Decision Ref:	2018-0003
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a member of a group income protection scheme which is underwritten by the Provider.

This complaint relates to an income protection claim submitted by the Complainant in April 2016, on the grounds of disability. Following assessment, the Provider declined the Complainant's claim on the grounds that he did not meet the definition of disablement contained in the policy conditions.

The Complainant disputes the Provider's assessment of his claim. The Complainant states that the Provider has placed too much emphasis on non-medical reasons, such as industrial relations issues, for his inability to return to the workplace, and has failed to take account of all of the relevant medical factors in assessing his claim.

The Complainant also submits that the Provider has failed to treat him as a "*vulnerable consumer*", and failed to make any real inquiry into the nature of his normal occupation.

The complaint is that the Provider has wrongly declined the Complainant's claim. The Complainant states that he is not capable of returning to work and he seeks full payment of benefit.

The Complainant's Case

The Complainant's occupation is that of a client adviser with an insurance broker. He has worked in the area of general insurance for over 40 years, and has been in his current job since 2006.

The Complainant states that he suffered a heart attack in October 2012, which led to the insertion of three cardiac stents, followed by a 6 week course of rehabilitation. The Complainant states that, following his return to work in January 2013, he began to suffer from increasing stress and anxiety, and that these symptoms grew steadily worse, until he was no longer well enough to function properly in the workplace.

The Complainant states that he has been absent from work on certified sick leave, on grounds of work-related stress, since mid-April 2015.

In April 2016, the Complainant notified the Provider of a disability claim under the group income protection scheme of which he has been a member since 2006, and which is underwritten by the Provider. As part of the assessment of his claim, the Complainant was requested by the Provider to attend psychiatric examinations by two independent Consultant Psychiatrists. Following these assessments, the Provider declined the Complainant's claim on the grounds that the objective medical evidence indicated that he did not meet the definition of disablement contained within the policy terms and conditions.

The Complainant disputes the Provider's assessment of his claim. He submits that he suffers from all of the recognised mental and physical symptoms of stress, anxiety and depression, but that there has been little acknowledgement of this by either of the independent Consultant Psychiatrists.

The Complainant has submitted the report of his own Consultant Psychiatrist (Dr L), dated 7 October 2016, in which she reported that the Complainant was suffering from "*Adjustment Disorder/episode of Mixed Anxiety and Depression*" and that it "*would be harmful to him to return to the same situation and would likely result in a deterioration in his mental and physical health with the potential to have a tragic outcome*". The Complainant states that neither the Provider, nor the independent Consultant Psychiatrists, have attached any weight to this medical opinion.

In a submission to this office dated 21 December 2016, the Complainant states as follows:

> *"I was paid a good salary and benefits in recognition of the fact that my job was a demanding one which had significant responsibilities and duties, and for which one had to be in a position to deal speedily and efficiently with whatever landed on one's desk in any given day. A quick turnaround was an essential component of the job.*

/Cont'd…

> *I know that my concentration levels, response times and overall general capacity to do the job (my normal occupation) are nothing to what they were as a result of prolonged stress, anxiety and depression.*
>
> *The Permanent Health Insurance Plan was included as part of the terms and conditions of my employment, together with pension benefits etc. However, in my dealings with* [the Provider] *I was made feel as if I was being dishonest in some way. That is wrong on every level and there was no concession to my status as a "vulnerable consumer".*
>
> *There was absolutely no recognition of the fact that I was a "vulnerable consumer" and I received no guidance or assistance either from my employer…or from the* [the Provider] *(apart from receiving generic brochures). The whole process has only exacerbated both my physical and mental symptoms as well as adding significant stress to my wife…*
>
> *I acknowledge that there were work issues with* [my employer]. *That is not the issue here. The issue is whether I can do my normal occupation.*
>
> *However, both the* [Provider] *Consultant Psychiatric reports appeared to focus more on the work issues rather than my ability to return "to my normal occupation" and resume my duties and responsibilities. There was no real inquiry as what my "normal occupation" entailed and how the physical and mental symptoms of my stress would impact on same".*

The Complainant contends that the Provider would appear to have relied solely on the medical evidence contained in the reports of the two Consultant Psychiatrists selected to examine him, without regard to the content of the medical evidence submitted by the Complainant in support of his claim.

The Complainant submits that the two independent Consultant Psychiatrists put him through unnecessary tests which he believes were more relevant to dementia than stress, anxiety and depression. The Complainant states that neither Consultant Psychiatrist addressed the issue of potential damage to his heart as a result of stress caused by a return to work, and that neither Consultant Psychiatrist addressed his physical symptoms, such as the pains in his arms, hands and fingers, and his inability to sleep without medication.

The Complainant submits that the reports of both of the Consultant Psychiatrists contained contradictions and inaccuracies, and do not appear to have taken into account the particular role and responsibilities of his normal occupation in assessing his ability to return to the workplace. The Complainant states that he was given no opportunity to address these issues with the Provider. He states that there appears to be no holistic view of his situation, and no interaction between the Provider and the Complainant in relation to content of the independent examination reports, or any other matter.

/Cont'd…

The Complainant acknowledges that he has had difficulties with his employers, as identified by the independent medical examiners in their reports, but disputes that non-medical issues such as these are the reason for his absence from work. The Complainant submits that he is unable to work due to his heart condition, stress and depression and that these physical and mental issues constitute medical reasons for his inability to return to the workplace.

