An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2018-0029
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - did not meet policy definition of disability Complaint handling (Consumer Protection Code) Dissatisfaction with customer service
Outcome:	Upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

This dispute relates to a Group Disability policy (the 'Scheme') owned by the Complainant's employer. The Complainant is an employee of the policyholder, and is member of the scheme.

The Complainant submitted a claim for disability benefit, through the administrators of the Scheme in April 2014. On the completed Claim Form the Complainant advised she was suffering from chronic lower back pain resulting in difficulty sitting at a computer and reading reports. The onset of back pain had commenced in the 1990's following a serious road traffic accident, and developed into chronic back pain in late 2011.

The Company requested a medical report from the Complainant's Consultant Pain Specialist, Dr M. Dr M confirmed the diagnosis of a significant chronic pain syndrome and that participation in a multidisciplinary pain management programme would be of benefit.

This claim was admitted by the Company with effect from April 2014 and a monthly disability benefit was paid to the Policyowner.

In order to continue to be eligible for benefit under this disability scheme the Complainant must be *'totally incapable by reason of illness or injury'* of following her normal occupation. Payment of benefit would cease if an employee no longer met this definition of total incapacity.

The Company states that in September 2014, the Complainant completed a Continuation Claim Form as part of the routine review of the claim. On this Claim Form the Complainant confirmed she continued to suffer from chronic lower back pain and had recently completed a three week hospital based pain management programme.

The Company say that Dr M advised he had last reviewed the Complainant in February 2014 and therefore the Company requested that the Complainant attend for a medical assessment with Dr G, Specialist in Occupational Health.

Dr G advised that the Complainant had participated well in the pain management programme and that the goal of further treatment should be restoration of normal activity including work.

The Company submit that Dr G noted that there was no evidence that returning to her pre-disability role would have any adverse effect on her condition and that ergonomic adaptations could be made to the workplace. Therefore, the Company advised that it was ceasing the payment of benefit.

The complaint is that the Company unreasonably ceased payment of benefit.

The Complainant's Case

The Complainant states she only ever endeavoured to have her benefit payments reinstated under the policy; and that payments should never have been ceased. The Complainant states that the employer (the policyholder) pays the Company an annual premium to protect its employees so that if they become incapable of working due to illness or injury they would be paid part of their income. The Complainant states that when one of the employer's long term employees become incapable to do their job due to illness, the Company, who admitted the claim but later decided to wrongfully remove them from the policy, shows distain to the Policyowner's employee when they are merely endeavouring to be returned to position that they are entitled to be in.

As regards whether the Company correctly and reasonably provided an explanation for the conduct complained of, the Complainant states that she does not believe she has yet been given a reasonable explanation as to why she no longer meets the policy definition of Disabled and is therefore no longer (in the Company's view) entitled to benefit payment under this policy. The Complainant's position is that there has been no improvement in her condition since she was admitted for benefit claim. The Complainant says that the Company has never stated that her condition has improved and that in its correspondence it accepts her diagnosis of chronic lower back pain. The Complainant states as confirmed in both appeals processes (the initial Company appeal and this referral to the Ombudsman) which have now dragged on for some time, with the lack of income since January 2015, have led to her condition worsening so much so that she now suffers from serious bouts of depression and anxiety. The Complainant submits that in other words there has been deterioration in her psychosocial state as a result of the Company's decision.

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The Complainant states that she believes that she has demonstrated categorically that she continues to be eligible for this benefit; and that her entitlement is based on factual medical evidence that supports her claim.

The Provider's Case

It is the Company's position that the medical evidence received from the Specialist in Occupational Health confirmed the Complainant no longer met the definition of total incapacity and was therefore no longer eligible to claim benefit.

Evidence

Claim Form completed by the Complainant

"Please state the exact nature of the incapacity from which you are suffering:

Chronic lower back pain – as a result of a road traffic accident ….. I sustained multiple injuries to include fracture of my back (L1,L2 + L3) fracture to my sternum, fracture to my Right Tibia & Fibia, fracture to my pelvis + pubic diastasis and pulmonary contusion. Because the burst fractures in my back were unstable my orthopaedic surgeon … operated to stabilise the spine. Rods were inserted from T11 to L1 using instrumentation. My right leg also required surgery and pins were inserted along my Tibia and Fibia and ankle bone.

"In what way does this incapacity prevent you from following your occupation?

In the last two years I have suffered chronic lower back pain. My job is largely office based which predominately involves sitting at a computer and / or reading reports for periods of time, this causes me intense stiffness and persistent lower back pain with regular episodes of severe pain. In order to manage my pain I require pain medication, regular exercise and to avoid stressful situations which further intensifies my pain.

"Which duties can you still perform?
As a [profession] the job role requires me to work full days whereby I am seated at a computer and working to tight deadlines both of which as stated above aggravates my chronic lower back condition.

"Please give details of any previous period of disability due to this or any other cause"

"My back injury occurred in [1990's] but I managed my condition until [2011] when following an elective [operation] my back pain became persistent and chronic. I took unpaid leave for July, August + Sept 2013 in order to try and withdraw from a dependency I have formed on codine based medicines that I rely on to deal with pain. When this proved unsuccessful I went to my doctor who signed me out as unfit for work".

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Medical Evidence

12 May 2014 – Dr M – Consultant in Interventional Pain Medicine

> *"In summary [the Complainant] suffers from a significant chronic pain syndrome most likely lumbar facet mediated. This occurs on a complex background of significant spinal injury and post [operation] chronic back pain. She is extremely psychologically deconditioned as a result of her ongoing pain and requires input both for physiotherapy and clinical psychology as part of a pain management programme. In view of her current ongoing low back pain and associated psychosocial issues including catastrophising, fear avoidant behaviour etc I do not feel she is currently in a position to return to full or part time working any capacity".*

7th January 2015 – Claims Department

> *"Dr G [Specialist in Occupational Health] has made recommendations for modifications to the workplace and we will provide this information to the employer, …"*

7th January 2015 – Claims Department

> *"I will get a letter out to Mr M detailing Dr G's recommendations once you have had a chance to notify them that payment of this claim is ceasing".*

14th August 2015 – the Complainant's employer to the Complainant:

> *"I understand that you have been advised that you no longer meet the definition of disablement under the income protection policy and have not lodged an appeal. I further note that it has been recommended that a return to work would be in your best interest.*
>
> *Can you please confirm your availability to meet with me to discuss the options for your return and the accommodations we can provide to make this transition as comfortable as possible for your".*

16 November 2015 – Dr M – Consultant in Interventional Pain Medicine

> *"As a result of her ongoing chronic low back pain and the adverse functional and psychological impact of this disorder I feel it appropriate that [the Complainant] is incapable of returning to work in her normal pre-existing capacity".*

9 December 2015 – Dr G – Specialist in Occupational Health

> *"Current Symptoms*

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Chronic back pain with stiffness, particularly in the morning; problems sitting or with heavy exertion; difficulty changing posture causing insomnia; pain is worse in the right lumbar region….

[The Complainant] says her job is mainly desk-based but she occasionally travels to client[s] …. ..

I believe the employer could reasonably offer [the Complainant] a rehabilitation programme, whereby she returns to work on a phased basis over a 2-3 month period and gradually increases her work hours as part of a work hardening program. The advice of a functional capacity evaluator .. would be helpful to the employer.

[The Complainant] will require considerable support and encouragement from her occupational health physician and HR Department in order to make a successful return to work.

In my opinion, [the Complainant] no longer meets the definition of disability; she can no longer be categorised as totally incapable of performing the occupational duties [of her employment]. I believe she is fit to return to work on a part time basis from the 01/01/2015 and on a full time basis within 2-3 months"

14/16 December 2015 – Chronic Pain Abilities Determination (CPAD), carried out by the Company's appointed Assessor.

"Conclusions

7.1 According to the results of physical testing, [the Complainant] performed with only fair reliability of effort over both days of CPAD testing. This conclusion is based on the number of consistencies and discrepancies demonstrated by her on both days of the assessment.

7.2 The areas of concern are listed as follows

- *[the Complainant] reported high levels of pain particularly on day 2 which are not consistent with her ability to converse and mobilise normally at all times.*
- *Her self-perceived exertion levels did not correlate with the corresponding heart rates during a number of CPAD tests.*
- *Her pain level at the conclusion of day 1 was lower than at the start of testing. Furthermore, her pain levels at the start and conclusion of day 2 were the same as before testing on day 1.*
- *The 5-postiion grip strength curves were non-bell shaped in both hands on day 2 testing and in the left hand on day 1, representing invalid test results.*

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- *The REG forces were greater than the corresponding 5 position grip strength forces in both hands on day 2 of testing, again representing invalid test results.*
- *The palmar pinch forces in both hands on day 2 and in the right hand on day 1 did not exceed the tip pinch forces, representing inappropriate test results.*
- *The coefficients of variation (CV) were higher than expected in the left REG test on day 1, right grip position 2 on day 1, left tip pinch on day 2, and in the left palmar pinch on day 2 representing a number of invalid test results.*

7.3 Bearing in mind the above inconsistencies, the results of the grip and pinch tests cannot be used to infer any weakness or fatigue in either hand. Furthermore, [the Complainant's] demonstrated work-day tolerances on both days of CPAD should be viewed as the very minimum she is able to safely undertake on a daily basis.

7.4 A comparison between the results on day 2 of physical testing (which represent her very minimum abilities) and [the Complainant's] self reported job description indicate that she is able to undertake all the functional components of her normal role over an 8 hour working day, 5 days a week. This conclusion is based on the following demonstrated work-day tolerances:

- *She is able to constantly (over 67% of the working day) sit, walk, perform bi-manual find dexterity tasks, reach out bilaterally, and perform bi-manual handling activities, all with regular breaks.*
- *[The Complainant] is able to occasionally (1-33% of the working day) stand, frequent breaks.*
- *She demonstrated normal ranges of lumbar movements in all planes except extension which is not expected to represent a barrier preventing her from returning to work.*
- *She demonstrated normal ankle power (5/5) on both sides, which would indicate an ability to use the pedals of her manual car without restriction.*
- *She is able to lift at the light physical demand level (PDL), and carry at the medium PDL.*
- *[The Complainant] was observed to climb stairs normally, and carry a large handbag on her right shoulder.*

7.5 With regards to [the Complainant's] reported inability to sit throughout a normal working day, representing a barrier preventing her returning to work, I note again the inconsistencies of her pain and self-perceived exertion levels above. Additionally, she was able to sit bolt upright without any difficulty on a constant basis. Notwithstanding these issues, there are a number of appropriate adaptions on the market which would allow [the

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Complainant] to improve on her self-perceived discomfort level whilst seated, examples of an ergonomic chair, sit/stand desk, perch stool for use with a sit/stand desk, and lumbar car seat supports have been provide in the Appendices section of this report) please see below) which her employer may wish to purchase for her. Should you or the employer require a more in-depth ergonomic assessment, [named provider] would of course be happy to provide this service".

26th January 2016 – letter from the Complainant's employer confirming that the Complainant has been absent due to chronic back pain since 7th October 2013.

An e-mail of the same date from the Employer's HR department referred to the paragraph in the letter from the Insurance Company that:

"a number of work-related concerns such as significant stress of role and increased workload in a highly pressurised environment, which may be contributing factors in preventing a return to work".
The Employer advised the Complainant that: *"It would be, (and always has been), our understanding that it is your chronic back pain alone that prevents your return to work. As you have specified below, this quoted statement is incorrect and will form (along with other inaccuracies) the basis of a dispute you intend to lodge with [the Company / its appointed Assessor]"*

22nd February 2016 - The CPAD assessor gives his response to the Complainant's comments on his assessment.

9th June 2016 – Dr M Consultant Pain Specialist

"From a pharmacological perspective [the Complainant] currently utilises the non-steroidal anti-inflammatory agent Difene, Transdermal Lidocaine preparation (Versatis 5%) and the opioid analgesic Tramadol in conjunction with Sopadeine. She also utilises the antidepressant agent Lexapro. [The Complainant] has indicated that use of these pharmacological agents is associated with an approximate 50% reduction in pain.

