



<u>Decision Ref:</u>	2018-0093
<u>Sector:</u>	Insurance
<u>Product / Service:</u>	Income Protection and Permanent Health
<u>Conduct(s) complained of:</u>	Rejection of claim - fit to return to work
<u>Outcome:</u>	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant was employed as a Claims Manager with her former Employer from May 2012 to 30 June 2016. This Employer was the policyholder of a Group Income Protection Policy with the Provider and the Complainant, during her time as an employee, was an insured person under this policy.

The Complainant's Case

The Complainant was employed as a Claims Manager with her former Employer from May 2012 to 30 June 2016.

In her correspondence to this Office dated 8 December 2016, the Complainant sets out her complaint as follows:

"I worked for [my former Employer] for just over four years. I received exemplary reviews and was well regarded. Unfortunately, a situation arose, where, over a sustained period of time, I was subjected to bullying and intimidation by my line manager, which eventually led to my suffering depression, anxiety attacks, severe sleep deprivation and ultimately thoughts of suicide, at which point I knew I needed to get medical help. I received medical and psychological help and have over a long period of time, improved significantly, although returning to work with [my Employer] was impossible, as they were insisting that I return to work with the same line manager.

The terms of the [Provider]'s policy for protection of income are that the policy comes into play, if an employee has been absent from work for six months. [My Employer] has accepted that my illness was genuine and had received continuous sickness certificates from the two GPs who were treating me and had paid me my full salary and benefits for the first six months of my illness. The final date of [my Employer]'s payment to me was the end of October 2015. They submitted my claim to [the Provider] in November 2015 ...

Unfortunately, [the Provider], obfuscated and delayed for six months, eventually denying my claim, after I had informed them that I was returning to work (I was back on [my Employer]'s payroll using up annual leave). I had tried to convince myself that I was well enough to return to work, but another 'breakdown' showed me that I wasn't and [my Employer] and I eventually came to a settlement that terminated my employment with them as of July 2016. The reason that I had tried to force myself back to work, even though I was not well enough, was that [the Provider]'s delay in paying my claim and eventual denial of it, had left me in severe financial hardship ...

Firstly, my claim is completely genuine. Three GP's and the psychologist who was treating me at the time and still is, were in complete agreement with each other as to my symptoms and the treatment including medication and psychological counselling. Two of the GP's are the two doctors from my local practice and the other GP was hired by...my employer to provide an independent assessment of me. That doctor...examined me ten days after [the Provider]'s paid psychiatrist and was in complete agreement with my own two doctors. The psychologist who examined me expressed my condition as a 'deep depression' in his letter to [the Provider] submitted as part of my appeal. [The Provider] calls these four medical opinions, 'subjective' and completely dismiss them as medical evidence submitted in support of my claim. They refer to their one, psychiatrists report, following his examination of me as 'objective' evidence and make it clear that despite asking me to submit any medical evidence I have supporting my claim, they are choosing to ignore those four medical opinions of my illness. As you will see from their letters to me of 29th April 2016 and 16th November 2016, [the Provider] choose instead, to concentrate on the causes of my illness, i.e. the work place 'dispute'/bullying that led to the illness, rather than the symptoms I was suffering. That is, [the Provider] say,

"the decision to cease work was against the background of a work grievance".

If this logic is followed, it must mean that the three GPs and psychologist who all treated or examined me were all wrong in their assessment of me. Are [the Provider] seriously saying these four professionals all got it wrong, or are all incompetent at their professions? Their assessments of me are dismissed in their entirety. I believe [the Provider] chooses to focus on the cause of my illness, as a cynical ruse to deny my claim...If I had, for example, during my employment with [my Employer], completed a physical activity that left me paralysed and unable to work, [the Provider] would not be able to either deny the symptoms of my paralysis or deny my

/Cont'd...

claim because the activity I had been doing had caused my disability. They would have to pay my claim, because my symptoms meant I was unable to work.

Yet in this case, they are completely focusing on the cause of my illness, i.e. my dispute with my employer over the work place bullying and intimidation and completely ignoring the end result of that, i.e. my physical symptoms of depression and anxiety etc. I just cannot see how [the Provider] can ignore four medical opinions that are in complete agreement with each other and instead only look at the 'trigger' of the illness. I am not denying for a moment what the cause of illness has been, I know it only too well. My claim is for compensation under [my Employer]'s policy...because my physical symptoms left me unable to work".

In addition, the Complainant states that the Provider were first informed of her claim by her Employer in October 2015 but that it delayed in assessing her claim insofar that it was 1 February 2016 before she attended for a medical examination arranged by the Provider and then it was *"after further chasing from me by email, [the Provider] finally issued their decision on 29th April 2016, six months after first notification of my claim"*.