The Complainant states that he is on medication for his heart condition and also for depression, and that he is completely incapable of fulfilling his previous duties. He states that he doubts if he is fit for "*for any job that requires focus, empathy, speed, constant reading and sending emails and ability to think and respond quickly*". The Complainant submits that the emphasis by the two independent Consultant Psychiatrists on his *"malingering*" and "*suspect feigning of symptoms*" is insulting. It is submitted on behalf of the Complainant, not that he is unable to work, but that he is unable to carry out his "*normal occupation*" with his employers, and all the demands and deadlines that that normal occupation entails.

The Complainant submits that both his GP, his counsellor and his Consultant Psychiatrist have advised that to return to his normal occupation would have a significant impact on both his mental and physical health. The Complainant states that he is not capable of returning to his normal occupation and he seeks full payment of benefit.

The Complainant raises additional concerns in relation to the correctness of the Provider's actions in releasing his personal information to a non-medical third party "Case Manager".

The Provider's Case

The Provider states that under the terms of the Complainant's group income protection scheme, an income protection claim is payable when the claimant meets the definition of disablement, as follows:

> *"total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration".*

The Provider states that the Complainant completed an Income Protection Claim Notification Form on 7 April 2016 advising that he was suffering from "*stress and depression".* The Provider states that it also received an Employment Information Form and detailed job description from the Complainant's employers, who confirmed that he had been absent from work since 10 April 2015.

The Provider states that, as part of the assessment of the Complainant's claim, it arranged for him to participate in a telephone interview with a nurse, on 4 May 2016, during which the Complainant advised that he was unable to work due to *"stress*". The Provider has

/Cont'd…

submitted to this office a copy of the transcript of this telephone interview, signed by the Complainant on 9 May 2016.

The Provider states that, in order to assess the Complainant's claim further, it arranged for the Complainant to attend an independent medical examination by a Consultant Psychiatrist (Dr K) on 7 June 2016. The Provider states that it also requested copies of medical reports from the Complainant's employer's Company Doctor (Dr T) and that these reports were received on 1 June 2016 and sent to the Consultant Psychiatrist (Dr K) in advance of his assessment.

The Provider states that it received Dr K's report on 14 June 2016, following his assessment of the Complainant, and that it was Dr K's opinion that the Complainant was "*currently fit to carry out his normal occupation. There is no objective evidence of disabling psychiatric illness that prevents him from performing the material and substantial duties of his normal occupation*". The Provider submits that, based on this report, it formed the opinion that the Complainant did not meet the definition of disablement as required by the policy, and that he was fit to carry out the duties of his normal occupation. The Provider states that it wrote to the Complainant on 30 June 2016, advising him of its decision to decline the claim and outlining the appeals process.

The Provider states that on 11 October 2016 it received a report from the Complainant's Consultant Psychiatrist (Dr L) in support of an appeal against the declinature of the claim and that, in order to consider the appeal further, it arranged for a further independent examination by a Consultant Psychiatrist (Dr D) to take place on 3 November 2016. The Provider states that it received Dr D's report on 7 November 2016, following his assessment of the Complainant, and that it was Dr D's opinion that the Complainant's symptoms were "*quite non-specific and mild and he is receiving very little treatment at present*". The Provider states that, in relation to the Complainant's fitness to work, it was Dr D's opinion that the Complainant "*is not unable by reason of illness or injury to carry out the duties of his normal occupation*".

The Provider states that, following receipt of Dr D's report, it remained its opinion that the Complainant did not meet the definition of disablement and was medically fit to return to work. However, in acknowledgement of the fact that work-related issues had been noted by Dr D, in his report, as a possible barrier which could impact on the Complainant's return to work, the Provider states that it was happy to make available to the Complainant the services of a specialist case manager to assist the Complainant in the return to work process. The Provider states that it wrote to the Complainant on 23 November 2016 to notify him of its decision, and to offer the services of this case manager.

The Provider states that it subsequently received an email from the Complainant on 25 November 2016 querying the options that were available to him. The Provider advised in response that, if the Complainant was not returning to work and did not wish to avail of the services of the specialist case manager, it would issue him with a letter to enable him to refer the matter to the Financial Services Ombudsman. The Provider states that the Complainant requested this letter on 2 December 2016, and that the letter was issued to him on 7 December 2016.

/Cont'd…

The Provider does not accept the allegation made by the Complainant that it failed to treat him as a "*vulnerable consumer*". The Provider states that income protection claimants are, by their very nature, treated as vulnerable consumers and the Provider does not accept that it has at any stage acted inappropriately towards the Complainant. The Provider submits that there was nothing to suggest that the Complainant required any additional assistance from it above and beyond how it would treat all of its claimants.

The Provider notes that the Complainant has advised that he has been accepted for Invalidity Pension by the Department of Employment Affairs and Social Protection, but submits that this cannot be a factor in its decision regarding his income protection claim. The Provider states that the criteria for payment of an income protection claim are different to the criteria for the payment of an ill-health early retirement pension, and that the Provider cannot be bound by the decision of a third party.

The Provider states that it can only pay claims where the medical evidence confirms that the claimant is medically unfit for work, and therefore meets the definition of disablement required under the policy. The Provider submits that the diagnosis of an illness or injury does not automatically equate to disability. The Provider states that it does not dispute that the Complainant suffers from anxiety, but that the weight of objective medical evidence confirms that he is not disabled from performing the duties of his normal occupation as a result.