Based on this assessment it is my opinion (as previously indicated in letters dated (12/05/2014 and 06/11/2015) that [the Complainant] remains incapable of returning to work in her normal pre-existing capacity.
…
I have not been able to find any studies supporting the use of this tool [CPAD] in the assessment of an individual suffering chronic pain. I would have concerns that the application of this test does not provide a true reflection of the capacity to perform sustained activities over a prolonged period. In addition I would appreciate any information that may be available on what adjustments are made to a standard CPAD test whilst testing in an individual suffering from chronic back pain with associated neuropathic features (as defined by validated questionnaire) versus a fibromyalgia / chronic fatigue suffer. In

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addition I would enquire as to what adjustments were made to the standard CPAD to specifically assess [the Complainant's] capacity to perform specifically her previous role with [her employer]"

24th June 2016 – [The Complainant's Specialist] – Dr JM

"Conclusions

1. *This lady is currently unable to fulfil the normal activities required in either a sedentary or active job. Her HR QOL of life is 60%. She is aerobically unfit. Her spinal muscle capability is deconditioned, she has not completed a sustained targeted rehabilitation program.*
2. *To ascertain her potential future capability she would need to engage, and complete an extensive customised rehabilitation program, involving pain management, physical rehabilitation and benefit from psychological input for managing pain.*
3. *It is only post a rehabilitation program that we can then assess if an improved baseline allows a potential return to work. It is at this stage that assessments such an FCE may be logical.*
4. *There is absolutely no guarantee that a rehabilitation process would be effective.*
5. *There is no guarantee that [the Complainant] would be able to complex (sic) a rehabilitation program.*

Recommendations
Integrated rehabilitation program should be considered.

In summary her baseline function is at a low level. She has chronic pain. Her current levels of physical capability, combined with her pain description and symptoms support .. opinion that she is currently unable to perform within the work force. Integrated rehabilitation involving pain management may improve her baseline. It is only post improving her baseline that we can assess if her pain levels will have reduced".

<u>Correspondence between the Complainant and the Company on CPAD assessment</u>

4 December 2015 – the Complainant to the Company

"Surely the test you requested should only focus on my "abilities to return to my own occupation" – i.e. no part of this test should refer to my abilities to return to alternative forms of employment".

8 December 2015 – Company to the Complainant

"[The Complainant's] policy is an own occupation one, and as such the assessment will focus on the demands of her normal role as a senior chartered surveyor".

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8 December 2015 – Complainant to Company

> *"Thank you for responding to my letter and providing me with the clarifications that I sought, particularly in relation to the CPAD test (that it will be for my 'own occupation' only)"*

9th December 2015 – The scheme administrators advised that:

> *"The involvement of the Chief Medical Officer in the appeal is to review all the medical information pertaining to the claim to establish whether the claim is medically admissible under the terms of the policy".*

In the medical reports completed by the Complainant's GP the degree to which the Complainant's condition was affected for "Sitting / Rising" was classified as **"Severe".**

Policy Provisions

> *"Provision 1 – Definitions*
> *1.3 "Disabled" in respect of a Member means that he is totally incapable by reason of illness or injury of following his normal Occupation and is not following any other occupation for remuneration, profit or reward, and "Disability" exists in respect of a Member when he is Disabled and has completed the deferred period as described in Schedule A.1*
> *1.4 "Occupation" means the occupation in which the Member is usually employed"*

Work History as per CPAD assessment

"[The Complainant] worked as a [profession] on a full-time basis of 39 hours per week, although she reports she would work longer hours and take work home with her. She states from 2009 her workload increased in a highly pressurised environment.

[The Complainant] reports that she would undertake inspections (15-20% of the working week) with a colleague anywhere in Ireland (travelling by car) but mostly Dublin-based for 30 – 40 minutes, where she would be required to hold a pen, folder and paper, climb stairs, … The remaining 80% of her working week was office based,….. The report writing was undertaken using a PC and mouse. The software programmes used were MS Word, Outlook, and occasionally Excel, and a bespoke programme (5% of the time spent on a PC). She reports that there may be occasions when she is required to stay overnight in the area she is working.

4.3 No in-depth ergonomic assessment was undertaken at her work-station.

4.4 [The Complainant] states that the barrier preventing a return to work is the significant stress of her role, and the requirement to sit all day which would impact on her lower back pain.

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4.5 [The Complainant] states that there is no aspect of her work she feels able to undertake".

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.

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 25th January 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 issue for investigation and adjudication is whether the Company correctly and reasonably assessed the Complainant's continuing eligibility for disablement benefit.

This claim was admitted with effect from April 2014 and a monthly disability benefit was paid to the Policyowner.

The Company states that in September 2014, the Complainant completed a Continuation Claim Form. The Complainant confirmed on the Claim Form she continued to suffer from chronic lower back pain and had recently completed a three week hospital based pain management programme. The Company say that Dr M advised he had last reviewed the Complainant in February 2014 and therefore the Company requested that the Complainant attend for a medical assessment with Dr G, Specialist in Occupational Health. This assessment took place in December 2014. Dr G advised that the Complainant had participated well in the pain management programme and that the goal of further treatment should be restoration of normal activity including work. The Company submit

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that Dr G noted that there was no evidence that returning to her pre-disability role would have any adverse effect on her condition and that ergonomic adaptations could be made to the workplace.

The Company states that payment of benefit to the Policyowner was subsequently ceased with effect from 31st January 2015, however the Company did offer to pay an additional three month partial benefit, to assist in a phased return to the workplace, upon receipt of a proposed return to work plan.

In addition, the Company also wrote to the Complainant's GP, Dr McN, offering to fund 8 — 10 sessions of cognitive behavioural therapy (as a follow up from the pain management programme) to assist in ongoing recovery, if Dr McN could make the appropriate referral. The Company says that it confirmed this decision could be appealed through the submission of medical evidence confirming the Complainant remained totally incapable of a return to work, as a result of her medical condition. Details of this appeals process was also issued directly to the Complainant by the broker to the scheme and to the Complainant's solicitor.

The Complainant wrote a detailed letter directly to the Company in November 2015 appealing the Company's decision to cease payment of benefit to her Employer (the Policyowner) and enclosed an updated medical report, dated 16th November 2015, from her Specialist, Dr M.

Dr M confirmed that the Complainant continued to suffer from significant chronic pain syndrome with ongoing chronic low back pain and that he felt that she was incapable of returning to work in her normal pre-existing capacity.

The Company states that in light of this appeal, it requested that the Complainant participate in a Chronic Pain Abilities Determination ('CPAD') assessment.

The CPAD was carried out over a three day period, with an intervening rest day. It assesses an individuals ability to undertake the physical and cognitive demands of their normal pre-disability role. This assessment took place in mid December 2015 and was carried out by evaluator / assessor.

The Company submit that at assessment, the Complainant reported she suffered from restricted range of lumbar spine movements, a constant nagging right-sided lower back pain, intermittent severe right-sided lower shin pain (the last episode had been 4 - months previously) and infrequent but severe headaches. The Company says that of concern, there were a number of inconsistencies and discrepancies demonstrated by the Complainant on both days of the assessment as evidenced by the results of physical testing, which indicated that she performed with only fair reliability of effort over both days of testing. The Company states that the results of the CPAD assessment concluded that the Complainant was fit to undertake all the functional components of her pre-disability role and as such, not totally incapable of performing her pre-disability occupation.

On this basis, the Company's decision to cease payment of benefit to the Policyowner remained unchanged. The Company submit however that, it did offer to pay a further 4 months benefit payment to facilitate implementing a phased return to work programme.

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A Final Response letter, for purposes of referral to the Financial Services Ombudsman, was issued directly to the Complainant in January 2016.

The Complainant submitted further medical reports in July 2016 including an updated report from Dr M, Consultant Pain Specialist, and a report from an occupational assessment. The Complainant also disputed the findings, of the CPAD assessment report.

The Company states that the Complainant's submissions were fully reviewed, in addition to the new medical evidence from Dr M and a report from an occupational specialist. The Company says that the Complainant had submitted the specialist's report as evidence questioning the validity of the CPAD report.

The Company submit that the form of assessment the Complainant undertook with her own occupational specialist can be of benefit in a rehabilitation context, in determining efficacy of rehabilitation undertaken, however it claims that it has not been proven to be an effective tool in assessing an individual's ability to return to their specific occupational role or determining functional capacity. The Company's positon it that having reviewed this assessment report the Company determined there were no definitive tasks undertaken to effectively quantify and qualify the Complainant's abilities to perform specific work-related tasks. The Company says that these measures are all addressed in the CPAD report.

The Company submit that furthermore, the assessment report from the Complainant's specialist did not provide details of any validity crosschecks that were carried out during the assessment which would ensure that the Complainant provided good reliability of effort, and that her demonstrated abilities were a true representation of her actual capabilities.

The Company says that likewise, there was no indication in the report that any symptom exaggeration crosscheck or distraction testing was carried out in order to properly evaluate the self-reported pain levels. Validity, distraction testing and symptom exaggeration crosschecks are said by the Company to be all addressed during the CPAD assessment.

The Company states that whilst the report from the Complainant's occupational specialist did make reference to psychological testing, the Company could find reference to only one questionnaire - the SF36-MCS. In contrast, the Company refer to the CPAD assessment using a battery of cognitive tests (with associated symptom exaggeration crosschecks) to provide conclusive evidence on the ability of an individual to return to work from a cognitive perspective.

The Complainant made numerous references, in her submission, stating that the detail in the CPAD report, was *'false, dishonest and intentionally deceptive...reckless, unfounded, untruthful, slanderous' and has stated that [the assessor's] behaviour was 'outrageous, unprofessional and unethical'*

The Company states that the Assessor had already responded to the Complainant extensively on this matter in his letter of 22nd February 2016, and the Company says it finds no benefit to this complaint on commenting on this further other than to say that the Dublin

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High Court, in their findings on **J.H.-v-Friends First Life Assurance Company Ltd 2014**, accepted the validity of the CPAD assessment as a 'recognised and effective tool to assess someone's physical and cognitive ability'.

The Complainant also submitted an updated report from Dr M, Consultant Pain Specialist. Dr M confirmed the Complainant had attended him for review on 9th June 2016 and that she remained incapable of returning to work due to ongoing significant low back pain.

Dr M confirmed that the Complainant had completed a pain detect questionnaire as part of her evaluation, this is a self reported questionnaire that provides a subjective evaluation of the perceived impact of pain across a range of functional domains. The Company says that again, as with the Complainant's specialist, these questionnaires appeared to rely solely on the Complainant's responses and on this basis are wholly subjective. There are no symptom exaggeration crosschecks built within the protocols of these questionnaires. The Company point out that as stated above, these cross checks are all addressed during the CPAD assessment.

The Company submit that Dr M stated that the Complainant had rated her pain as between 7 & 9 out of 10.

The Company states that on the basis of these numeric rating, it assumed that a score of 10 equated to the worst pain imaginable, and therefore these self reported pain scores of 7 and 9 would be classed as being in the very high range. The Company state however that however, Dr M made no reference to the Complainant's presentation during assessment and that it would be expected with scores this high that there would have been associated organic signs noted during the assessment, such as breathlessness, sweating, increased heart rate, possible difficulty in communicating, lapses in concentration or agitation.