The Complainant notes that *"the financial loss I have suffered is loss of five months' salary and pension benefits at 75% reimbursement"* and seeks the *"full reimbursement of this lost salary and pension contributions"*, which she calculates to be €33,750 in total.

The Complainant's complaint is that the Provider wrongly or unfairly declined her claim and also that the Provider delayed unduly in assessing her claim.

The Provider's Case

The Complainant was employed as a Claims Manager with her former Employer from May 2012 to 30 June 2016. This Employer was the policyholder of a Group Income Protection Policy with the Provider and the Complainant, during her time as an employee, was an insured person under this policy.

Provider records indicate that the Complainant completed a Claim Form on 18 November 2015, detailing her illness as *"suffering depression and acute anxiety symptoms, including palpitations, disrupted sleep (sometimes no sleep for days) and panic attacks, brought about by the bullying and harassing of me, by my line manager who is also the CEO...The first anxiety attacks and leave of absence I had was a two week period from 23/01/15. The second period has been from 24/04/15, to date. I have been attending my doctors regularly and have received counselling. My condition is continuing but has stabilized, although I still suffer occasional anxiety attacks"*.

The Provider previously received an Employer Claim Form dated 15 October 2015 wherein the Complainant's Employer advised that the Complainant was unfit for work due to *"work related stress"* from 27 April 2015. The Provider notes that as the policy has a 26 week deferred period, which ended on 27 October 2015, the first date for which cover could commence from was 28 October 2015. The Provider notes that ideally it should have

/Cont'd...

received notification of this claim in June or July 2015 so as to afford it the opportunity to fully consider the claim prior to the end of the 26 week deferred period.

In order for a claim to be payable, the Provider notes that the claimant must satisfy the policy definition of disablement, as follows:

“The member’s inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury; upon occurrence of which the benefit under the policy becomes payable, after the deferred period. The member must not be engaged in any other occupation”.

The Provider received a Practitioner Report dated 17 December 2015 from the Complainant’s GP, Dr S., who detailed the nature and cause of the Complainant’s disability as *“Acute work related stress and anxiety caused by alleged work place bullying”*, indicated that the expected duration of absence was between 0-3 months and advised *“I would anticipate resolution of her problems with the resolution of her work related problems. She is attending psychotherapy”*.

The Provider states that it is not concerned with the cause of the psychiatric symptoms, rather its sole aim is to evaluate whether these psychiatric symptoms are disabling enough to the extent that they prevent the Complainant from working, which is the essence of income protection and how not just the Provider but all insurers assess claims of this nature. In order to assess the Complainant’s claim and establish if she met the policy definition of disablement, the Provider arranged for the Complainant to attend an independent medical examination with a Consultant Psychiatrist, Dr D., on 1 February 2016. The ensuing report received from Dr D., dated 1 February 2016, provides, as follows:

“Mini-Mental State Exam Test:

This is a test of cognitive functioning and includes measures of orientation in time and place, recall and memory, language and reading comprehension.

[The Complainant] scored 30 out of 30 items on this test.

Test of Executive Functioning:

[The Complainant] satisfactorily performed the Clock Test, a screening test of Executive Functioning.

Mental State on 01/02/2016:

[The Complainant] presented for interview appropriately dressed and groomed. She had driven to the appointment and was early. She was very pleasant and courteous in manner and cooperative to the interview process.

She appeared slightly tense at the outset, but relaxed as the interview proceeded. She did not appear depressed or anxious. There was no evidence of psychosis and she

/Cont’d...

was not suicidal though she has some suicidal thoughts early on in the development of her symptoms.

She was well oriented. Her concentration and memory appeared normal and she was judged to be of higher than average intelligence.

Conclusions/Opinion:

In the context of perceived bullying by her line manager, [the Complainant] developed an emotional reaction which included low mood, anxiety symptoms and poor sleep.

The main obstacle to her return to work is the apparent impasse between herself and her employers where they are insisting that she will have to again report to the same manager (she perceived bullied her) and work in the same office with her.

[The Complainant] is experiencing anticipatory anxiety regarding this proposal.

[The Complainant]'s current symptoms do not cause her to be unable to perform the duties of her occupation.

[The Complainant] is not unable to perform the material and substantial duties of her normal insured occupation as a result of psychiatric illness or injury”.

The Provider understood that the Complainant had an assessment carried out at her Employer's request and it requested a copy of this report, which it received on 24 March 2016 and provided to Dr D. for him to review. The Provider then received an additional report dated 27 March 2016 wherein Dr D. advised *“I remain of the opinion that [the Complainant] is not unable to perform the material and substantial duties of her normal insured occupation as a result of psychiatric illness or injury”.*

As a result, the Provider advised the Complainant's Employer by way of correspondence dated 29 April 2016, as follows:

“Based on the evidence received throughout the claims assessment, I regret to advise we are unable to consider [the Complainant]'s claim for Income Protection benefits. [Independent Medical Examination] findings indicate that [the Complainant] is currently fit to carry out her normal occupation. There is no objective evidence or diagnosis of disabling illness that is preventing her from performing the material and substantial duties of her normal occupation. The main obstacle regarding her inability to work [is] related to a work place dispute and she has now informed [the Provider] of her return to work with [the Employer]. There is no evidence to suggest she had a disabling medical illness preventing her from working”.

