior to these events he reports he was struggling to get by at work due to his mental health. He was able to work but he reports he was struggling in general. The life stressors just pushed him too far and he felt he could not keep going to work due to his mental health…

Based on the members reporting at assessment, it is unclear what would prevent the member from undertaking a suited role. The member reports a varied and unspecific typical day which is not indicative of significant functional restriction. Whilst the member reports a history of anxiety stemming from a work- related incident, he explained that he was coping at work prior to the recent stressful events that occurred in his personal life in December 2022. The member reports multiple absences from work due to different stressors at each point in time…

It is of note that since being absent from work, the members activities of daily living do not appear significantly impacted or restricted.

Given the circumstances and reported triggers, I do not think there will be a medical solution to the situation. Hence it follows that the priority now should be for management and the member to address any issues at work and determine whether it is possible to reach an agreement regarding the circumstances in which he would feel able to return to work…

It is my opinion that the member is fit to undertake a suited sedentary role and that these absences are related to stress triggers.'

L&G assessed the available medical and other evidence. And it concluded that the evidence didn't indicate that Mr D was suffering from a mental illness which prevented him from carrying out his own or any suited occupation. Instead, it felt that Mr D was likely suffering with a reaction to personal stressors and that there wasn't evidence to suggest that he was suffering with a substantial or pervasive mental health condition of a severity which affected his day-to-day ability to function.

Following L&G's initial decision to decline Mr D's claim, he provided a letter from his mental health nurse, dated May 2023. This letter stated:

'*Mr D is currently being treated for anxiety and depression and at present is prescribed (anti-depressant) once daily.*
Mr D has requested a letter from myself to confirm this as he reports he was recently assessed by legal and general [sic] who felt it was stress rather than depression and anxiety.'

However, despite this letter and Mr D's appeal, L&G maintained its stance.

I've thought very carefully about everything that's been said and presented. I must make it clear that I'm not a medical expert and therefore, my decisions must necessarily be based on an assessment of the available medical evidence. It's clear that Mr D was suffering from symptoms which can also be indicative of a significant mental health condition. But Mr D specifically stated that the trigger for his illness was a reaction to life stressors. And I've borne in mind that a VCS concluded that Mr D was fit to work in a suited sedentary role.

I appreciate Mr D was medically signed-off work by a medical practitioner. But I don't think this means L&G is bound to conclude that he met the policy definition of incapacity. It's clear that Mr D's fit notes cite depression and anxiety (and latterly, a broken ankle) as the cause of his absence. But the notes don't indicate how Mr D's symptoms affected his ability to work in any suited occupation or how they affected his functional impairment. Nor do I think the mental health nurse's letter explains how Mr D's symptoms affect him or the impact of his condition on his ability to function. And I don't think it was unreasonable for L&G to find that there wasn't enough objective medical evidence to show that Mr D was incapacitated in line with the policy terms. This means I don't think it was unfair for L&G to conclude that Mr D hadn't shown he met the policy definition of incapacity during the deferred period.

Mr G has told us that Mr D now has further medical evidence to support his claim. As the investigator explained, as it doesn't appear that L&G has had an opportunity to consider and assess this evidence, it isn't something I can take into account here. That's because, in the interests of fairness, L&G must be given a chance to review any new evidence before we can comment on it. If Mr D is unhappy with the outcome of any further review of his claim based on the new evidence, he may be able to make a new complaint about that issue alone.

Overall though, despite my natural sympathy with Mr D's position, I find it was fair and reasonable for L&G to turn down his income protection claim based on the evidence it had available when it issued its final response to his complaint in June 2023.

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 D to accept or reject my decision before 2 January 2024.

Lisa Barham
Ombudsman