The Company says that Dr M stated he was not in a position to comment on the findings of the Complainant's specific CPAD test, however he noted that he had done some research of this type of testing and had found only one paper relating to CPAD. Dr M expressed his concerns that the application of the CPAD did not provide a true reflection of the capacity to perform sustained activities over a prolonged period. Dr M's comments were referred to the Company's appointed specialist who provided the following response:

> *"Dr [M] is quite correct in stating that CPAD was initially designed to assess individuals suffering from Chronic Fatigue Syndrome and Fibromyalgia. As the assessment has evolved, so have the types of conditions assessed through CPAD. These include chronic pain, MS, Parkinson 's, migraine, various cancers and brain injuries, where the outstanding reported symptoms of fatigue and/or pain are preventing the individual from returning to work. CPAD utilises peer-reviewed researched tests which were specifically designed to address the capacity of an individual to perform sustained activities over a prolonged period (including the MTM tests which are commonly used as part of pre-employment screenings). Dr [M] has asked which adjustments in the CPAD assessment were made for [the Complainant]. As mentioned above, the CPAD tests are used for a spectrum of conditions. The tests undertaken are chosen according to the requirements of the work demands which*

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> *the individual is expected to perform as part of their normal role. Therefore, in addition to lumbar inclinometry, lower back palpation, power testing, and simulation testing, the tests undertaken were specific to her expected normal working activities ".*

In relation to the Complainant's comments regarding the assessor's use of hand-held range of motion inclinometers, the assessor also responded as follows:

> *"[The Complainant] states that a hand-held inclinometer requires consistent effort by the assessor to avoid measurement error. I would wholly agree with this and can state that based on my years of experience, the training that I have both received and provided to other assessors and the number of assessments I have undertaken, consistent effort is always provided by myself (and the other assessors …".*

Following a review of this medical evidence, the Company's decision to cease payment of benefit remained unchanged.

The Complainant raised several complaints in relation to the Company's conduct and it responded to each of these as follows:

COPY MEDICAL REPORTS

The Complainant expressed unhappiness that her Specialist, Dr M, did not receive a copy of Dr G's report until 24th February 2015.

The Company states that it can categorically confirm that a copy of Dr G's report was posted to both Dr M, Consultant Pain Specialist, and Dr McN, GP, on 7th January 2015. The Company says that it understands Dr McN did receive a copy of this report, however Dr M did not. The Company submits that it is not responsible for any delays / failure to deliver of the postal system, however it assures that a copy of Dr G's medical report was issued to both doctors on 7th January 2015.

APPEAL BY GP / PAIN SPECIALIST

The Complainant has stated it was unjust of the Company not to arrange a second medical assessment following her appointment with Dr G. The Company's position is that having reviewed the file, it confirms there was no basis for the Company to arrange a further medical appointment, without the submission of medical evidence from the Complainant's own doctors contradicting the opinion of Dr G.

The Company states that the responsibility for appealing the claims decision is that of the Policyholder / Complainant should they believe the decision to be incorrect. It is not the Company's procedure to write directly to a Complainant's doctors requesting that a decision be appealed.

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The Company says that in this instance, the Company forwarded copies of the independent medical reports to the Complainant's treating doctors and it was at the discretion of each doctor to submit an appeal should they have felt it appropriate to do so.

The Company states that its letter of 3rd March 2015 is correct in stating no appeal had been received from either of the Complainant's treating doctors. The Complainant, by her own admission, has confirmed that an appeal, in the form of a medical report from Dr M, was not submitted to the Company until 20th November 2015.

POLICY DOCUMENT

The Complainant referred to the difficulties and a delay experienced in obtaining a copy of the Policy Document pertaining to this Employer sponsored disability scheme. The Complainant advised that she first requested a copy of the Policy Document from 'Mr C from the administrator of the Scheme on 26th June 2014, however the Company states that this request was not communicated to the Company at that time.

The Company received a request for a copy of the Policy Document from the Complainant's solicitors, on 15th January 2015. The Company responded to solicitors on 23rd January as follows:

'As our contract is with the Employer and not directly with your client we are unable to forward you a copy of the Policy Document and Schedules as requested. I would refer you to [the Complainant's] Employer regarding this request '.

The Company states that further letters were issued to the Complainant's solicitors on 3rd March and 15th April 2015 respectively again reiterating that the Policy Document related to a contract of insurance owned by the Complainant's Employer and therefore could not be issued directly to the Complainant, however the Company confirmed it would be happy to release the requested information on receipt of the Policy owners' instruction. It is the Company's position that it had no authority to issue a Policy Document to a third party and directed the Complainant's Solicitors to contact the Policyowner. It was at the discretion of the Policyowner whether they chose to release a copy of the Policy Document relating to their contract of insurance.

The Company states that it cannot be held accountable for the delays the Complainant experienced in obtaining the Policy Document and it is unreasonable for the Complainant to suggest so. The Company says that it should also be noted that access to the Policy Document is not a prerequisite to submitting an appeal and details of the appeals process had already been provided to the Complainant and her Solicitors.

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DELAY GETTING PERSONAL DATA FROM THE COMPANY

The Company states that it accepts there was a delay in issuing a copy of personal data under Data Protection legislation and it apologises for this. The Company says that it understands the Complainant's solicitors have reported this delay to the Data Protection Commissioner who is dealing with the matter.

The Complainant has alleged that 'numerous pieces of correspondence' were omitted when a copy of her file was issued to her solicitors under her data access request. The Company's positon is that a complete copy of the correspondence that it holds on file was issued.

UNHAPPINESS WITH THE CPAD REPORT

The Complainant expressed unhappiness with the contents of the CPAD report stating it contained untrue statements, in particular in relation to work-related issues and her upset throughout the clinical history being taken at assessment. The Complainant requested that the authors of the CPAD report issue a revised report in order to correct these perceived inaccuracies, alleging the report was "false, dishonest and intentionally deceptive".

The Company's position is that the author of the CPAD report, responded in detail to the Complainant's comments. It did not accept that a revised CPAD report was required.

APPEALS PROCESS

The Complainant has stated that she did not receive information in relation to the appeals process, and has alleged this prejudiced her position.

The Company's response is that it confirmed via email on 7th January 2015 to the Broker to the scheme that the appeals process was open to the Complainant and advised that it would issue a copy of Dr G's assessment report to both of the Complainant's treating doctors, Dr M and Dr McN, in order to give both her doctors an opportunity to respond should they deem it appropriate to do so. The Broker to the scheme, issued a letter directly to the Complainant on 8th January 2015 in relation to the cessation of the claim and provided instruction on the appeals process. This correspondence was also emailed to the Complainant on 8th January 2015. The Company states that having had sight of same, the Company believes there was sufficient information in this correspondence regarding the appeals process and says that it set out clearly what steps the Complainant would need to take in order to initiate an appeal.

The Company states that furthermore, further details in relation to the appeals process were sent to the Complainant's Solicitors on 3rd March 2015 and 12th May 2015 respectively. In addition, the option of referring the complaint directly to the Financial Services Ombudsman was provided to the Complainant's Solicitors on 15th July 2015. The Complainant has stated she knows that other insurance companies provide individuals with a lot more information however the Company states it cannot comment on other insurance companies practices.

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The Company submits that it is not responsible for the delays experienced by the Complainant in submitting medical evidence in support of her appeal, however it says it should be noted that this delay did not prejudice the review of the claims decision.

ARBITRATION

The Complainant raised an issue regarding the Company's refusal to engage in Arbitration. Section 2.4 of the Policy Document states as follows:

> *'In the event of any dispute between the contracting parties concerning any matters arising from this policy, the dispute will be referred to two arbitrators, one to be chosen by each party '.*

The Complainant's Solicitors wrote to the Company on 29th June 2015 advising that the Complainant wished her dispute to be referred to Arbitration. The Company responded to the Solicitors on 6th July 2015 confirming the right to arbitrate, as set out in the policy terms and conditions, was open only to the contracting parties (i.e. the Policyowner and the Insurance Company) and on this basis the Complainant was not in a position to invoke the arbitration clause. The Company states that it has confirmed to the Complainant on a number of occasions that she is neither a Policyowner nor a contracting party to this insurance policy and is therefore not entitled to invoke the arbitration clause. A detailed letter of explanation was issued to the Complainant's solicitors, on 6th July 2015 in relation to this matter. The Company says that it also clarified this matter with the Policyowner via email on 9th July 2015 and provided the option of referring the complaint directly to the Financial Services Ombudsman on 15th July 2015.

DELAY IN ISSUING FINAL RESPONSE LETTER

The Complainant refers to the delay experienced in obtaining a Final Response letter, following her written request for same which the Company says was received by it on 27th November 2015. The Company states that it is important to note that, following this request and on the basis of the information supplied by the Complainant in this letter, that the Company arranged a CPAD assessment which took place on 14th and 16th December 2015 respectively. The Company states that it was not in a position to issue a Final Response letter until the review of this appeal had been finalised. Following review of the CPAD report, the Company issued a Final Response letter to the Complainant on 19th January 2016.

The Company rejects the allegation that there were unnecessary delays. The Company states that the Complainant was fully aware that her appeal was being actively prioritised and progressed during this period.

CLAIMS COMMENCEMENT

The Complainant has stated there was a delay of over 4 months in commencing payment of benefit under the policy, stating she should have received her first benefit payment on 1st May 2014 in line with the policy conditions.

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The Company's position is that, the Complainant has misinterpreted the policy conditions as this statement refers to the fact benefit will be calculated and become payable from the 1st of the month following end of the deferred period (the deferred period is the initial 26 week period of sick leave absence that must be completed prior to a claim being considered). The Company states that furthermore it should be noted that the Complainant submitted her completed Claim Form significantly outside the claim time limits.

Therefore, the Company says it was not afforded the opportunity to assess the claim prior to the end of the 26 week deferred period. Section 5.8.1 of the Policy Document states as follows:

> *'A completed Claim Form must be given to the Insurer at least two months before Benefits are due to commence. In the event that a Claim Form is not submitted within this period, benefits will only commence two months from the date that the completed Claim Form is received by the Insurer'*

The Company submit that as the Complainant has rightly pointed out, benefit was due to commence from 7th April 2014, therefore in line with policy conditions, a completed Claim Form should have been submitted to the Company by 7th February 2014 at the latest. However a completed Claim Form was not sent to the Company until 24th April 2014, at which stage the deferred period had already expired. The Company says that it should be noted that it did not penalise the Policyowner for this late submission, despite it's entitlement to do so under Section 5.8.1 of the Policy Document.

The Company says that the benefit was set up for payment in July 2014, however this payment was backdated to the end of the deferred period (in April 2014) and all arrears were paid in July 2014.

NEW PHI CLAIM

The Complainant has queried why the Company internal mail, dated 25th April 2014, contained the statement 'New PHI Claim!' and has further asserted that the Company has never addressed this question.

The Company's response is that a full explanation was issued to the Complainants solicitors, on 12th May 2015 confirming the exclamation mark merely denoted that activity was required on the part of the email recipient.

X-RAYS

The Complainant has queried why the examining assessors have not accepted copies of her x-rays. The Company's response is that these x-rays confirm the significant surgery the Complainant had undergone in the past, prior to submission of the claim. The Company states that it is not questioning nor disputing the surgery undergone and therefore a copy of the supporting x-ray evidence is not required for the file. The Company submit that the x-ray images themselves are not indicative of pain or disability levels or a measure of the Complainants current pain symptomology.

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MEDICAL OPINION OF PAIN SPECIALIST / CPAD TEST REQUIREMENT

The Company states that the CPAD assessment was arranged in order to progress the Complainant's appeal.

The Company's position is that Complainant's Pain Specialist, Dr M, provided an updated report to the Company on 20th November 2015 stating the Complainant remained physically and psychosocially deconditioned as a result of ongoing pain.

The Company says that the reference to 'deconditioned' indicates there is opportunity for rehabilitation and improvement and therefore entirely reasonable the Company to request a CPAD assessment which in part focuses and comments on suitable areas of rehabilitation based upon the abilities determination.

Prior to attending this assessment, the Complainant expressed a number of concerns regarding this assessment in correspondence to the Company dated 4th December 2015.

A response, addressing these concerns, was issued to the scheme administrator, for forwarding to the Complainant.

It is the Company's position that it made its determination on the income protection claim based on whether or not the Complainant satisfied the contractual requirements pursuant to the Policy Document.

The Company state that this assessment was an objective decision based on the medical evidence available at the time and was not unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant as these are the same requirements that would apply for any claimant under the same or similar policy. Furthermore, the Complainant had the opportunity to appeal this decision.

The Company state that it admitted the claim and set it up for payment without requesting the Complainant attend for an independent medical assessment. The Company states that the decision to admit the claim was based solely on the medical report of Dr M, the Complainant's Consultant Pain Specialist.