The Provider must be guided by the weight of objective medical evidence and in this regard the Consultant Psychiatrist, Dr D. indicated that the Complainant was fit for work. In addition, the Complainant's GP, Dr S., indicated that the Complainant would be able to

/Cont'd...

perform her job once the work-related issues were completely resolved. The Provider acknowledges that the Complainant may have some residual symptoms, however it is satisfied that these are not disabling in nature.

The Provider notes that this is a particularly complex case. It had to determine whether the Complainant was medically fit to work at the end of the deferred period in October 2015. It therefore assessed the evidence submitted to make a retrospective decision.

In particular, the Provider notes that the Complainant's GP, Dr S., states in the Practitioner Report dated 17 December 2015 that she last saw the Complainant in early October 2015 at which time *"I would anticipate resolution of her problems with the resolution of her work related problems"* and that *"[the Complainant] would be able to perform her job once work related issues are completely resolved"*. The Provider contends that this is an important statement from the Complainant's GP as it implies that the work-related grievances are the core reason for the Complainant's absence and not a disabling medical complaint. In this regard, the Provider submits that if the Complainant had a genuine disabling medical complaint, then it is unlikely that the resolution of any work issues would have enabled her to return to work as the disabling psychiatric illness and symptoms would be the core reason preventing her from working.

The Provider further submits that the interview with the Consultant Psychiatrist, Dr D. and the Complainant's responses give further insight into why the Complainant was not working at that time, as follows:

"[The Complainant] was read the [Provider] definition of disablement and was asked specifically is she regarded herself as unable to perform the material and substantial duties of her normal occupation as a result of illness or injury. She emphatically replied, "Yes..."

Asked to elaborate, she said "That job was incredibly demanding...making decisions all day long...when I go to the supermarket, I can't [make] decisions...my decisions at work involved millions and millions of dollars..."

They're insisting I go back to work with that woman (her line manager who is also the CEO)".

The Provider is satisfied that it is clear from the Complainant's responses that she describes no symptoms of an illness which could be construed as disabling. Her responses instead highlight that she ceased working because of the work demands and the relationship she had with her line manager. Whilst it acknowledges that there were some reactive symptoms secondary to the work place issues when Dr D. reviewed the Complainant, the Provider is satisfied that these were considered mild at best and not disabling. In any event, the Provider notes that the diagnosis of a condition does not of itself automatically equate to disability or satisfy the policy definition of disablement.

The Provider states that it is satisfied that the overall weight of evidence does not demonstrate that the Complainant had a disabling medical complaint, rather her absence

/Cont'd...

from work was due to a grievance which on resolution would enable her to return to work and that the Complainant's GP, Dr S., confirmed this when she completed the Practitioner Report dated 17 December 2015.

The Complainant submitted an appeal in October 2016 and provided reports from her GP, Dr K. and Mr O'R., her Counsellor. The Provider notes that the letters submitted to support this appeal cannot be used retrospectively as the Provider was considering a claim for the period from 28 October 2015 to 30 June 2016, when the Complainant's employment was terminated. The Provider can only make a judgement on fitness for work based on the objective evidence it had at that time.

Whilst the independent medical examination was carried out subsequent to the initial period of liability, the Provider does not believe that the outcome would have been any different even if the independent medical examination had been arranged earlier. The Provider acknowledges that there were some service delays on its behalf incurred during the claims process which was due to a high volume of claims and it apologised to the Complainant for this. However, it states that these delays did not have any bearing on the claims decision.

In conclusion, the Provider asserts that it is satisfied that the independent medical evidence shows that the Complainant's absence was more related to a longstanding work dispute rather than an objective medical complaint. The Provider considers that the Complainant's GP alludes to this also. As a result, the Provider concluded that the Complainant never met the policy definition of disability and it is satisfied that in declining the claim that the Provider administered the policy in accordance with its terms and conditions. The Provider does acknowledge that there were some service delays on its behalf incurred during the claims process which was due to a high volume of claims and it has apologised to the Complainant for this.

Having considered the circumstances of the complaint in full, the Provider, in its email to this Office dated 5 December 2107, advised *"we would like to place an offer of €5k on the record in full and final settlement of the claim"...*

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

/Cont'd...

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 10 August 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, my final determination is set out below.

The complaint at hand is, in essence, that the Provider wrongly or unfairly declined the Complainant's disability claim made under her Employer's Group Income Protection Policy and, in addition, that the Provider also delayed unduly in assessing her claim.