The Provider notes that the reports of both independent medical examiners make reference to non-medical workplace issues discussed with the Complainant, but does not accept the Complainant's contention that specific emphasis was placed on such factors. The Provider submits that it understands why such issues may be mentioned in a medical examiner's report as they may have an impact on the insured person's motivation and incentive to return to work. The Provider states, however, that non-medical factors of this nature cannot be a consideration in making a decision on an insured person's fitness for work.

With respect to the objective tests and evaluations carried out during the examinations of the two independent medical examiners, the Provider notes the Complainant's comments in this regard, but states that it is up to the examining doctor to determine what testing is appropriate as part of their examination in order to assist them in reaching their conclusion. The Provider states that these additional tests form only one part of the overall assessment, and do not determine the outcome of any particular examination.

The Provider submits that it was very clear that the Complainant's claim had been made on mental health grounds. The Provider acknowledges that the Complainant had a heart attack in 2012 and that he required four months absence from work at that time. The Provider states, however, that the Complainant had returned to work for a significant length of time after the heart attack, before ultimately ceasing work on mental health/stress grounds in April 2015. The Provider states that both the Claim Notification Form and the telephone nurse interview record that the claim was made on mental health

/Cont'd…

grounds, and that the previous heart attack was mentioned in relation to previous absences from the workplace.

In response to concern expressed by the Complainant in respect of the possible consequences of returning to work and then either suffering another myocardial infarction, or being let go by his employers, the Provider points out that the Complainant's cover will remain in place for as long as he remains an employee of his employer, and that a claim will be paid when the definition of disablement is met. The Provider states that it can make no further comment on hypothetical scenarios which may or may not arise in the future.

In response to the Complainant's query why his case was referred to a specialist third party case manager, the Provider states that this was done on the grounds that the medical evidence indicated that a return to work was in the best interests of the Complainant, but that work related issues were impacting on his potential return to the workplace. The Provider submits that it was for this reason that it was prepared to make available the services of a specialist case manager, with expertise in assisting employees/employers in return to work scenarios in complex work-related situations, to assist the Complainant in the return to work process. The Provider acknowledges that the Complainant did not wish to avail of this service.

The Provider denies that there was any incorrect release of the Complainant's personal information to this third party. The Provider refers to consents signed by the Complainant when he completed the Claim Notification Form, and when he signed the transcript of the telephone interview. The Provider submits that these consents allowed the Provider to share information about the management and assessment of his claim. The Provider states that the third party specialist case manager is not a medical organisation, and that no medical information was released at any stage to the organisation in question.

The Provider acknowledges the dissatisfaction of the Complainant with the decision on his claim, and regrets that he feels that the claims process has had a negative impact on him. The Provider submits that it makes every effort to assess claims in a caring and sympathetic manner and believes that it has treated the Complainant fairly at all times. The Provider submits that it is not its intention to cause distress to any of its customers and that it is sorry if that was the case here.

In conclusion, the Provider submits that the decision on the Complainant's claim was made on the basis of the objective medical evidence received. The Provider is satisfied, based on this medical evidence, that the correct decision was made on the basis that the Complainant does not meet the definition of disablement contained in the policy.

<u>Policy Provisions, Conditions and Privileges</u>

1. ***"Disablement –*** *For the purpose of this Policy*

   (i) *total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason*

/Cont'd…

of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration

and

(ii) partial disablement shall be deemed to exist where (a) following a period of total disablement as in Sub-Provision 1(i), which period is to be decided by the Company, an Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person with the written consent of the Company re-engages in his normal occupation with loss of earnings as a result or engages in some other occupation for profit or reward or remuneration."

7. "Provision of Evidence Tests and Information –

(i) Subject to Provision 10, the Grantees and Insured Persons shall furnish to the Company at the Grantees expense all such data, evidence, tests, and information as the Company shall require upon or with regard to the happening of any matter affecting or relating to the insurance of any person under this Policy and the Company shall be entitled to act upon the data, evidence, tests and information so furnished…

(iv) The Insured Person as often as is required by the Company shall submit to medical examination and tests to include the taking of blood, urine or other samples…"

10. "Claim Procedure –

Written notice of the disablement of the Insured Person shall be given to the Company at least 105 days prior to the date on which the Benefit is due to become payable. All certificates, data, evidence, tests and information required by the Company as a result of such notice shall be furnished at the expense of the Grantees and shall be in such form and of such nature as the Company may prescribe…"

Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint.

/Cont'd…

Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on 21 February 2018, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

In the absence of additional submissions from the parties, the final determination of this office is set out below.

The principal issue in dispute is whether or not the Complainant's income protection claim satisfies the policy criteria for payment of disability benefit and whether, in this instance, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the claim and was reasonably entitled to arrive at the decision it did upon assessment of the medical evidence received. Both parties to the complaint have submitted medical evidence in this regard. To benefit, pursuant to the policy, the Complainant must show that he is "*unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted*".

The background to the Complainant's claim is well set out in the submissions. Prior to his disability claim the Complainant worked as a Client Advisor for a firm of insurance brokers, and had done so for approximately nine years. The Complainant suffered from a heart attack in October 2012, followed by the insertion of cardiac stents, and a 6 week course of cardiac rehabilitation. The Complainant returned to work in January 2013, although he believes that he did so too early, and he continued to work until April 2015. The Complainant states that, following his return to work in January 2003, he suffered ongoing stress and anxiety in the workplace, and that he experienced his first panic attack on 21 November 2014.