The Company submit that it would generally require an independent medical assessment prior to making a final decision regarding admittance of a claim, but that in this case, the requirement for an independent assessment was waived, as the claim had already been submitted late, outside of the requisite time frame, and the Company wished to expedite matters to assist the Policyowner / Complainant. The Company state that it was for this reason an independent medical assessment was arranged shortly after admittance of the claim. The Company's positon is that although the Company did admit this claim, this decision to make continued benefit payment is subject to review and it was not a decision to pay benefit indefinitely. Continued payment of benefit is dependent on the medical circumstances of the claimant, and their continued satisfaction of the policy criteria of 'total incapacity'. The Company states that it reserves it's right to cease payment of benefits if a claimant no longer meets the policy criteria for a continued valid claim.

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The Company states that it is not disputing the diagnosis of Chronic Pain Syndrome however it says that there is insufficient medical evidence confirming the Complainant is rendered totally incapable, as a result of ongoing symptoms, of performing her pre-disability occupational duties. The Company submit that given the content of Dr G's and the Assessor's reports, the Company believes its decision to cease payment of benefit on medical grounds was not incorrect or unreasonable. It states that the decision to cease payment of benefit is supported by experts who have carried out the appropriate medical assessments / tests and the Company believes their views are reasonably grounded on the evidence available.

The Company states that the purpose of Dr G's assessment was not to make a diagnosis and that this is not the responsibility of the Insurance Company. The Company says that Dr G is a Specialist in Occupational Health and her role is to determine how the Complainant's medical condition impacts on her ability to carry out her occupational duties. The Company submit that likewise, the purpose of the CPAD assessment is to determine an individual's ability to undertake the physical and cognitive demand of their occupation.

<u>The Complainant's submission on the Company's formal response.</u>

As regards the Company's position that 'no direct contract of insurance' exists between the Complainant and the Company the Complainant states that this is not a relevant consideration as it does not affect her ability to appeal the decision made by the Company.

As regards her claim the Complainant states that it is important to note that although she has been on sick leave since October 2013, it was not until 11 April 2014 that her employer asked her to complete the Company's Claim Form urgently. The Complainant says that the reason she was given by employer for the urgency for completion was that the benefit payment under the policy should have commenced from 7 April 2014.

The Complainant states that the Company only says that she advised the following on the Claim Form in relation to her condition —that she was 'suffering from chronic lower back pain resulting in difficulty sitting at a computer and reading reports.' The Complainant states that this is not the full detail of what she stated on this form — in particular it should be noted that in addition she also stated the following:

> *"My job is largely office based which predominantly involves sitting at a computer and/or reading reports for periods of time. This causes me intense stiffness, and persistent lower back pain with regular episodes of severe pain. In order to manage my pain I require pain medication, regular exercise and to avoid stressful situations which further intensifies my pain"'*
>
> *"As a Senior [profession] the job role requires me to work full days whereby I am seated at a computer and working to tight deadlines. Both of which, as stated above, aggravates my chronic lower back condition. "*

The Complainant says that similar information was further reiterated on the Disability Insurance Continuation Claim Form which she completed on 12 September 2014. On that form the Complainant further explained the severity of her condition.

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The Complainant refers to the Company's statement that 'the onset of back pain had commenced in 1990s following a serious road traffic accident, and developed into chronic back pain in late 2011.' The Complainant submits that this is not entirely correct, and that the following is more accurate in this regard and is what she stated on the claim form:

> *"My back injury occurred in September [1990s] but I managed my condition until December 2011 when following an elective [operation] my back pain became consistent and chronic"*

The Complainant states that furthermore it should be noted that she stated on the claim form that she 'took unpaid leave for July, August and September 2013 in order to withdraw a dependency she had formed on codeine based medicines that she relied on to deal with pain. The Complainant states that when this proved unsuccessful she went to her doctor who signed her out as unfit for work.

As regards the Company's statement it requested a medical report from the her Consultant and that the report was received on 16th June 2014, the Complainant state that the report which was received by the Company on 16 June 2014 was prepared by the consultant on 12 May 2014 and is dated as such. The Complainant says that as far as she understands, the delay in issuing this report revolved around the fact that Dr M's office required payment from the Company for the report before it could be released.

As regards the Company's statement that Dr M's report confirms his diagnosis 'of a significant chronic pain syndrome and that participation in a multidisciplinary pain management programme would be of benefit.', the Complainant states that this is not the complete diagnosis since his report also states that her condition 'occurs on a complex background of significant spinal injury and post pregnancy chronic back pain.'

The Complainant's states that in addition it is of vital importance to note that Dr M's report states that it is his medical opinion that she is not in a position to return to full or part-time work in any capacity.

The Complainant clarifies that, it was not until 26 June 2014 that it was confirmed to her via the broker to the scheme that her claim was being admitted. The first monthly benefit payment that the Complainant received was made on 8 September 2014 and included the back payments to 7 April 2014.

As regards the Company's statement that it was a 'routine review' of her claim, the Complainant states that when informing her that the Company had requested that she attend for an IME the broker to the scheme stated the same to her (i.e. that this was routine and nothing to worry about). The Complainant states that it is now clear to her that this was not the case. The Complainant refers to the final section (Section 29) of the Company's letter dated 10 April 2017, where the Company confirm the following:

> *"The Company would generally require an independent medical assessment prior to making a final decision regarding admittance of a claim but in this case, the requirement for an independent assessment was waived, as the claim had already been submitted late, outside of the requisite time frame, and the Company wished*

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to expedite matters to assist the Policyowner/Complainant. It was for this reason an independent medical assessment was arranged shortly after admittance of the claim."

The Complainant submits that in other words this was most definitely not a routine review of her claim and it was clearly non-routine since the Company is saying it was only required in this circumstance where there was a delay in notification of the claim to the Company. The Complainant states that surely the late notification of claims (thus requiring IME in this manner) is not a regular occurrence — i.e. surely this is not routine.

The Complainant refers to the Company's statement that "[Dr M] advised he had last reviewed the Complainant in February 2014".

In this regard the Complainant states that from the documents provided it is clear to see that on the September 2014 Disability Insurance Continuation Claim Form she confirmed to the Company that her most recent date of attendance with Dr M was on 6 August 2014. The Complainant says that it appears from what is said here that the IMA was requested by the Company because it believed that Dr M's most recent review of her had been many months prior, whereas in fact the most recent review took place on 6 August 2014 (as the Complainant had advised on the Claim Form). The Complainant states that given that the cessation of her claim was based SOLELY on this IMA report, she wonders if all the past two years of hell could have been avoided had the Company requested a report from Dr M based on his 6 August 2014 review of her. The Complainant states that in fact by the time she attended the IMA in December 2014, she had attended a further medical appointment with Dr M on 5 November 2014. The Complainant submits that surely Dr G who conducted the IMA should have been provided with medical reports from Dr M based on the 6 August 2014 and 5 November 2014 reviews.

The Complainant's position is that until now the Company had not told her that the reason she was sent for an IMA was because Dr M's most recent review of her had been many months prior. The Complainant highlights what she says appears to be a discrepancy in the Company's letter regarding the reason she was sent for an IMA as the reason that Dr M's most recent review of her had been many months prior is at odds with the reason set out by the Company i.e. that the reason for the IMA was because one was not possible at the time of claim admittance.

The Complainant submits that the reason (i.e. the one that she was sent for an IMA was because Dr M's most recent review of her had been many months prior) could and should have been communicated to her at the time and the relevant more recent reports could have been requested from Dr M as required.

The Complainant states finally on this point that, the summary given by the Company of Dr G's IMA report fails to recognise a vital finding that it was her diagnosis (as set out in the Conclusions & Recommendations section of the report) that she suffers from 'a chronic pain syndrome with chronic low back pain'. The Complainant says that in addition to what is said here, it should be added that Dr G stated that she believed that 'resuming work would be therapeutic' for her; a statement the Complainant previously expressed her opinion on.

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The Complainant says that the Company state that "In order to continue to be eligible for benefit under this disability scheme the Complainant must be 'totally incapable by reason of illness or injury' of following their normal occupation. Payment of benefit will cease if an employee no longer meets this definition of total incapacity". The Complainant submits that the Company has not demonstrated to her why she no longer met the definition.

The Complainant's position is that her condition has not improved and that in fact there was no change in her circumstances and the Company has nothing to support its contention that she "no longer meets this definition of total incapacity". The Complainant says that this statement alone shows that she was entitled to be admitted to the policy. The Complainant says that she means to 'no longer' be entitled to something proves the contention that she was entitled to it.

The Complainant submits that the policy conditions do not contain the term total incapacity. The Policy Document defines the term Disabled as being 'totally incapable by reason of illness or injury of following his normal Occupation'.

The Complainant says that in her case this definition requires that her condition renders her incapable of her own occupation — i.e. as Senior [profession] with her employer. The Complainant says that the Company stated that she met this definition when the CMO considered her medical history and medical reports and admitted her to be eligible for benefit claim payments to commence under the policy.

The Complainant states that, this is the fact that her complaint hinges on. The Complainant says that in fact in the interim period (i.e. the time period from January 2015 when her claim benefit ceased to the present date) there was now further medical evidence available to the Company that further demonstrates that she continued to meet the definition of Disabled and thus the Company had no right to cease payment of her benefit.

The Complainant states that the medical evidence received from Dr G confirmed she no longer met the definition of total incapacity and therefor no longer eligible to claim benefit.

The Complainant submits that again the term total incapacity appears here, and that the policy conditions do not contain the term total incapacity. The term Disabled is defined in the Policy Document as being 'totally incapable, by reason of illness or injury of following his normal Occupation'.

The Complainant notes that a very similar paragraph appeared in the Company's final response letter dated 19 January 2016 but in that letter the term used was incapacity and not total incapacity. The Complainant questions whether this is the Company attempting to try to change the definition which is clearly set out in the Policy Document. The paragraph that appeared in the Company's final response letter dated 19 January 2016 was as follows: "The medical evidence received confirmed you no longer met the definition of incapacity as outlined above and therefore no longer eligible to claim benefit."

The Complainant considers that this sentence should be amended to be corrected as follows: "The medical evidence received from Dr G confirmed that it was her opinion that although [the Complainant] suffers from chronic lower back pain etc. the Complainant no

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longer met the definition of Disabled as outlined above and the Company therefore decided [the Complainant] was no longer eligible to claim benefit."

The Complainant states that this paragraph states (or at least attempts to state) that the medical evidence received confirmed she no longer met the definition of total incapacity. The Complainant states that this is misleading. The Complainant submits that it is only in Dr G's Independent Medical Assessment report where this is stated. The Complainant states that just because Dr G writes it in her report doesn't make it true —a paper never refuses ink. All other medical evidence (i.e. that from Pain Specialist, GP and the State Medical Assessors) state and clearly confirm that she continued to meet the definition of Disability under this policy.

The Complainant states that she was removed from the PHI policy based exclusively on this IMA report.

The Complainant's position is that the Company fittingly requested and relied upon medical reports prepared by Dr M Consultant Pain Specialist to determine whether, on admittance, she met the definition of Disabled under the policy. The Complainant states that she has an established and ongoing Doctor-patient relationship with Dr M and he has an in-depth knowledge of her condition and its limitations. The Complainant says that the Company accepted and relied upon this report and commenced payment of benefit under the policy based on Dr M's medical diagnosis.

The Complainant states that then, through what appears to be as a result of miscommunication as to when she last met with Dr M, the Company requested that she attend Dr G for an IMA.

The Complainant says that Dr G is a GP who works in the area of Occupational Health and who has no relevant experience in relation to spinal injury, pain management etc. The Complainant states that she met with Dr G for approx. 25 minutes for what was largely an informal chat but because she wrote in her report that, in her opinion, she no longer met the definition of Disabled, she was removed from the policy. The Complainant states that it must be noted that Dr G fully acknowledged her medical condition in the report. The Complainant submits that Dr G never implied that she exaggerated her symptoms or that she was in any way a malingerer. Dr G reported to the Company (who instructed the report) that notwithstanding that it is undisputed that the Complainant suffers from chronic low back pain and chronic pain syndrome etc., returning to work (in a full time 39 hour a week desk based job) would be therapeutic for the Complainant by providing her with the opportunity to engage in social contact, meaningful activity and gainful employment.