In this regard, the Complainant was employed as a Claims Manager with her former Employer from May 2012 to 30 June 2016. This Employer was the policyholder of a Group Income Protection Policy with the Provider and the Complainant, during her time as an employee, was an insured person under this policy.

I note that the Complainant's absence commenced on 27 April 2015. As the Employer's Group Income Protection Policy has a 26 week deferred period, the first date for which cover could commence from was 28 October 2015.

In order for a claim to be payable, the claimant must satisfy the policy definition of disablement. In this regard, the Policy Conditions of the applicable Group Income Protection Policy booklet defines 'Disability' at pg. 4, as follows:

*"The member's inability to perform the **material and substantial duties** of their normal insured occupation as a result of their illness or injury; upon occurrence of which the **benefit** under the **policy** becomes payable, after the **deferred period**.*

*The **member** must not be engaged in any other occupation".*

I note from the documentary evidence before me that the Complainant completed an Employee Claim Form on 18 November 2015, wherein she described her illness at pg. 3, as follows:

"I have been suffering depression and acute anxiety symptoms, including palpitations, disrupted sleep (sometimes no sleep for days) and panic attacks, brought about by the bullying and harassing of me, by my line manager who is also the CEO...The first anxiety attacks and leave of absence I had was a two week period from 23/01/15. The second period has been from 24/04/15, to date. I have been

/Cont'd...

attending my doctors regularly and have received counselling. My condition is continuing but has stabilized, although I still suffer occasional anxiety attacks ...

The Complainant also provides the following additional information at pg. 10 of this Employee Claim Form, as follows:

“The situation with my health and being unable to work has been caused by the bullying and harassment of me by my line manager who is also the CEO of [my Employer]. I was ignored and isolated and made to feel extremely vulnerable and unwelcome in the office. The perpetrator of this also instigated an internal investigation into me which left me completely traumatised. I was subsequently cleared of every accusation.

I had transferred to London, away from the Dublin office and had hoped the bullying and harassment by my line manager/CEO would stop, but it continued. I was reduced to tears, or left feeling teary most days. I didn't sleep properly for over a year and was constantly worried about what this abusive behaviour towards me would lead to next. I believe this person was/is determined to drive me out of the Provider. I was told by H.R. that the only way this could be dealt with was to bring an official grievance for bullying against my line manager. This whole situation has left me devastated, depressed and has had a hugely negative impact on my confidence. I have a job I love, despite everything and am very good at it. I am doing everything I can to try to get back to normal health, but I feel physically sick every time I think of having to be around this abuser again and lie awake at night worrying constantly about having to be back in this situation. My confidence has been completely undermined by everything that has happened and I still have days where I can't even get out of bed.

I sometimes don't leave my home for days on end and find meeting new people to be particularly difficult, because of my lack of confidence. I have to force myself to take part in social events with my partner and sometimes I just can't. I often have trouble concentrating and find it difficult to make decisions”.

I note that the Employer Claim Form completed on 15 October 2015 advises that the Complainant was unfit for work due to “work related stress” from 27 April 2015.

Furthermore, I note from the documentary evidence before me that the Complainant's GP, Dr S., in correspondence to the Complainant's Employer dated 10 August 2015, advises, as follows:

“[The Complainant] first attended me on 23rd January 2015 having experienced severe anxiety related symptoms that she left were related to a work situation where she was experiencing bullying and harassment. She was found to be experiencing very high levels of anxiety characterised by palpitations, disrupted sleep, panic attacks and depression. She was started on appropriate medication. In addition, she was referred for psychotherapy which she has been attending regularly. [The Complainant] has no previous history of anxiety or depression.

/Cont'd...

She has attended us for review on approximately a monthly basis going forward.

[The Complainant] is in excellent physical health. However, the psychological impact of both the difficult situation at work and the ongoing resolution process has significantly affected her capacity to perform her duties as an Insurance Claims Manager. I feel that were this situation resolved in full then [the Complainant] would be able to carry out her work duties”.

In addition, I note that the Provider received a Practitioner Report dated 17 December 2015 from the Complainant’s GP, Dr S., who detailed the nature and cause of the Complainant’s disability as “Acute work related stress and anxiety caused by alleged work place bullying”, indicated that the expected duration of absence was between 0-3 months and advised that the Complainant “would be able to perform her job once the work related issues are completely resolved.

I would be uncertain about the possibility of her continuing to work with [the Employer]. She would have to decide based on negotiations with them...I would anticipate resolution of her problems with the resolution of her work related problems. She is attending psychotherapy”.