On 10 April 2015, following an incident at work, the Complainant was suspended from duty for a period of 5 days, whilst his employers carried out an internal investigation. The Complainant has been absent from work on certified sick leave, on grounds of ill health, since that date.

On 7 April 2016 the Complainant submitted a Claim Notification Form for Income Protection Benefit to the Provider, under his employer's Group Income Protection Scheme, stating that he was unable to work at his normal occupation due to "*stress and depression*".

/Cont'd…

The Provider arranged for the Complainant to complete a telephone interview with a nurse on 4 May 2016, during which information was collated with which to complete the Complainant's Claim Form for Income Protection Benefit. The evidence indicates that the Complainant was furnished with a copy of the completed Claim Form for review and amendment as required, and that the Complainant affirmed the content of the Claim Form with his signature, dated 9 May 2016, and returned it to the Provider. This Claim Form, together with the Claim Notification Form, formed part of the Complainant's application for disability benefit.

I note that, in his Claim Form, the Complainant advised that he had worked in the insurance business for some 40 years, and had been with his current employers since 2006. He indicated that his role as a Client Advisor was an office based job, and that he worked 35 hours per week, Monday to Friday, from 9am to 5pm. In response to the question "*What are your responsibilities*?" the following response is recorded:

> *"Had a designated list of clients (corporate companies) and looked after all their insurance needs, eg. renewal, changes mid term, new business and ongoing problems with contracts or claims."*

In response to the question "*Which parts are stressful or difficult and why is this?"* the following response is recorded:

> *"There is always a degree of stress as often had 50 emails during the course of the day and insurance companies do not have technical knowledge. Stress of the job was a continuous stress but a healthy stress and got a good vibe out of it. Built up relationships with 15 or 16 companies and had a connection all the time. Had a strong sense of personal achievement. However, company is a different kind of stress as not supportive. Had good relationship with clients and company's view was to put the company first. Had a sense of alienation and no validation. 2 things – one was fighting insurance companies on behalf of clients and the other was the company".*

When asked "*What is the condition or injury that is preventing you from working?"* the Complainant responded as follows:

> *"Stress".*

In the Medical Section of the Claim Form, the Complainant indicated that he had been diagnosed by his GP with "*work related stress and depression*", and that his "*GP is worried stress levels will put pressure on heart and advised to stay off work, come up with a programme and get counselling*". The Complainant advised that he was not on any medical treatment for stress and depression as the "*GP is reluctant to prescribe medication for stress and depression and describes it as edge of depression but not fallen down into the pit*". I note that the Complainant provided details of the medication he was taking for his heart condition and cholesterol, and indicated that "*has an apt with consultant about heart in September 2016".*

/Cont'd…

The submissions show that the Provider obtained an Employment Information Form from the Complainant's employers, dated 14 April 2016, providing details of the Complainant's employment, and a full job description for the role of a Client Advisor, including the following:

> ***"Job Title***: *Client Advisor*
>
> *…*
>
> ***Job Purpose***: *With responsibility for the day to day professional management and servicing of all aspects of client's insurance portfolio this role will also provide assistance to Client Executives and provide Client Support within the team.*
>
> ***Main Responsibilities:***
>
> *To fulfil this role, the Client Advisor will:*
>
> - *Provide the best technical advice and service to Clients and Client Executives, utilising own knowledge and that of colleagues as necessary.*
> - *Negotiate renewals, re-marketing and finalise insurance placements.*
> - *Provide day to day client support and service with a prompt response to enquiries including invoicing, issue of cover notes, endorsements, and summaries within agreed timescales.*
> - *Develop and maintain a good working relationship with colleagues, insurance companies, and their personnel.*
> - *Ensure that compliance procedures and policies are maintained and adhered to at all times.*
> - *Ensure cover placement in line with client instructions is delivered on time.*
> - *Support the Team Manager with projects and other work as required."*

I note that the Provider also obtained from the Complainant's employers a number of medical reports which had been compiled following a health assessment of the Complainant by an Occupational Physician (Dr T) at the request of his employers in April 2015 and in August 2015, and ensuing correspondence between the Occupational Physician and the Complainant's employers, the latest dated 19 February 2016.

From a review of this medical evidence, it is evident that these reports were requested by the Complainant's employers in order to ascertain whether the Complainant was fit to engage in an internal investigation process following an incident in the workplace, and in order to ascertain whether he was fit to attend an investigation meeting. In a letter to the Complainant's employers, dated 19 February 2016, the Occupational Physician advised that the Complainant had been assessed by a specialist and found to be "*fit to engage in an industrial relations process, and fit to make a decision as to whether he wants to return to work at this stage or not*".

In response to his employer's requests to engage in the internal investigation process, the Complainant submitted letters from his General Practitioner dated 28 April 2015 and 18 March 2016. The letter dated 28 April 2015, addressed "To Whom it May Concern", stated

/Cont'd…

that the Complainant was certified unfit to work until 8 May 2015, and that he was "*therefore unfit for work and for all engagements with his employer until that time*". The letter dated 18 March 2016, also addressed "To Whom it May Concern", stated that the Complainant "*has been on work related stress leave since 2014. He has been invited to attend an investigation meeting on Monday 21 March 2016. Unfortunately, due to ongoing stress, he is medically unfit currently to attend this meeting as it would likely exacerbate his mental and physical health complaints*".