The Complainant submits that she has written at length in relation to the unsound nature of the CPAD report and in her letter dated 3 January 2017 she provided factual contradictory evidence which demonstrated that details Mr. N wrote in the CPAD report were false. The Complainant says that therefore it is reasonable to state that this report must be considered null and void.

The Complainant states that it is her understanding that the adjudication process within the Financial Services Ombudsman offices (once the exchange of documentation is complete)

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would largely involve a review of the evidence before them and weighing up the evidence presented. The Complainant states that the only document that the Company has that claims that she is fit to return to work is Dr G's IMA where she states that, in her opinion, the Complainant no longer meets the definition (albeit the Complainant is of the view that the medical facts demonstrate otherwise).

The Complainant submits that the Company's offer of 8-10 sessions of Cognitive Behavioural Therapy (CBT) was unhelpful and futile. The Complainant says that given her condition, no amount of CBT sessions would enable her to return to her occupation. The Complainant say that as part of the Pain Management Programme she studied CBT and found it extremely interesting and she would be interested in studying CBT further to help her deal with things like negative thinking and teach her ways to try to focus her mind on something other than pain most of the day, but unfortunately sitting in a group chatting with a therapist about feelings would not cure her chronic low back pain.

As regards the Company's statement that they "confirmed its decision could be appealed through the submission of medical evidence confirming the Complainant remained totally incapable of a return to work, as a result of her medical condition". The Complainant states that it is clear from documents provided that the Company is claiming to have confirmed that it should be one of the medical practitioners who instigated an appeal by submitting contrary medical evidence. The Complainant states that the Company claim to have confirmed this to both her GP and her Pain Specialist. The Complainant states that as per the Company's two letters dated 7 January 2015, it merely stated to both parties that a copy of the IMA was being sent to it for their information. The Complainant states that there is no call to action/reply, no mention that they had made a decision to cease the benefit payment based on the report and no mention that an appeal was possible or how to go about it. The Complainant says that in fact the Company's letter dated 8 January 2015 states that 'a copy of the IMA report completed by Dr G Specialist in Occupational Health is being sent to both your GP (Dr C McN) and your Specialist (Dr M) for their information'.

The Complainant submits that the Company's letter to her (dated 8 January 2015), which confirmed that the decision was to cease benefit, stated that under an appeal its Chief Medical Officer (CMO) would review and consider supporting medical evidence. The Complainant says that nowhere in the Schedule of Evidence provided by the Company can proof be seen that the CMO was involved in either the decision to cease the claim benefits or the decision to reject her appeal. The Complainant states that surely this is something the Company need to provide proof of to demonstrate that the appeal process was followed correctly. The Schedule of Evidence provided with the Company's letter dated 10 April 2017 included an internal CMO Referral Sheet which was signed and dated by the CMO on 15 December 2015. The Complainant states that here it appears that the CMO is being asked whether he agrees with the view that a CPAD (which the Complainant says was 50% complete as at 15 December 2015; the date on which this form was signed by the CMO) was the appropriate way forward for the appeal. The Complainant states that this is the only evidence of the CMO's input into her file. The Complainant questions where is the proof that the CMO reviewed the full file including the CPAD report before the decision was made in January 2016 not to reinstate her benefit.

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The Complainant submits that what the Company fails to mention is the reason as to why it was not until November 2015 before it received her letter of appeal of the decision that it made in January 2015. It is the Complainant's position that it was the Company's actions that caused the most significant delays. The Complainant says that during that time the following occurred:

- There was a delay in getting copies of her correspondence from the Company.
- There was a delay in trying to instigate arbitration with the Company to resolve the matter.
- There was a lengthy delay in getting a copy of the Company's policy document.
- There was a delay getting an updated medical report from Dr M due to his workload.

The Complainant argues that the Company's summary of Dr M's report is incomplete. The Complainant considers that the following should be added also:

- Dr M also stated that the chronic pain syndrome 'occurs on a complex background of pre-existing significant spinal injury and post-partum chronic low back pain. '
- He also states that 'as a result of her ongoing chronic low back pain and the adverse functional and psychosocial impact of this disorder I feel it appropriate that [the Complainant] is incapable of returning to work in her normal pre-existing capacity'.

As regards the Company's request for the Complainant to participate in a Chronic Pain Abilities Determination (CPAD) assessment the Complainant states that she previously corresponded at length about the non-reliable nature of the CPAD assessment and her strong convictions on the lack of weight that can be placed on such an assessment. The Complainant refers to the text from the Company's Final Response letter dated 16 January 2016 where she states that the Company purports to confirm what she reported to the Assessor in the CPAD Assessment. As regards the reported last episode of pain been 4 months previously the Complainant states that this is referring only to her intermittent right leg pain. The Complainant submits that that it is very misleading to include detail on her leg (shin) pain and her headaches in this Final Response letter as these are conditions that she suffers from but not issues that render her incapable of work.

The Complainant reiterates that it is the chronic low back pain she suffers from which prevents her return to work. The Complainant states that should a person scan through this paragraph, it would suggest that the last episode of severe pain which she suffered was 4 months prior; and that this is simply not true. The Complainant questions why it was not made clear here that it is acknowledged and well documented that she suffers from chronic low back pain and chronic pain syndrome each and every single day. The Complainant states that instead this paragraph attempts to dilute her condition by referring to her last episode of severe pain being 4 months prior. The Complainant does not see why her leg pain is referred to at all in this Final Response letter which relates to her entitlement to a benefit relating to her chronic low back pain. The Complainant states that she suffers in silence in relation to her leg pain. The Complainant state that the company refer to her specialist's report being provided 'as evidence questioning the validity of the CPAD report'. The Complainant's position is that it should be noted that in addition this report is also further medical evidence. In the conclusion section of the report it states that the Complainant is

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“unable to fulfil the normal activities required in either a sedentary or active job" and it further states "Her current levels of physical capability, combined with her pain description and symptoms support [Dr M’] opinion that she is unable to perform within the work force”. As regards the Company’s position that the specialist report did indicate definitive tasks undertaken to effectively quantify and qualify the Complainant’s abilities to perform specific work-related tasks (which it feels were measured in the CPAD report), the Complainant submits that the specialist’s assessment did quantify her abilities. The Complainant states that as pointed out previously, she does not believe the tasks performed in the CPAD assessment are a true test of her ability to perform her role over a prolonged period. The Complainant says that this was also a concern that Dr M raised when he stated in his letter that the *'application of this test does not provide a true reflection of the capacity to perform sustained activities over a prolonged period*'.

As regards the Company’s view that there are no details of validity crosschecks showing (i) good reliability of effort and true representation of actual capabilities (ii) any symptom exaggeration crosschecks or distraction testing to properly evaluate the self-reported pain levels, in contrast to such cross checks in the CPAD assessment, the Complainant states it is confirmed here that this is an assumption that because the specialist’s report does not explicitly refer to validity crosschecks, then no such crosschecks were carried out. The Complainant’s position is that this is an incorrect assumption as she can confirm that each of the physical tests performed in the specialist’s assessment were conducted three times (as was the case with the CPAD test). In addition the specialist’s assessment was conducted over two days (as was also the case with the CPAD test).

The Complainant states that in fact the CPAD tests included less (when compared to the her specialist’s assessment) in terms of validity crosschecks for e.g. the range of movement tests. The Complainant says that these tests/readings were taken by state-of-the-art machines in her specialist’s assessment (thus no independent cross-check was required) whereas they were taken manually in the CPAD assessment and so an independent cross-check should have been performed to avoid human error or the results being questionable.

The Complainant states that her specialist’s assessment included the Oswestry Health Related Index test which as shown previously has a symptom exaggeration cross-check on the self-reported pain levels whereby only a score of over 80% would indicate symptom exaggeration. The result reported for the Complainant was 60%.

The Complainant submits that it is stated by the Company that distraction testing was part of the CPAD assessment but it should be noted these only formed part of the cognitive tests; the Complainant says they were not part of the physical tests that the Assessor undertook. The Complainant states that this therefore is an irrelevant point since it is the physical chronic low back pain that is preventing her return to work; it is not her cognitive ability.

As regards the Company comparison of the two assessments on psychological testing the Complainant states that similar to the preceding point, this point regarding psychological testing is irrelevant since it is the physical chronic low back pain that is preventing her return to work: it is not her cognitive ability.

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The Complainant says that she notes that this paragraph on psychological testing provided by the Company is almost identical to a section from the Assessor's email dated 22 July 2016 where the Assessor states the following in that email:

"The CPAD assessment uses a battery of cognitive tests (again with symptom exaggeration crosschecks) which provides a conclusion on the ability of an individual to return to work from a cognitive perspective"

The Complainant states that the Assessor says 'conclusion on' but the Company changes this to 'conclusive evidence'. The Complainant states that this is a key difference as it shows that the Company has taken something which the Assessor has stated and exaggerated it for its summary. The Complainant points out that 'conclusion' is defined in the Oxford Dictionary as the end or close; final part; the last main division of a discourse, usually containing a summing up of the points and a statement of opinion or decisions reached.

Conclusive is defined as serving to settle or decide a question; decisive; convincing; conclusive evidence; tending to terminate; closing.

As regards the Company's reference to the Complainant's comments about the CPAD Assessment and assessor and its comment that this assessment was accepted by the Courts as a *"recognised and effective tool to assess someone's physical and cognitive ability".*

The Complainant states that here the Company is providing an excerpt from the findings of the J.H.-v-Friends First Life Assurance Company Ltd High Court case in 2014. On this matter the Complainant's comments are as follows:

"As you will see from the judgement document, this statement is taken from paragraph 65 of the High Court judgement for the 2014 case of Holohan -v- Friends First Life Assurance Company Limited.

It is important to point out that [the Company] have not provided the full paragraph in this regard; leaving out the following sentence which is very important:

> *"The court does not accept the submission made at Para. 27 of the defendant's submission that the CPAD assessment stands on its own and that there was no evidence to challenge the accuracy of the CPAD assessment."*
>
> *In other words, it was the courts view that there is evidence to challenge the accuracy of a CPAD assessment; Paragraph 66 states that 'the defendant (the insurance company) is not correct when he states there has been no evidence to challenge the CPAD evidence as Prof. M has called into question certain aspects of it.' It is also the courts view that a CPAD assessment cannot stand on its own; Paragraph 66 states that 'the report on the CPAD testing is taken together with all the expert evidence in the trial of the action and considered in the context of the requirement of the plaintiff on the balance of probabilities to discharge the onus of proof upon him'.*

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It is important to note in this High Court case that the court accepted the medical evidence presented on behalf of the plaintiff over the evidence presented on behalf of the defendant (the insurance company).

In other words while the court allowed the CPAD results in the proceedings the High Court judge made his ruling without regard to its findings and the court ruled against the CPAD report and the evidence of Dr [G]. The court agreed with the evidence presented by the plaintiff's doctors and specialists and relied upon their evidence.

Of utmost importance here is to highlight that this High Court statement must be considered in the context of the case in question. The court is stating this for the case of an individual suffering from fibromyalgia; it is not saying a CPAD assessment is an effective tool to assess a person's ability when suffering from other illnesses. A CPAD in the case of a patient suffering from fibromyalgia includes both a fibromyalgia impact questionnaire and an algometry 21-point tenderness test, both of which are not part of a CPAD for a person not suffering from condition like mine. This again reinforces my Specialist's (Dr M's) concern that there is no peer-reviewed medical literature covering the validity of applying a CPAD test in the case of an individual suffering from chronic low back pain and chronic pain syndrome".

With regard to the Company's commentary on Dr M's assessment (Consultant Pain Specialist), the Complainant states that Dr M said in his 9 June 2016 report that based on the assessment he completed that it was his medical opinion that the Complainant 'remains incapable of returning to work in her normal pre-existing capacity'.

The Complainant submits that it should be noted that Dr M's letter is further medical evidence reaffirming again that she remains incapable of returning to work; i.e. Dr M reiterates his medical opinion that the Complainant "remain incapable of returning to work in her normal pre-existing capacity".