I note that as part of its assessment of the claim, the Provider arranged for the Complainant to attend an independent medical examination with Dr D., Consultant Psychiatrist on 1 February 2016. The ensuing report from Dr D., dated 1 February 2016, provides, as follows:

“Background Summary:

1. *[The Complainant] went off work in her role as Claims Manager with an insurance Provider on 23/01/2015 for 2 weeks following an anxiety attack.*
2. *[The Complainant] had perceived that she was being bullied by her line manager for the previous year and a half, “She sent me to Coventry...” Also, the line manager had initiated an investigation against her.*
3. *In November 2014, she had transferred to the London office, “to get away from the line manager...but she carried on the bullying from a distance...I was home on Fridays and went back to London on Mondays...”*
4. *In or around March 2015, [the Complainant] lodged a grievance following which an investigation took place which found that bullying had not taken place, but the manager needed to improve her management style. She appealed the decision, but her appeal was not upheld. She experienced another anxiety attack in April 2015 and has been on sick leave since 24/04/2015.*
5. *Over this drawn-out period, she had the following symptoms:*
 - *Difficulty with her sleep;*
 - *“Teary a lot of the time at work and outside of work...”*
 - *“Feeling very panicky about things...”*

/Cont’d...

- “No one was listening to me...”
- She had some suicidal thoughts ...

[The Complainant]’s Perception of her Ability to Work:

[The Complainant] was read the [Provider] definition of disablement and was asked specifically is she regarded herself as unable to perform the material and substantial duties of her normal occupation as a result of illness or injury. She emphatically replied, “Yes...”

Asked to elaborate, she said, “That job was incredibly demanding...making decisions all day long...when I got to the supermarket, I can’t [make] decisions...my decisions at work involved million and millions of dollars...”

“They’re insisting I got back to work with that woman her line manager who is also the CEO...”

She had several meetings with the Chair of the Provider and HR. [The Complainant] was upset the investigation of a complaint she had lodged made a finding in March 2015 that no bullying had taken place, but the manager’s management style needed improving and “they’re going to send her on a course...” She had no faith this course will improve matters.

[The Complainant] stated it has been agreed that mediation would be arranged “between her and me...” with the expectation it will take place “within 2 months of my being back at work...”

“I would physically be in the same office as her...that fills me with horror...I dread the idea of it...”

[The Complainant] was asked if it has been mentioned that mediation could take place before she returned to work or exactly on resuming work and she said she had never thought of that, but that it might represent a possible option.

Another aspect of the most recent discussions was that her Provider wish her to remain in the Irish office and the accommodation previously provided to her of working in London will no longer be available.

[The Complainant] sees as a solution that she will report to a different line manager and that “a buffer...” will be placed between herself and the CEO.

Asked what specific targets she had made, she said, “I would like to be back to work in 2 or 3 months if I was well enough...I feel I’m getting there if they would just give me a little bit more time...I’ve thought about writing to the Chairman to reconsider the line management plan and me not having to work in the same office with her...”

When it was put to [the Complainant] that the situation had the appearance of an impasse, she agreed.

Asked if she thought about resignation, she said she had, "but first of all, I have a job I love if I was well enough to do it...I work in a very specialised area...my chance of getting another job are slim to none especially at the salary I'm on...but I'm feeling I haven't done anything wrong...all I did was stand up to a bully..."

[The Complainant] pointed out that her work in the Dublin office is a tiny open-plan office and she would be "yards away from..." the person she perceived was bullying her.

[The Complainant] spoke about her work rate and she was often working from 7 am to 7 pm "trying to keep the lid on my area..." She believed she was short-staffed. "I went outside her to other senior people...that was around 9 months leading up going to London in November 2014...she was absolutely furious with me..."

Her performance evaluations were outstanding ever year, but in December 2014, "she made me be investigated...but I was cleared of everything...I then had a performance evaluation with her in January...that's when I took the sick leave...I had an anxiety attack...I thought it was so inappropriate..."

Asked the solution, [the Complainant] felt she could go back to work and work for another manager. She added, "but I'm fearful of this woman..."

Asked if any legal action was pending, she said, "I am taking legal advice..." ...

Mental State on 01/02/2016:

[The Complainant] presented for interview appropriately dressed and groomed. She had driven to the appointment and was early. She was very pleasant and courteous in manner and cooperative to the interview process.

She appeared slightly tense at the outset, but relaxed as the interview proceeded. She did not appear depressed or anxious. There was no evidence of psychosis and she was not suicidal though she has some suicidal thoughts early on in the development of her symptoms.

She was well oriented. Her concentration and memory appeared normal and she was judged to be of higher than average intelligence.

Conclusions/Opinion:

- 1. In the context of perceived bullying by her line manager, [the Complainant] developed an emotional reaction which included low mood, anxiety symptoms and poor sleep.*
- 2. She had taken 2 weeks off in January 2015 following an anxiety attack.*

/Cont'd...