It is not in dispute that the Complainant has not returned to the workplace since April 2015 and, in his submissions to this office, the Complainant has stated that he is now in receipt of an Invalidity Pension from the Department of Employment Affairs and Social Protection, although I note that no documentary evidence of this has been submitted. An Invalidity Pension would not, in itself, entitle the Complainant to income protection benefit under the terms of his Income Protection Plan. While the Department of Employment Affairs and Social Protection may have determined the Complainant suitable for an Invalidity Pension on grounds of ill health, there may be differences between the relevant criteria employed by the Department of Employment Affairs and Social Protection in such a case, and the Provider's criteria for qualifying for disability benefit under the terms of the Complainant's income protection policy. For the purposes of payment of benefit under the policy, the Complainant's condition is evaluated on the basis of the medical evidence furnished to the Provider, and in accordance with the terms and conditions of the insurance contract, in particular the definition of "Disablement" contained in the policy.

Under the terms of the Complainant's employer's Group Income Protection Scheme, an income protection claim is payable when the claimant meets the definition of disablement, as follows:

> *"total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging in any other occupation for profit or reward or remuneration".*

The claim may be turned down, or stopped, by the Provider where, on the basis of the medical evidence, the level of disability could not be considered serious enough to prevent the insured person from pursuing his normal occupation. If there is no objective medical reason why a claimant is prevented from carrying out the normal duties of his or her occupation, there is no ground for the payment of disability benefit by the Provider.

It is important to stress that, from the point of view of assessing this complaint, it is not the role of the Ombudsman to comment on or form an opinion as to the nature or severity of the Complainant's condition but rather to establish whether in this instance, on the basis of an objective assessment of the medical evidence submitted, the Provider has adequately assessed the claim and was reasonably entitled to arrive at the decision it did upon assessment of the medical evidence received.

/Cont'd…

I have given careful consideration to the submissions made in this complaint. I have reviewed the medical evidence submitted by both parties to the complaint. The Provider has submitted the reports of two independent medical examinations carried out by two Consultant Psychiatrists over a period of five months. The first psychiatric assessment took place on 7 June 2016 (Dr K) and included a Montgomery-Asberg Depression Rating Scale assessment (MADRS), a Hamilton Anxiety Rating Scale assessment (HAM-A), a Montreal Cognitive Assessment (MOCA), a Structured Inventory of Malingered Symptomatology (SIMS), and a Rey 15 Item Test, as well as a mental state examination. The second psychiatric assessment took place on 3 November 2016 (Dr D), and included a Rey 15 Item Test, a Structured Inventory of Malingered Symptomatology (SIMS), a Mini-Mental State Examination Test, a Clock Test, and a mental state examination.

The Provider has also submitted a transcript of the tele-interview in which the Complainant participated with a nurse at the request of the Provider in May 2016, and a copy of the medical evidence it received from the Complainant's employers as part of the assessment of his claim, as I have noted above. This includes two medical reports which had been compiled following health assessments of the Complainant by an Occupational Physician (Dr T) at the request of the Complainant's employers in April 2015 and in August 2015, and ensuing correspondence between the Occupational Physician and the Complainant's employers, the latest dated 19 February 2016.

The Complainant in turn has submitted a copy of the two letters from his General Practitioner, to which I have referred above, addressed "To Whom It May Concern" and dated 28 April 2015 and 18 March 2016 respectively, which comment on the Complainant's fitness to attend meetings with his employers and engage in an investigation process in the workplace. The Complainant has also submitted a report from his Consultant Psychiatrist (Dr L) dated 7 October 2016, in support of his appeal against the Provider's decision on 30 June 2016 to decline his claim.

I note that, despite a number of references in the Claim Form to the Complainant's history of heart attack, and the potential impact of stress on his heart condition, neither party has submitted objective medical evidence pertaining to the Complainant's cardiac condition, or pertaining to the impact, if any, of the Complainant's mental health on his cardiac health, and the significance of this in terms of his ability to work.

From a consideration of the medical reports submitted, I accept that it is acknowledged in these reports that the Complainant suffers from stress and anxiety, and that he receives counselling therapy and, latterly, treatment in the form of antidepressant medication. However, the medical opinion differs on the question of the Complainant's ability to return to work.

The Complainant's claim that he is unable to carry out the duties of his normal occupation is supported by his Consultant Psychiatrist (Dr L) who, in a report dated 7 October 2016, stated that the Complainant was suffering from:

> *"…Adjustment Disorder/episode of Mixed Anxiety and Depression that relates to his perception of the situation in his workplace from 2012 and particularly since 2014.*

/Cont'd…

> *This is having a significant impact on his mental and physical health and he is not functioning at present. Currently symptomatic with depressed mood and anxiety, poor concentration, panic and re-emerging OCD symptoms…*
>
> *Likely all triggered by myocardial infarction in 2012 and has struggled at various levels to manage in the workplace since that time…*
>
> *GP started medication, Escitalopram 5mg daily. Attending therapy which is helping…*
>
> ***Risk**: Has considered suicide and looked up means. Potential and needs monitoring."*

On the issue of the Complainant's fitness to work, the Complainant's Consultant Psychiatrist (Dr L) was of the following opinion:

> *"…with his current level of symptoms, agitation and distress, I find it hard to see how he would be able at present to return to the workplace…Overall, I consider that as things stand at present it would be harmful for him to return to the same situation and would likely result in a deterioration in his mental and physical health with the potential to have a tragic outcome…"*

The medical opinion of Dr L contrasts with that of Dr K, Consultant in General Adult Psychiatry, who carried out an examination of the Complainant on 7 June 2016. This assessment included a number of mental state examinations, questionnaires and tests to assess the Complainant's cognitive function and to determine the severity of his symptoms. In his psychiatric report, Dr K noted that the Complainant had "*developed symptoms in response to problems in the workplace, which culminated in him being suspended*". He found that the Complainant's current symptoms were "*mild*" and "*not diagnostic of any significant psychiatric disorder*", and that "*there is no objective evidence of a significant depressive illness*". Dr K expressed the opinion that the Complainant "*is currently fit to carry out his normal occupation. There is no objective evidence of disabling psychiatric illness that prevents him from performing the material and substantial duties of his normal occupation. Any residual symptoms are not disabling in nature*".

The findings of Dr K are echoed in the report of Dr D, Consultant Psychiatrist, who assessed the Complainant on 3 November 2016 at the request of the Provider and carried out a Rey 15 Item Test, a Structured Inventory of Malingered Symptomatology (SIMS), a Mini-Mental State Examination Test, a Clock Test, and a mental state examination. Dr D noted in his report that the Complainant's "*symptoms are quite non-specific and mild and he is receiving very little treatment for them at present…He does experience a sense of loss and unfulfillment which is more than likely related to the absence of a current occupational role. It would be very much in his interest to return to work which would offer him an increased sense of focus and self-esteem*". On the issue of fitness to work, it was Dr D's view that the Complainant was "*not unable by reason of illness or injury to carry out the duties of his normal occupation. His prognosis is good*".

/Cont'd…

I note that the reports of both independent medical examiners identify non-medical reasons for the development of the Complainant's symptoms. Dr K noted in his report, dated 7 June 2016, that the Complainant "*expressed negative feelings about his employer on a number of occasions during the assessment*" and commented that "*there are workplace issues which need to be resolved in this case and the outcome is going to depend on resolution of these problems*". Dr D commented in his report, dated 3 November 2016, that the Complainant was "*unhappy in his work after his myocardial infarction in 2012. He perceived that there was animosity towards him and he also felt animosity towards his employers of whom he had a low opinion….he did not return to work after his suspension claiming unfitness due to stress and depression.* [The Complainant] *was subsequently regarded as mentally fit to engage in the investigation against him at work and also fit to return to work. However, it appears that he has no intention of returning to his current employers."*

The Complainant, while acknowledging the work-related issues identified, submits that too much emphasis has been placed by the Provider and the independent examiners on these non-medical issues, rather than on the impact of the Complainant's physical and mental condition on his ability to carry out his normal occupation – "*Instead, they focus on "workplace issues" to the exclusion of all other issues. This is not the core issue – rather the definition of "disablement" under the Income Protection Scheme".*

In many complaints concerning income continuance claims for stress and anxiety conditions, a claim may be triggered by a situation or difficulty in the workplace. In the circumstances of this complaint, workplace difficulties were detailed by the Complainant himself in his claim submissions, and specifically referred to in each of the independent medical reports. Indeed, the report of the Complainant's own Consultant Psychiatrist, Dr L, dated 7 October 2016, refers to "*ongoing issues in the workplace with excess demands, investigations and a sense of being undervalued, unsupported and humiliated*" and links the Complainant's symptoms of anxiety and depression to his perception of the situation in his workplace. Dr L commented that "*this is having a significant impact on his mental and physical health*".

It is evident that work-related issues have been a recurring aspect of the Complainant's claim for disability since the outset, both in his own account of the circumstances of his claim, and in the reports of the medical examiners who have assessed him. I accept that these issues are detailed in the medical reports of the independent examiners, as an aspect of the circumstances surrounding the Complainant's claim and his potential return to the workplace. The medical evidence submitted, both by the Complainant and by the Provider, links problems in the workplace with the Complainant's anxiety and depression. I accept that non-medical factors such as difficulties in the workplace are not a consideration when determining a person's fitness for work under the terms of the policy. Non-medical matters such as these may not be factors in determining a claimant's fitness to carry out the duties of his or her normal occupation.

The Complainant has raised a number of objections to the examinations and subsequent reports of the two Consultant Psychiatrists (Dr K and Dr D). The Complainant has submitted that the psychiatric tests performed during these examinations were

/Cont'd…

unnecessary and irrelevant to his condition, and he submits that there was an emphasis during these psychiatric assessments on detecting "*malingering*" and "*suspect feigning of symptoms*" which he found deeply insulting. The Complainant has also submitted that the reports of both Consultant Psychiatrists contain inaccuracies, which he was not given an opportunity to address, and that the reports give no indication of having taken into account the particular role and responsibilities of the Complainant's normal occupation.

The Provider is entitled under the terms of the policy, as part of the process of assessing a disability claim, to seek the reports of independent medical examiners. These examiners may in turn carry out any additional tests they consider to be appropriate or useful in the circumstances of the assessment being carried out. The opinions of medical examiners regarding fitness to work and suitability for benefit should be based on the claimant's clinical history, the clinical findings during examination, the results of investigations and any collateral evidence furnished (which would include the full details of occupation) and not just on presentation on the day of assessment. The role of the appointed medical examiner is to determine the individual's medical ability or otherwise to perform the duties of his or her normal occupation.