The Complainant refers to the Company's statement that the purpose of the pain detect questionnaire Dr M facilitated was to evaluate *'the perceived impact of pain across a range of functional domains'* and that this questionnaire is therefore a subjective evaluation as was confirmed by Dr M in his letter. The Complainant states that there is no other way to evaluate a person's self-perception of the impact that pain is having on them without asking them what they themselves perceive the impact to be on them. The Complainant states that by its very nature such an evaluation has to be subjective and thatthere is no way to get an objective version of such an evaluation.

The Complainant sates that such an evaluation cannot by its nature include symptom exaggeration crosschecks. The Complainant states that there is no difference between this self-reported questionnaire and the self-reported questionnaire, namely the McGill Pain Questionnaire that the Assessor instructed to be filled out on both days of the CPAD assessment. The Complainant states that the McGill Pain Questionnaire (completed as part of the CPAD assessment) does not have any symptom exaggeration crosschecks built into it either.

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The Complainant states what the Company is doing here is criticising the self-reported questionnaire that she filled out for Dr M on 9 June 2016. The Complainant says that these comments are almost verbatim the comments that the Assessor communicated to the Company representative in his letter to her dated 22 July 2016. The Complainant questions how can the Assessor make such statements when such a significant part of his CPAD assessment and findings are based her completion of self-reported questionnaires on her pain levels — i.e. the McGill Pain Questionnaire and the Visual Analogue Scale Questionnaire both of which the Complainant completed at the request of the Assessor as part of his CPAD assessment. The Complainant submits that both are self-reported questionnaires that provide a subjective evaluation of the perceived impact of pain. The Complainant states that they also are wholly subjective and have no symptom exaggeration crosschecks built in. In other words, the CPAD questionnaires are the same as Dr M's questionnaire in this regard.

The Complainant's position is that in fact, as seen from the VAS Questionnaire which she filled in for the Assessor at the beginning and end of each assessment day they are not in any way scientific. The Complainant says that Mr. N's statement in his CPAD report that she 'performed with only with fair reliability of effort" on this result.

The Complainant submits that the Assessor as an Osteopath can use self-perceived questionnaires as a significant portion of his CPAD assessment format and use results as his 'findings' but when Dr M refers to a single self perceived questionnaire that she filled out for him, the Assessor claims that its results cannot be relied upon. The Complainant considers that it is appalling that the Assessor based his 'fair reliability of effort' comment in his CPAD report on the results of this self-perceived VAS questionnaire. The Complainant submits that in fact, given that this is the first time she has been provided with copies of the completed VAS questionnaire sheets she feels it important to confirm that, following a very quick internet search, she found the following in relation to how the vertical and horizontal versions of this scale compare:

"Vertical and Horizontal Visual Analogue Scales have been compared in the measurement of pain. There was a good correlation between the two scales, but the scores from horizontal scales tended to be slightly lower than those from the vertical scales."

The Complainant's view on the above is that this shows that by giving her the vertical scale at the start of each day of assessment and the horizontal scale at the end of each day of the assessment would tend to give results showing a fall in pain, all other things being equal. The fall from 6.5 to 5.5 on day one was what the Assessor based his 'fair reliability of effort' comment upon.

The Company stated as follows:

> *"Dr M stated that the Complainant had rated her pain as between 7 & 9 out of 10. On the basis of these numeric ratings, [the Company] assumed that a score of 10 equated to the worst pain imaginable, and therefore these self reported pain scores of 7 and 9 would be classed as being in the very high range. However, Dr M made no reference to the Complainant's presentation – it would be expected with scores this high that there would have been associated organic signs noted during the*

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assessment, such as breathlessness, sweating, increased heart rate, possible difficulty in communicating, lapses in concentration or agitation".

The Complainant's position on the above is that here the Company has made an unreasonable assumption that because Dr M has not included comments on her presentation on 9 June 2016 that she must have presented without any organic signs of pain. The Complainant states that Dr M does not comment on her presentation in his report and it is unfair for the Company to make the assumption that it has. The Complainant questions if information on her presentation was required why was this specifically not requested.

The Complainant states that in any event even if a person were to present without obvious signs of breathlessness, sweating, increased heartrate etc. this most certainly does not mean the person is pain-free; for example a cancer patient might present without symptoms such as breathlessness, sweating etc. even though they require significant opiate pain relievers to help control the pain. The Complainant states that these patients, as she is, are aware of the side effects and very real potential of suffering from liver and/or kidney damage, gastrointestinal bleeding or a stomach ulcer as a result of their taking high levels of pain medication, but need to take this pain medication to manage their pain. The Complainant states that in her opinion this is the Company attempting to discredit Dr M's professional medical opinion, which has been consistent; that she remains incapable of returning to work in my normal pre-existing capacity. The Complainant submits that this is a very detailed and informative report and all the Company can speak to is something that the Report does not make comment on.

As regards the Company's comments on the CPAD test, in particular that the research showing that the application of the test does not provide a true reflection of the capacity to perform sustained activities over a prolonged period, the Complainant submits that it should be noted that the 'some research' as the Company state was performed by Dr M was not a casual search. In his letter Dr M had advised that his research involved a thorough search of medical literature he said he "investigated this text via a thorough search of the medical literature utilising the US National Library of Medicine/National Institute of Health'. The Complainant says that Dr M's thorough research only produced the one paper which it will be noted was actually co-authored by the Assessor himself; the Complainant states that these are *hardly independent findings*.

The Complainant states that a very important point to note is that the single paper covers the use of a CPAD test for patients suffering from Chronic Fatigue Syndrome or Fibromyalgia and it clearly does not cover the use of a CPAD test for patients who like her are suffering from chronic low back pain and chronic pain syndrome. The Complainant submits that this single paper should therefore not be considered relevant in this case. The Complainant consider that the only paper that would be of relevance here would be one covering the use of a CPAD test for patients who are suffering from chronic low back pain and chronic pain syndrome. The Complainant states that all there is here is the Assessor stating that the CPAD testing has evolved over time to cover illnesses other than Chronic Fatigue Syndrome or Fibromyalgia; and she questions where is the peer-reviewed medical literature covering the validity of this evolution.

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The Complainant says that in his letter, Dr M expressed his concern that the 'application of this test does not provide a true reflection of the capacity to perform sustained activities over a prolonged period'. The Company's response on this point is as follows: "CPAD utilises peer-reviewed researched tests which were specifically designed to address the capacity of an individual to perform sustained activities over a prolonged period (including the MTM tests which are commonly used as part of pre-employment screenings)".

The Complainant states that at the end of the day, the only 100% accurate test of one's capability to perform sustained activities over a prolonged period is to actually do so. In relation to her situation the Complainant states that Dr G acknowledged in her IMA report that she attempted to work for 10 months following the onset of unmanageable low back pain in December 2011 (from October 2012 to July 2013) and that the Complainant was unable to continue performing the tasks required of her role due to chronic low back pain and chronic pain syndrome.

In relation to the Company's reference to the Assessor's comments on the Complainant reference to use of hand held range of motion inclinometers, the Complainant states that:

> *"These comments do not address why [the Assessor] did not use a machine in his CPAD assessment. Use of a machine would provide reliable results for range of motion ability which would not be open to question in the same way as results derived from the subjective use of hand-held inclinometers.*
>
> *What [the Assessor's] comments amount to is a statement that says that while he is not a machine he knows how to use a hand held inclinometer, and yes it relies on consistent effort by the assessor, but you can trust him he has had plenty of training.*
>
> *[The Assessor] acknowledges that measurement error can occur in using hand-held inclinometers if 'consistent effort by the assessor' is not given. I would therefore have expected that a second individual would have also taken readings (independent of [the Assessor]) using the hand-held inclinometers to provide a validity cross-check on his results. Such a validity cross-check is not required where readings are taken by a machine since consistency of effort is not an issue when a precise and calibrated machine is taking the readings.*
>
> *It therefore clearly follows that the results for range of motion as set out in [her specialist's] report (which were arrived at by using the state of the art DAVID machine) are more reliable than the results for same contained in [the Assessor's] report (arrived at by using hand-held range of motion inclinometers)".*

As regards the Company's position that it sent Dr D's report to the Complainant's specialist Dr M in January 2015, the Complainant states that as previously stated, Dr M confirmed that his office had no record of receiving this report from the Company in January 2015. The Complainant says that she provided a copy of this report to Mr M at a later date i.e. on 27 February 2015 (not 24 February 2015 as she says the Company incorrectly stated).

As regards the Company's position that it was at the discretion of the treating doctors to appeal (upon their receipt of the independent medical report), should they have felt it

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appropriate to do so, the Complainant states that it is clear from the documents provided that the Company is claiming to have confirmed that it should be one of the medical practitioners who instigated an appeal by submitting contrary medical evidence. The Complainant states that the Company claim to have confirmed this to both her GP and her Pain Specialist. The Complainant says that in the Company's two letters dated 7 January 2015, merely stated that a copy of the IMA was being sent to the doctors for their information. The Complainant states that there is no call to action/reply, no mention of an appeal being possible or how to go about it and certainly no mention of the decision made to cease the benefit. The Complainant states that in fact it is noted that the Company letter (dated 8 January 2015) states that 'a copy of the IMA report completed by Dr G, Specialist in Occupational Health is being sent to both your GP (Dr McN) and your Specialist (Dr PM) for their information'.

The Complainant considers that the Company should change its policy in this regard so that it provides the treating specialists of future claimants with full details of a decision in this type of case along with full details of how an appeal can be instigated.

The Complainant submits that as stated above the reason for her appeal not being submitted until 20 November 2015 was as a result of significant delays, absolutely all of which were beyond her control. The Complainant states that the Company fails to mention the reason as to why it was not until November 2015 before it received her letter of appeal of the decision that it made in January 2015. The Complainant set out the cause of this time gap and states that all the reasons were beyond her control. The Complainant states that during that time the following occurred:

- There was a delay in getting copies of her correspondence from the Company.
- There was a delay in trying to instigate arbitration with the Company to resolve the matter.
- There was a lengthy delay in getting a copy of the Company's policy document.
- There was a delay getting an updated medical report from Dr M due to his workload.

The Complainant had requested the Policy Document on 26 June 2014 when the claim was admitted. It is the Complainant's position that she was not advised at that time that the Company's view was that she was not entitled to receive this document. The Complainant states that the representative (Mr. C) was awaiting word from the employer to release the document to her but never came back to her to confirm the situation despite her follow up with him on this.

The Complainant refers to Company's letter of 26 January 2016 where the Company representative ended the letter with the following statement: "1 trust this is satisfactory and as [the Company] has issued you with a Final Response Letter, I would be grateful that any future communication is directed via the Financial Services Ombudsman's Bureau." The Complainant states that the dismissive tone of this sign-off is similar to that the tone of a representative in the 10 June 2015 telephone conversation. The Complainant states that on that call the views expressed echo the tone behind the previously mentioned internal email titled 'New PHI Claim' and states that she is disappointed at the tone. The Complainant argues that the Company incorrectly stopped benefit. The Complainant states

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she has approached the appeal in a perfectly professional manner and the Company representative demonstrated a dismissive approach to her situation on a number of occasions as though she was in some way trying to frustrate or annoy her. The Complainant says that she only ever endeavoured to have her benefit payments reinstated under the policy; payments that should never have been ceased. The Complainant states that her employer (the policyholder) pays the Company an annual premium to protect its employees so that if they become incapable of working due to 'illness or injury' they will be paid part of their income. The Complainant says that then when one of their employees submits a claim (a claim that was accepted and then wrongfully declined) and they are looking to get their benefit payments reinstated, they get this dismissive tone from the Company.

The Complainant expressed unhappiness with the CPAD assessment / report, and had sought to have it amended. The Company's response was that the author of the report responded to the Complainant's comments. It was not accepted that a revised CPAD report be issued.

The Complainant's response to the above is that the medical evidence letter from Medfit provides factual results based contradictory evidence to the *unfounded* CPAD report undertaken by the Assessor and provided further supporting evidence to Dr M, Consultant Pain Specialist's medical opinion that she is incapable of returning to work.