3. *Following an investigation which did not uphold her claim of bullying, she suffered another anxiety attack for which she went off work on 24/04/2015 from which she had not returned*
4. *[The Complainant] has received appropriate treatment in terms of anti-depressant medication and approximately 10 sessions of counselling (which she had to terminate because of loss of her salary).*
5. *Her symptoms are now mild and quite non-specific.*
6. *Her activities of daily living are quite satisfactory.*
7. *The main obstacle to her return to work is the apparent impasse between herself and her employers where they are insisting that she will have to again report to the same manager (she perceived bullied her) and work in the same office with her.*
8. *[The Complainant] is experiencing anticipatory anxiety regarding this proposal.*
9. *[The Complainant]'s current symptoms do not cause her to be unable to perform the duties of her occupation.*
10. *[The Complainant] is not unable to perform the material and substantial duties of her normal insured occupation as a result of psychiatric illness or injury.*
11. *This statement, of course, comes with the proviso that [the Complainant] is employed in a safe working environment.*
12. *It is in [the Complainant]'s interest to resolve this stand-off between herself and her employers as quickly and as efficiently as possible.*
13. *It would seem preferable to conduct the mediation prior to or at the point of return rather than within 2 months of her actual return.*
14. *Through the mediation, some solid boundaries could be established which could allow for a more satisfactory working relationship.*
15. *There is a reasonable prospect that these arrangements will not lead to a resolution of [the Complainant]'s current difficulty and that these matters will eventually be resolved in the legal arena.*
16. *Her prognosis is good”.*

In and around this time the Complainant's Employer arranged for the Complainant to attend for assessment with Dr C-M., a Specialist in Occupational Health on 12 February 2016. I note that Dr C-M. advises in the ensuing Report dated 18 February 2016, as follows:

/Cont'd...

“[The Complainant] has been certified off work by her GP since April 2015...

She started feeling symptoms about 18 months ago due to a work related situation. In April 2015 she was diagnosed with anxiety and reactive depression. Since then, she has been under medical treatment and counselling prescribed by her own GP (for financial reasons she had to stop attending her counselling appointments). She feels improvement and would like to go back to work but she still feels lack of confidence and fear of going under the management of certain people in the Provider.

My feeling is that it is reactive anxiety – i.e. related to the work situation as opposed to an Endogenous or clinical Anxiety – and so I agree with her own GP regarding medication prescribed, psychotherapy and to continue off work at the moment. I have suggested [the Complainant] to restart counselling ...

However I would suggest the [Employer] to consider [the Complainant] changing team when back to work to prevent further symptoms, as it also might improve her productivity at work.

*In my opinion she is **NOT medically fit** to go back to work at the moment despite partial improvement in her medical condition”.*

I note that the Provider requested a copy of this Report, which it received on 24 March 2016 and forwarded to Dr D., the Consultant Psychiatrist who carried out an independent medical examination with the Complainant on 1 February 2016 at the request of the Provider, for him to review. Following this review, the Provider then received an additional Report from Dr D., dated 27 March 2016, wherein he advised, as follows:

“Having carefully reviewed my Independent Confidential Psychiatric Assessment Report of 01/02/2016 as well as my handwritten notes of that date and [Dr C-M]’s report, I wish to state as follows:

- 1. [Dr C-M.] has diagnosed Reactive Anxiety and I am largely in agreement this was the cause of her absence from work.*
- 2. However, she has had adequate treatment in the interim and her activities of daily living are quite satisfactory.*
- 3. In addition, her symptoms have improved satisfactorily and were, at the time of my assessment, quite mild and non-specific.*
- 4. I noted in my assessment that [the Complainant] was experiencing anticipatory anxiety regarding the proposal that she work in the same office with the line manager she perceived bullied her.*
- 5. The barriers to [the Complainant]’s return to work are industrial relations in nature and as I pointed out in Point 15 of the Conclusions/Opinion of my report:*

/Cont’d...

There is a reasonable prospect that these arrangements will not lead to a resolution of [the Complainant]'s current difficulty and that these matters will eventually be resolved in the legal arena.

6. *Because of the above, I remain of the opinion that [the Complainant] is not unable to perform the material and substantial duties of her normal insured occupation as a result of psychiatric illness or injury.*
7. *This opinion would not, of course, preclude her from availing of counselling on her return to work to deal with any early difficulties”.*

As a result, the Provider advised the Complainant's Employer by way of correspondence dated 29 April 2016, as follows:

“Based on the evidence received throughout the claims assessment, I regret to advise we are unable to consider [the Complainant]'s claim for Income Protection benefits. [Independent Medical Examination] findings indicate that [the Complainant] is currently fit to carry out her normal occupation.

There is no objective evidence or diagnosis of disabling illness that is preventing her from performing the material and substantial duties of her normal occupation.

The main obstacle regarding her inability to work [is] related to a work place dispute and she has now informed [the Provider] of her return to work with [the Employer]. There is no evidence to suggest she had a disabling medical illness preventing her from working”.