With regard to the manner in which the medical examiners who examined the Complainant, at the request of the Provider, carried out their assessments, the appropriateness of any additional testing, and the accuracy of the content of any resulting medical reports, both the Complainant and the Provider were entitled to expect these medical professionals to carry out their work in an unbiased, diligent and professional manner. I make no comment in relation to these aspects of the Complainant's complaint and would suggest that any concern or complaint which the Complainant has about a medical examiner, a medical assessment, or the content of a reported medical opinion, should be addressed more appropriately to the Medical Council, for investigation.

I note, however, that the medical examiners who carried out psychiatric assessments of the Complainant at the request of the Provider, on 7 June 2016 and on 3 November 2016, had been furnished by the Provider with an Employment Information Form from the Complainant's employers, dated 14 April 2016, in advance of the assessments. The Employment Information Form provided details of the Complainant's employment, and a full job description for the role of Client Advisor. This included job title, job purpose, and a list of the role's main responsibilities. In these circumstances, I accept that each of the medical examiners had been made aware of the nature of the Complainant's occupation and the duties and responsibilities held by him within the context of that role, and that his fitness to work, from a mental health perspective, was assessed against the correct occupation.

While it is evident that the Complainant's claim has been assessed by the Provider on the basis of his ability to work from a mental health perspective, it is also evident that the Complainant's claim has not been assessed from the point of view of his physical health.

In a submission to this office dated 7 February 2017, the Complainant objected to the fact that the reports of the Consultant Psychiatrists commissioned by the Provider failed to take into account the combination and effect of mental and physical factors on the

/Cont'd…

Complainant, or the effect of continuous stress on the Complainant's heart condition, in assessing his ability to return to his workplace.

A letter to this office from the Complainant, dated 21 June 2017, emphasised not just the Complainant's stress and depression, but also his medical history of heart disease, the effect of stress on his heart, and the deterioration in his overall medical health. The Complainant submitted that "*it is through a combination of both* [his] *physical condition (heart) and his mental condition (stress and depression) that he is unable to carry out the duties pertaining to his normal occupation*". The Complainant argues that the Provider's assessment of his claim has failed to take into account both his mental health and his physical health.

In a submission to this office dated 27 June 2017, the Provider responded to this aspect of the Complainant's complaint as follows:

> *"We did indeed focus on the mental health aspects of* [the Complainant's] *claim as it was this element that was claimed for. We were aware of the previous heart attack and noted he returned to work after four months, a significant time period, before he ultimately ceased work again due to stress. Had a claim been made on both physical and mental health grounds we would have assessed both. As no objective medical evidence has been provided to us at claims or appeals stage regarding any physical aspects, I am satisfied the claim was assessed on the correct illness and note that this is now being introduced at a late dispute stage."*

The Complainant, in a submission dated 19 July 2017, argued that there is a well known correlation between stress and heart disease, and a clear link between the Complainant's heart attack in 2012 and subsequent stress and depression. The Complainant submitted that for the Provider to state that this is only being introduced to the claim at a late dispute stage is "*simply disingenuous*", and states as follows:

> *"It is quite evident from the GP certificates provided,* [the Complainant's Consultant Psychiatrist's] *report and previous correspondence with* [the Provider] *that both* [the Complainant's] *mental and physical health impacted on why it is not possible for him to return to work".*

The Complainant argues that "[the Provider] *should introduce that element into the claim and I find it unbelievable that they have not done so".*

In considering this aspect of the complaint, I am mindful of the fact that, when asked in the Claim Form "*what is the condition or injury that is preventing you from working?"* the Complainant responded "*stress",* and did not identify his cardiac condition as having a role to play in his disability. Indeed, the Complainant, while furnishing the Provider with a report from his Consultant Psychiatrist in support of his claim for stress, has submitted no medical evidence from his Consultant Cardiologist on the impact of his stress on his heart condition, or the role, if any, of his heart condition on any inability to return to work.

/Cont'd…

Be that as it may, the Complainant's Claim Form, dated 9 May 2016, contains several references to the Complainant's heart condition. It is recorded in Section 3, Medical Details, that the "*cause of the stress in claimant opinion was the heart attack…Physical symptoms are pain in the chest…"* Section 3 of the Claim Form also records that the Complainant's "*GP is worried stress level will put pressure on heart and advised to stay off work, come up with a programme and get counselling. This is why referred to the heart programme*."

The Claim Form details that the Complainant is on a "*monitoring programme for people who have had a heart attack*", that the Complainant is taking medication for cholesterol and to keep his blood thin and, importantly, that the Complainant "*has an appt with consultant about heart in Sept 2016 and assumes will have a stress test".*

In view of the repeated references to the Complainant's heart condition in his Claim Form, in association with his stress and depression, it is evident that this has represented a recurring aspect of the Complainant's claim from the outset. It is my opinion that the Provider should have made reasonable inquiry into this aspect of the Complainant's claim, with a view to assessing the Complainant's claim on both physical and mental health grounds. The Provider did not request the provision of any medical reports pertaining to the Complainant's cardiac health, either from the Complainant's GP or from his Consultant Cardiologist. Nor did it arrange an examination of the Complainant by an independent Consultant Cardiologist, with a view to assessing this aspect of his claim.