The Complainant is disputing and questioning the validity of the CPAD report that the Assessor issued. The Complainant states that her specialist's medical evidence provides further evidence that the detail that the Assessor put in the CPAD report was intentionally misleading. The Complainant's view is that the inaccuracies in the CPAD report are not 'perceived inaccuracies'; but are 'real inaccuracies'.

The Complainant states that she can categorically confirm there are no work-related issues involved here as the Company has suggested and that this can be confirmed with her employer who support her appeal of the Company's decision. The Complainant states that she does not agree that CPAD's Assessor's responses address the concerns that she raised.

The Company's position is that the Complainant, her solicitor and her doctors received the specialists report and could have responded to same. The Complainant says that the two letters dated 7 January 2015 to her doctor and solicitor, merely stated that a copy of the IMA was being sent to her GP and Specialist for their information. There is no call to action/reply, no mention of an appeal being possible or how to go about it and certainly no mention of the decision made to cease benefit. The Complainant states that in fact the Company letter to her (dated 8 January 2015) states that 'a copy of the IMA report completed by Dr G, Specialist in Occupational Health is being sent to both your GP (Dr McN) and your Specialist (Dr M) for their information'.

Despite what the Company states the Complainant states that she does not agree that she was provided with sufficient information whatsoever. As regards the information provided to the her Solicitors on 3rd March 2015 and 12th May 2015, the information was similar as was provided to her by the Company.

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As regards the Company's position that Arbitration was only available to the policyholder (the Complainant's employer) the Complainant's response is that she received legal advice from her solicitor to pursue arbitration however this turned out not to be an avenue open to her and this further added to my frustration on this matter.

The Company state that upon the Complainant requesting a Final Response it arranged the CPAD assessment, and that it was not in a positon to issue a Final Response until the review had been finalised. The Company reject the allegation that there was any unnecessary delays. The Company states that the Complainant was aware that her appeal was being actively prioritised and progressed.

The Complainant's response to the above is that the only update she was given on the status of the final response letter following the CPAD (which took place on 14 & 16 December 2015) was a letter from the scheme representative on 21 December 2015 where it was stated that the Company had advised 'that it will likely be early to mid-January before they have had an opportunity to complete their assessment and advise further'. The Complainant therefore does not agree that she was made fully aware of the progress of her appeal. The Complainant states that the appeal result was not communicated to her until 19 January 2016 — over 7 weeks after she lodged her appeal and almost 5 weeks after completing the CPAD assessment.

The Company refer to the deferred period under the policy and that it would have to be first satisfied before a payment is made. The Company also refer to positon where the claim is submitted outside the specified time frame and that it had not penalised the Complainant in either circumstance. The payment was set up for July 2014 and backdated to the end of the deferred period (April 2014. The arrears were paid in the first lump sum payment in July 2014.

The Complainant's response to the above is that when one factors in to the delay calculation the fact that the Policy Document states that the benefit becomes payable 'from the 1st of the month following end of the deferred period', the delay experienced was 4 months and 1 week. The Complainant says that the Policy Document states in section 5.10.2 the following in this regard:

> *'Benefits shall be payable by monthly instalments in arrears with the first instalment being due on the first of the month following the date on which the Benefits become payable under the provisions of this policy'*

The Complainant states that given that the claim was admitted with effect from 7 April 2014, the first instalment became due on 1 May 2014 as per the Policy Document — i.e. the first of the month following 7 April 2014 and therefore should have been paid the first instalment of benefit on 1 May 2014. The Complainant says that what actually happened is that she received her first payment on 8 September 2014 which was some 4 months and 1 week later than 1 May 2014.

The Complainant says that it appears the Company is trying to say that the delay experienced was something shorter than 4 months and 2 weeks; i.e. it is attempting to lower the delay period to something that is, for all intents and purposes, not significantly

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different. The Complainant's position is that either way it does not change the fact that a delay was experienced in her claim commencement.

As regards late notification under Section 5.9.1 of the Policy Document where it sates that: 'Written notice shall be given to the Insurer at least two months before Benefits are due to commence.'

The Complainant states that there is nothing stated about any repercussions (of not getting the first two months of payments) as a result of being notified of a claim late — i.e. outside of a 2 month limit. The Complainant says that it is therefore not correct for the Company to state they did not penalise her employer for the late submission as there is no such entitlement for them to do so under the Policy Document.

The Complainant states that she was in no way responsible for the delay in submission of the claim form to the Company. The Complainant submits that although she had been on sick leave since October 2013, it was not until 11 April 2014 that her employer asked her to complete the Claim Form urgently (which she says she did that day). The Complainant states that the reason she was given for the urgency on this was that the benefit payment under this policy should have commenced from 7 April 2014. The Complainant states that if she had been provided with a Claim Form at an earlier date, she would have completed same promptly also.

As regards the reference to "NEW PHI CLAIM!" the Company states that the exclamation mark only denoted that activity was required on the part of the e-mail recipient.

The Complainant states that she believes this is not a full explanation on this as in the response to her solicitor the Company stated that there was 'no reason to believe that an exclamation mark on an internal email would indicate an adverse comment in relation to your clients claim or PHI claims in general'. The Complainant says that she does not accept this explanation since she considers this inappropriate in a professional environment.

The Company's reason for the examining assessors non acceptance of copies of X-Rays confirming the Complainant's significant surgery, is that the Company is not disputing the surgery, and the x-ray images are not indicative of pain or disability levels or a measure of the current pain symptomatology.

The Complainant's position on the X-Rays is that a medical opinion is based on a number of factors one of which is obviously the person's clinical history. This is something the Company actually state in its 12 May 2015 letter where it states that 'Dr G's ...opinion... was based on' factors including 'a clinical history. The Complainant submits that no words can do justice to the extent of the surgery she went through and she believes both Dr G and the Assessor should have requested / accepted copies of these x-rays from her to see the extent of the surgery for themselves to ensure that all parties had a full and accurate picture of her case. The Complainant states that surely these x-rays form a very important part of her clinical history as they show the underlying cause for her chronic pain and the significant underlying pathology that Dr M referred to in his 12 May 2014 letter. The Complainant states that furthermore, following the Assessor's declining to take copies of these x-rays from her in the December 2015 CPAD assessment. The Complainant had submitted copies of these x-

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rays (along with copies of photos of her surgery scars) to the Company on 21 December 2015.

The Company's position is that the CPAD assessment was required due to the conclusion by the Complainant's doctor that she was "deconditioned" and that this indicated there was an opportunity for rehabilitation. The Complainant had expressed concerns about the CPAD and the Company says that it responded to the administrator of the scheme regarding same.

The Complainant's position on the above is that here the Company is attempting to justify its decision to send her to their CPAD assessment by saying that because Dr M's November 2015 report contained a reference to her being 'deconditioned' (when he says "As a result of [the Complainant's] ongoing pain she remains physically and psychosocially deconditioned') this indicates in the Company's opinion that there is an opportunity for rehabilitation and improvement (something that Dr M most certainly did not say in his report). The Complainant says that given this misplaced assertion, the Company then go on to say that it was reasonable to request a CPAD as it 'in part focuses and comments on suitable areas of rehabilitation'.

The Complainant submits that as seen from the Assessor's report, there is almost no information in his CPAD report relating to suitable areas of rehabilitation. The only reference which one might construe as relating possibly to rehabilitation is the brief reference in the conclusions to potential ergonomic adaptations available on the market. The Complainant says that every other part of this report deals with the Assessor following the Company's instruction (as is stated in the opening section re: Statement of Aim) 'to assess the individual's ability to perform tasks within her home and work environments'.

The Complainant states that she feels that the Assessor's purpose of the CPAD assessment certainly was not to help support her or advise on rehabilitative measures.

As regards the extent of the information that was supplied to the Complainant following the data request, and the position that a jointly held policy information was also provided, the Company states that in an effort to fully supply all personal data that policy information was given to the Complainant. The Company says it provided an explanation and apologised. The Company says it understands that the Complainant is pursuing this matter further with the Data Protection Commissioner. The Complainant states that this should not distract from the adjudication. I can confirm that it does not prevent an adjudication on the substantive complaint.

The Company advise that the funding of an early pain management programme was explored, but as the advice received was that it was only run on public basis, the opportunity to expedite involvement in the course was not possible.

Following the decision to end benefit payments an additional three months partial benefit to facilitate a phased return to work was offered by the Company. Cognitive behavioural therapy sessions were also offered. In January 2016 the Company offered 4 months benefit to facilitate a phased return to work programme. The Company state that no response was received from either the Policyowner or the Complainant.

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The Complainant's response to the above the offer of 8-10 sessions of Cognitive Behavioural Therapy (CBT) was, that this was unhelpful and futile. The Complainant states that given her condition, no number of CBT sessions would enable her to return to her occupation. The Complainant states that as part of the Pain Management Programme she studied CBT and found it extremely interesting and would be interested in studying CBT further to help her deal with things like negative thinking and learn ways to try to focus her mind on something other than pain most of the day, but says that unfortunately sitting in a group chatting with a therapist about her feelings will not cure her chronic low back pain.

As regards the rehabilitation offers (of three months partial benefit to the Complainant and separately four months benefit to her employer) the Complainant states that these are unhelpful as they are offered as a precursor to phased return to work which is something that is simply not possible. The Complainant states that evidence that a return to work is not possible is clearly demonstrated by the fact that she took three months unpaid leave from work (in July, August and September 2013) in an attempt to address her chronic low back pain. The Complainant's position is that when this proved unsuccessful she went to her GP who signed her out as unfit for work from 7 October 2013.

The specific policy provision which the Provider is relying upon for denial of the claim is Section 5.1 (a) of the Policy Document which stipulates as follows:

'[The] Insurer will, If a Member becomes Disabled and his disability continues after the end of the Deferred Period, pay the Benefits to the Policyholder in accordance with this Fifth Schedule from the end of the Deferred Period until whichever is the earliest of:

(a) ...the date on which the Member, in the opinion of the Insurer's Chief Medical Officer, ceases to be Disabled even if the Member's position is no longer available
(b) The date on which the Benefits ceases to be payable in accordance with Provisions 5.4 or 5.5
(c) ….'.

The Company's position is that it considers that the Complainant no longer meets the policy criteria for claim payment following receipt of a medical report from Dr G, Specialist in Occupational Health, dated 17th December 2014. The Company states that further to an appeal of this decision, the Company requested that the Complainant undergo a CPAD assessment, which took place over a 2 day period. The Company say that the finding of the assessment also supported the decision to continue to cease payment of benefit due to the policy condition of 'total incapacity' not being met.

The Complainant's position is that the relevant section of the Policy Document has been incorrectly quoted here by the Company.

The Complainant states that the correct provision is Provision 5 which states the following:

> *'[T]he Insure will, If a Member becomes Disabled and his disability continues after the end of the Deferred Period, pay the Benefits to the Policyholder in accordance with this Provision 5 from the end of the Deferred Period until whichever is the earliest of:*

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... the date on which the Member, ceases to be Disabled'.

The Complainant states that this is the decision she is asking for adjudication on since the medical evidence she believes shows that she continues to meet the definition of Disabled under the policy.

The Complainant states that the Policy Document does not contain the term total incapacity, a term which the Company is quoting. The term Disabled is defined as being 'totally incapable by reason of illness or injury of following his normal Occupation'.

The Company states that a gross payment of €30,102.36 was made to the Policyowner.

The Complainant states that it appears that the Company used an incorrect Pensionable Salary figure (of €45,000 per annum) to calculate her benefit as the policy document clearly states (in Schedule A under the definition of Income Benefit) that her benefit should have been based on Pensionable Salary which would have been higher than this as it should have also included (along with the Basic Salary) an amount representing the average of three years of fluctuating emoluments. The Complainant states that the correct figure that should have been used for Pensionable Salary should have been €52,666.67 not €45,000 as the Company had used.

The total net income benefit payment (i.e. the after tax income) that she received over the 9.8 month period was €14,274.35.

Despite the Company's positon on advising the Complainant / scheme administrator of the appeals process, the Complainant states that she does not believe that the information provided to her on 7/8 January 2015 included sufficient details on the appeals process. The Complainant's position is that the workings of the appeal process was not communicated to her, to her GP or to her pain specialist at the time cessation of benefit payments was communicated.