I note that the Complainant later submitted an appeal to the Provider in October 2016 and as part of this appeal provided correspondence from her GP, Dr K. and her Psychotherapist, Mr O'R. In this regard, I note that the correspondence from the Complainant's GP, Dr K. dated 20 September 2016 advises, as follows:

“[The Complainant] initially attended this practice on 23/01/2015 complaining of acute work related stress and anxiety related to perceived work place bullying. [The Complainant] was employed as a Claims Manager with [the Employer] in the UK. Her medical assessment at this time was consistent with a diagnosis of severe reactive anxiety and moderate depression and she was commenced on pharmacological treatment. In addition she also attended a psychotherapist. She was certified as sick for 2 weeks initially and then monthly for the remainder of 2015.

[The Complainant] attended the surgery on ten further occasions in 2015 and on the 21/01/2016 and 19/02/2016 where she was certified as sick up until 03/04/2016. All of these consultations were directly related to the work situation and on all of these occasions it was felt that [the Complainant] was not fit to perform her usual work duties due to reactive anxiety and depression. Therefore during this period [the

/Cont'd...

Complainant] *was in fact not able to perform the material and substantial duties of her normal insured occupation as a result of psychiatric illness*".

In addition, the correspondence from the Complainant's Psychotherapist, Mr O'R., dated 9 September 2016, advises, as follows:

"I worked with [the Complainant] over 8 sessions spanning the period: 23/6/2015 to 16/9/2015.

From the beginning, and throughout the weeks and months to follow, [the Complainant] displayed high levels of anxiety. She was suffering from very poor sleep patterns, terrible nightmares and on occasion panic attacks when considering a return to work & more specifically to returning to her manager.

[The Complainant] was also experiencing a great sadness at the situation she found herself in and had slipped into a deep depression. She was struggling to get out of bed and at times to leave her home on her own. She displayed an inability to make simple decisions.

At times [the Complainant]'s intense anxiety would bring on bouts of nausea.

Through all of my time with [the Complainant] I witnessed her confidence diminish to little or nothing. On leaving me on the 16/9/2015 she appeared overwhelmed and afraid.

[The Complainant] returned on the 5th September 2016 & we continue to work with her levels of anxiety & lack of confidence".

I note that the Provider next wrote to the Complainant on 16 November 2016 to advise that it was upholding its decision to decline the claim, as follows:

"We have carried out a thorough review of your claim however it remains our opinion that you did not satisfy the definition of disability ...

We would also like to advise that the decision to decline your claim is based entirely on the objective medical evidence received which shows that you did not satisfy the definition of disability during the period of liability. The decision to cease work was against the background of a work grievance. [The Provider] cannot take into account work related issues when assessing work disability ...

In order for an Income Protection claim to be payable, a claimant must satisfy the definition of disablement.

[The Provider] must be guided by the weight of objective medical evidence and the Consultant Psychiatrist, [Dr D.] indicated you were fit for work. In addition, your GP indicated that [you] would be able to perform your job once the work related issues were completely resolved. We acknowledge that you may have some ongoing residual symptoms, however any residual symptoms are not disabling in nature".

/Cont'd...

Having considered all of the documentary evidence before me, I accept that it was reasonable for the Provider to conclude from the evidence before it that the Complainant's absence was more related to a longstanding work dispute rather than an objective medical complaint and that she did not meet the policy definition of disablement, and thus decline the claim. In this regard, such evidence includes the information provided by the Complainant herself in the Employee Claim Form she completed on 18 November 2015, information provided by the Complainant's GP, Dr S., in her correspondence to the Complainant's Employer dated 10 August 2015 and in the Practitioner Report she completed on 17 December 2015, as well as the Report from Dr D., the Consultant Psychiatrist who carried out an independent medical examination with the Complainant on 1 February 2016 at the request of the Provider.

I note that the Complainant has expressed her dissatisfaction with the independent medical examination that the Provider arranged for her with Dr D., Consultant Psychiatrist on 1 February 2016. In this regard, in her correspondence to this Office dated 8 December 2016, the Complainant submits, as follows:

"I take issue with the whole matter of [the Provider's] paid psychiatrist's examination of me. Firstly, it was very brief – about 25 minutes in total, followed by me filling in a whole questionnaire process. The psychiatrist spent the briefest of times asking me what my job entailed and just as brief a time asking me how I was actually feeling.

I tried to convey to him at the time, why my symptoms meant I couldn't carry out my normal work, but he really seemed not to want to hear it. For example, as the Claims Manger for [my Employer], I was responsible for the handling of claims worth tens of millions of dollars, not small household or car insurance claims.

I was responsible for any litigation management resulting from those claims, negotiating at a very high level, the settlement of those claims and reporting to the most senior people in the Provider, i.e. the owners, all details of all claims in my care. In other words, this was a very high pressured job, where things moved at a very fast pace, where every day, I had to make very responsible decisions involving vast amounts of Provider money and the demands on me, went to the top of the Provider. Up until my illness manifested, I had greatly enjoyed this job.