In the absence of this inquiry, I take the view that the Provider has failed fully to assess all aspects of the Complainant's claim, both mental and physical, and has thereby failed adequately to assess the claim. In these circumstances, I consider that the claim should be re-assessed on both mental and physical grounds.

With respect to the remaining elements of the Complainant's complaint, and the Complainant's contention that the Provider has failed to treat him as a "vulnerable consumer", I see no evidence that the Provider has acted in any way inappropriately towards the Complainant, or in such a way that it has failed to observe the vulnerable status of the Complainant in his capacity as a claimant for disability benefit. It appears that its communications with the Complainant in relation to his claim have been clear and professional. The Provider has indicated that it does provide services to claimants who require assistance in making a claim, such as translators, hand signers, and the provision of transport where required. However, it does not appear that the Complainant made it known that he required any additional assistance from the Provider in his dealings with the Provider in relation to his claim, and I cannot find any wrongdoing on the part of the Provider in this regard.

The Complainant has raised a further query in the context of the Provider's offer of a third party non-medical "Case Manager", with expertise in complex return-to-work scenarios, to assist him in the process of a return to the workplace, should he wish to avail of this service. The Complainant has indicated that he chose not to use the third party service offered to him by the Provider, but is concerned that the Provider has wrongfully released his private and personal information to the non-medical third party entity.

/Cont'd…

The Provider has submitted that the Complainant, as part of his application for benefit, gave his consent to the Provider to share information about the management and assessment of his claim as the Provider deemed necessary. The Provider has submitted that as, in its opinion, the medical evidence indicated that a return to work was in the best interests of the Complainant, and that work-related issues were impacting on a potential return to work, the Provider was prepared to make available the services of a specialist case manager to assist the Complainant and his employers in the return-to-work process. The Provider has submitted that the Complainant's employers were willing to engage with this service, but that the Complainant himself declined this approach. The Provider submits that the third party specialist "Case Manager" in question, which is a UK based company operating in Ireland, is not a medical organisation, and that no medical information pertaining to the Complainant was released to it at any stage.

When an individual gives their personal data to an organisation, they have the right to expect that the organisation will protect their data, and keep it private and safe. I note that in signing the Claim Form, dated 9 May 2016, the Complainant gave a number of consents to the Provider in respect of the requesting and sharing of his personal data.

Any complaint which the Complainant may have in relation to the use or misuse of his personal data by the Provider should be directed to the Office of the Data Protection Commissioner for investigation.

Summary

In conclusion, having reviewed and considered the submissions made by the parties to this complaint, as set out above, it is my Decision that this complaint is upheld in part.

I take the view that the Provider has failed fully to assess all aspects of the Complainant's claim for disability benefit, both mental and physical, and has thereby failed adequately to assess the claim. Consequently, I consider that the Complainant's claim should be re-assessed by the Provider on both mental and physical grounds.

In these circumstances, the Complainant is to be given the opportunity to submit to the Provider medical evidence from his GP and from his Consultant Cardiologist, pertaining to his ability to return to work from the point of view of his cardiac health, for assessment by the Provider. Thereafter, if the Provider wishes to obtain further specialist medical evidence, the Provider may request the Complainant to undergo an examination by a specialist medical examiner, if it wishes to do so.

Once the Provider has received this additional medical evidence, the Provider is to complete its final assessment of the Complainant's claim, taking into account all the medical evidence presented, relating to both mental and physical aspects of the claim, and issue its decision to the Complainant.

/Cont'd…

Thereafter, if the Complainant remains unhappy with the outcome of the full assessment of his claim, it remains open to the Complainant to submit an appeal to the Provider in the normal way, and ultimately to pursue a new complaint to this office.

In the meantime, I consider that the Provider's failure adequately to assess the Complainant's claim, in all its aspects, has impacted negatively upon the Complainant and has caused him undue uncertainty, inconvenience, and distress. For this reason I consider that a compensatory payment is called for, and I direct the Provider to make a payment of compensation in the sum of €5,000.00 to an account of the Complainant's choosing within a period of 35 days from the date of this decision.

To this extent, it is my Legally Binding Decision that this complaint is partially upheld.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(g).***

- Pursuant to ***Section 60(4)(a) and (d)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that the Respondent Provider review, rectify, mitigate or change the conduct complained of in relation to the assessment of the Complainant's claim (as set out above), and pay an amount of compensation (as set out above) to the Complainant for any loss, expense or inconvenience sustained by the Complainant as a result of the conduct complained of.

- Pursuant to ***Section 60(6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, where the amount is not paid within 35 days of the date of this decision.

- Pursuant to ***Section 60(8)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** the Respondent Provider is now required, not later than 14 days after the period specified above for the implementation of the directions pursuant to Section 60(4)(a)&(d), to notify this office in writing of the action taken or proposed to be taken in consequence of the said directions outlined above.

The above Decision is legally binding on the parties, subject only to an appeal to the High Court not later than 35 days after the date of notification of this Decision.

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

16 March 2018

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will publish legally binding decisions in relation to complaints concerning financial service providers in such a manner that—

(a) ensures that—

(i) a complainant shall not be identified by name, address or otherwise,

(ii) a provider shall not be identified by name or address,

and

(b) in accordance with the Data Protection Acts 1988 and 2003.