As regards the Company's statement that the: ***'decision may be appealed through the submission of medical evidence which states that the claimant is completely incapable of carrying out their occupational duties as a result of an ongoing medical condition'****,* the Complainant submits that this misrepresents the definition of Disabled as per the Policy Document which states that Disabled is when a Member is *'totally incapable by reason of illness or injury of following their normal occupation'.*

The Complainant states that this text should read as follows to be in line with what was communicated to her on 7/8 January 2015 - the *'decision may be appealed through the submission of medical evidence supporting your appeal'*.

The Company states the following, in relation to medical evidence: *"Medical evidence submitted during an appeal must provide a detailed explanation as to the factors rendering the claimant incapable of working. Confirmation of a diagnosis in itself is not sufficient."*

The Complainant states that it should be noted that this is not something which was ever communicated to her by either the Company or the administrator of the scheme. The

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Complainant's position is that had the Company communicated this to her back then she could have requested this specifically from her doctor.

The Company refers to the deferred period as being on Section 1.10 of the Policy Document. The Complainant states that it is Schedule A (part 1) not Section 1.10 of the Policy Document that defines the 'deferred period' as 'any period of 26 consecutive weeks during which the Member has been Disabled'.

The Complainant states that Section 5.1 of the Policy Document is incorrectly quoted by the Company as it does not include the text at the end saying 'to the Policyholder'; it states the following: *'the Insured will, if a Member becomes Disabled and his disability continues after the end of the deferred period, pay the Benefits'.*

The Complainant states that Section 5.9.1 of the policy document covers the late notification of benefit; it states that: 'Written notice shall be given to the Insurer at least two months before Benefits are due to commence'. The Complainant's position is that there is nothing stated about any repercussions (in terms of the first two months of benefit) as a result of being notified of a claim outside of the required 2 month limit. The Complainant states that it is therefore not correct for the Company to state it did not enforce the policy conditions in this regard as there are in fact no such policy conditions to enforce.

The Complainant states that there is insufficient evidence from the documents provided to show what role the CMO has had over this time period. The Complainant states that she is still surprised to see from this 'complete' file that there is no written evidence that the CMO made the decision around her eligibility for the benefit or in fact had any input in to the decision that her benefit should be ceased.

The Company refer to the policy being issued to the Policyholder (the employer). The Company explain that no premium is received from the Member of the scheme (the Complainant here) and benefits are paid directly to the employer. The Company states that it is not obliged to pay benefits to the member and refer to clause 5.0.1 of the Policy Document.

The Complainants response to the above is that clause 5.9.1 referred to does not exist in the policy document. The Complainant states that the Policy Document says the Company agrees to pay the benefits but it does not say to the Policyowner (her employer). The Complainant states that therefore she cannot see where it is stated that the Company could not make payments to the member directly.

The Complainant states that, as seen from the Schedule of Evidence, she was provided with a form (on claim admittance) that she could have opted to complete to instruct that payments be made directly to her rather than through the employer's payroll. The Direct Credit Option as it is called requires bank details and hence the requirement to complete a form if one elects this option. The Complainant states that she did not elect to avail of this option; but that she opted to have payments made to the employer and then on to her via their payroll.

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Analysis

With regard to the professionalism of the doctors who assessed the Complainant and the manner in which they carried out their assessments, it would be expected that such trained professionals would carry out their work in an unbiased, diligent and professional manner.

I cannot comment on the ability or expertise of a medical practitioner acting in that capacity in particular in their examination of a patient / claimant and submission of medical opinion. If a patient or claimant has any issues with a doctor there is another body (Medical Council) who may investigate such matters. On the basis of the doctors taking comprehensive histories and providing their considered reports and in general acting in a professional manner, their objectivity is accepted by me.

As regards the Complainant's issues about her request for information from the Company, any issue with respect to the release of personal data should be referred to the Data Protection Commissioner, who are the appropriate body to deal with such complaints. I understand that the Complainant has brought her concerns regarding the release of information to the Data Protection Commissioner.

In relation to the substantive matter which this office could investigate, it is my Legally Binding Decision that, on the balance of the evidence, the income benefit should not have ceased, but that greater enquiries could have been made by the Company in relation to the Complainant's capacity for work. I also consider that there were failings by the Company in its general administration of this claim and in relation to complaint that arose.

The Company in its response to the complaint (dated 10th April 2017) quoted policy provisions that were not contained in the policy document the Company had provided to this office or in the policy document it had provided to the Complainant. The Complainant queried this in May 2017 upon receipt of the Company's response, but without any clarification from the Company. This office also queried the position on 7th December 2017. The Company's response was that: *"A copy of the Policy Document provided to the Financial Services Ombudsman on 10th April 2017 details the relevant policy terms and conditions".* This office further sought clarification on the matter from the Company on 13th December 2017, and in the Company's response of 19th December 2017 it advised as follows:

> *"Having reviewed this file, I can confirm that although [the Company] relied upon the correct and relevant policy wording in our submission of 10th April 2017, we in error provided the original policy document to both the Complainant and the Financial Services Ombudsman Bureau. While the wording differs, the material impact of the changes did not affect the ongoing assessment of this claim or our decision regarding the payment of benefit. I wish to express my sincere apologies to both the Complainant and the Financial Services Ombudsman Bureau for this error".*

It was most disappointing that the Company did not check this matter when it was first brought to its attention by the Complainant in May 2017 and later by this office. The Complainant has also highlighted correspondence that indicates that the Company also failed to provide the updated policy to the Broker to the Scheme and to the Policyowner

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(the Complainant's employer). This failure by the Company added to the time it has taken to finalise the complaint and has caused the Complainant additional concerns about the administration of her claim by the Company. The Complainant's submissions outlined above clearly shows what unnecessary confusion the difference in policy wording has caused.

Section 5.1 of Fifth Schedule of the policy sets out the criteria for payment of benefit as follows:

> *"Subject to the provisions of this policy, the Insurer will, if a Member becomes Disabled and his disability continues after the end of the Deferred Period, pay the Benefits to the Policyholder in accordance with this Fifth Schedule from the end of the Deferred Period until whichever is the earliest of:*
>
> *(a) Subject to Provisions 5.4 and 5.5, the date on which the Member, in the opinion of the Insurer's Chief Medical Officer, ceases to be Disabled even if the Member's position is no longer available.*
> *(b) The date on which the Benefits ceases to be payable in accordance with Provisions 5.4 or 5.5*
> *(c) ….'.*

The Complainant questioned the limited role that the Company's Chief Medical Officer appeared to play in the decisions on her claim.

The Company's response to this concern was that:

> *"[T]he Chief Medical Officer acts in a consultancy capacity to the Claim Assessor. He provides a professional medical opinion when it is deemed necessary and appropriate by the Claims Assessor. The role of the Chief Medical Officer is not detailed in the policy document nor is this role documented in the previous submission to the Financial Services Ombudsman Bureau".*

The Company's Chief Medical Officer also provided the following information in a correspondence dated 4th January 2018:

> *"I act in an advisory capacity to the [the Company's] Underwriting and Claims Departments.*
>
> *I delegate my authority to the Underwriting Manager and the Claims Manager at their discretion as it is not practical for me to review every piece of medical evidence received by [the Company]"*

With regard to the Income Protection claim, it is the Company's stated position (in the policy provisions quoted above), that it relies on the opinion of the Company's Chief Medical Officer in relation to the claim. I therefore accept that it is reasonable that the Complainant would have expected that the Chief Medical Officer would have had a direct role in deciding that her incapacity had ended. I accept that a Chief Medical Officer would play a role in interpreting medical reports compiled by specialist consulting doctors. A Chief Medical

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Officer could assist the Claim Assessors in assessing an Insured's condition by providing medical expertise in relation to the illness or injury, that the benefit is being claimed for.

I accept that it may not be practical for a Chief Medical Officer to be involved in all stages of the claim process, but I do consider that where a policy specifically provides that benefit will end when it is *"the opinion of the Insurer's Chief Medical Officer"*, that the Insured ceased to be Disabled, that such opinion should come directly from the Chief Medical Officer and be duly evidenced on the claim file.

I therefore consider that it was reasonable of the Complainant to expect to see greater evidence of the Chief Medical Officer's involvement at such key stages of the claim assessment. I accept that such evidence is lacking on this claim file. The only evidence of the Chief Medical Officer's role in this claim is his decision to send the Complainant for a Chronic Pain Assessment Determination (which was dated after the commencement of the Complainant's CPAD assessment).

The Complainant's specialist is a Consultant in Interventional Pain Medicine and he provided his opinion on the Complainant's capacity for work – that is that she was incapable of returning to work. I accept that the Company's action in arranging a CPAD assessment, and in having an assessment of the Complainant carried out by the Specialist in Occupational Health would not have been incorrect assessments to have arranged. However, I consider that, in addition, the Company, could reasonably have arranged for a comparable Specialist to that of the Complainant's own specialist, who specialised in the area of spinal injury or pain management to provide an opinion as to the Complainant's fitness to work.

What I also find missing in this claim process is a greater explanation from the Employer to the Company (at the Company's request) as to amount of time an employee such as the Complainant would be sitting when carrying out their occupational role. I would have expected to see stronger evidence of the Complainant having good ability for sustained sitting, the Complainant's own evidence is that prolonged sitting results in the Complainant experiencing increased pain intensity.

I accept that greater objective evidence of the Complainant's capabilities relative to her work activities was required in this claim, prior to any cessation of benefit.

While I note that the Complainant's employer appears to have been willing to discuss a return to work and to take into consideration the suggested modifications recommended by the Specialist in Occupational Health, there is no indication as to whether there would be a monetary disadvantage for the Complainant if her capacity for the role had diminished. For instance, the additional time / breaks away from the desk duties etc. or any reductions in her role because of her medical needs.

Without these greater enquiries by the Company in its assessment of this claim, and having regard to the other administration failings identified above I accept that the Complainant is entitled to be paid Benefit from the date of the Company's termination of the claim, and into the future. Therefore, it is my Preliminary Decision that the complaint is upheld and the

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Company is to pay the amount it would have had to pay had it not unreasonably ceased benefit.

As regards the benefit payment amount and whether it was correctly paid in line with the policy provisions, the Policy document states in the *"Addendum to the First Schedule"* that:

"1.12 **"Salary"** of a member means his basic annual salary, excluding overtime and fluctuating emolument, at the last renewal date.

1.13 **"Income Benefit"** in respect of a member means 2/3 of Pensionable Salary at last Renewal Date".

The Policy does not set out what is meant by "Pensionable Salary". However, the policy that had been previously submitted into evidence by the Company states that Pensionable salary is ***"defined as annual basis salary plus the average of fluctuating emoluments from the past three years"***.

In the absence of a definition of "Pensionable Salary" or any evidence that a change in how "Income Benefit" was to be calculated being correctly communicated to the Complainant, I consider that the existing definition of "Pensionable Salary" should be applied to this claim. I therefore also find that, using that definition, the Complainant is to receive from the Company the difference that should have applied to the benefits already paid by the Company.

I also consider that a compensatory payment for the additional inconveniences to the Complainant, caused by the Company's identified failings, should be paid here. I deem that compensatory payment to be €8,000 (eight thousand euro).

In accordance with the Policy provisions, the Company remains entitled to review the Complainant's claim on an ongoing basis and I direct that if the Company does wish to carry out such a review it is to first arrange for a specialist, who specialises in the area of spinal injury or pain management to provide an opinion as to the Complainant's fitness to work. The Company should also establish what the employer requires from the employee when carrying out her role, in its fullest sense. The stated psychological impact of the Complainant's medical disorder should also be examined. In this regard I would ask the Complainant to note that income protection benefit is not a guaranteed payment, but subject to review by a Company to assess whether the claimant continues to satisfy the policy criteria for payment. I accept that this was made clear throughout the claim process here and in the Company's communications with the Complainant.

It is my Legally Binding Decision that the complaint is upheld.

Conclusion

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

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- 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 payment of benefit, 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 by 35 days after 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 OMBUDSMAN

19th February 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.