One of the symptoms of my illness unfortunately, was that I lost all confidence and was completely unable to make even the simplest of decisions. I gave [the Provider's] psychiatrist the example, of how firstly, I would at times be unable to even leave the house for several days at a time, let alone get into my office. I would go to my local supermarket to buy food to make the evening meal with, but leave empty handed, because I couldn't even make a decision about what to buy. If I couldn't even make a decision as simple as this, how on earth could I have made huge decisions about claims involving tens of millions of dollars? I was unable to attend social functions with my partner as I just couldn't cope with social settings and spent most days crying, unable to do anything. I had stopped driving as I didn't feel safe, due to lack of ability to concentrate. No one who knew me, i.e. family and friends, could believe the change in me at that time. I was giving him this as an example, at his request, of

/Cont'd...

why, at that time, I was unable to fulfil my obligations to my employers. I didn't feel their claims were safe with me. His response to this kind of example was to dismiss it completely in his report and say that in his opinion I was fit to work. One of his conclusions was,

"Her activities of daily living are quite satisfactory".

I have to say, I was left stunned at how he could come to this conclusion, given all of the above, which I had told him. Again, I would point to the four other medical professionals who did not believe me able to be at work at that time and who did not think my daily living activities were normal, three of whom were monitoring me closely and regularly over a period of over a year. [My Employer]'s independent Doctor, Dr C-M., concluded in her report, following her examination of me eleven days after the examination of me by [the Provider]'s psychiatrist,

"I agree with her own GP regarding medication prescribed, psychotherapy and to continue off work at the moment"

And further,

"In my opinion she is NOT (her emphasis) medically fit to go back to work at the moment despite partial improvement in her medical condition" ...

[The Provider]'s psychiatrist examined me three months after [my Employer] had first made their claim under the policy on my behalf. That is, cover, if granted, should have begun from the beginning of November 2015, but [the Provider]'s psychiatrist's examination of me took place on the 1st February 2016. How could this psychiatrist have any idea of what my state of mind was in November and December of 2015 and January 2016 and therefore, whether I was able to work or not?

This delay in examination was solely down to [the Provider]. [It] received notice from [my Employer] in October 2015 that this claim was coming, then received the paperwork from [my Employer] on 19th November 2015, [the Provider] could have immediately arranged for their psychiatrist to examine me. They had already received details of my illness from my doctor...Instead, they delayed, and in December, asked for a further report, which they received from my doctor on 21st December 2015. Even then, [the Provider] could have made the appointment with their psychiatrist whilst waiting for the further report from my GP, but instead waited, even though I was chasing them by email and in 'phone calls, resulting in me not being examined for three months after they were first told of my claim by [my Employer]. I notice [the Provider] greatly play all of this down in their letter dismissing my appeal. This is cynical and disingenuous ...

[The Provider] grasp at the fact that one of my GPs said in her report that she believed I would eventually be able to return to work if I were not forced to work with the line manager who had been bullying me. That is, my symptoms would gradually ease if I were not forced to work in that situation. [My Employer]'s independent doctor also

/Cont'd...

recommended I not be made to work with this person again. Again, I believe [the Provider] is being disingenuous in trying to twist what my doctor has said, as justification for not paying my claim. Obviously, if the trigger of what had caused my illness were removed, I would hope to improve over time. Taking what my doctor said, out of context, is, I believe, a blatant example of [the Provider] grasping at straws in order not to have to pay out a claim”.

In addition to her dissatisfaction with the independent medical examination that the Provider arranged for her with Dr D., Consultant Psychiatrist on 1 February 2016, as expressed in her above cited correspondence to this Office dated 8 December 2016, the Complainant, who was absence from work since 27 April 2015, states in this correspondence that *“if the trigger of what had caused my illness were removed, I would hope to improve over time”*. In this regard, the Complainant submits that due to her absence from work since 27 April 2015 that her health would have improved somewhat by the time she made the claim in October 2015 and would have further improved by 1 February 2016, when she attended the independent medical examination with Dr D., the Consultant Psychiatrist.

Be that as it may, I accept the Provider’s position that it was considering a claim for the period from 28 October 2015, when the 26 week deferred period ended, to 30 June 2016, when the Complainant’s employment was terminated. In any event, I accept that it was reasonable for the Provider to conclude from all of the evidence before it that the Complainant’s absence was more related to a longstanding work dispute rather than an objective medical complaint and that she did not meet the policy definition of disablement and that such evidence not only included the Report from Dr D., the Consultant Psychiatrist who carried out an independent medical examination with the Complainant on 1 February 2016 at the request of the Provider, but also included, among other things, the information provided by the Complainant herself in the Employee Claim Form she completed on 18 November 2015 and the information provided by her GP, Dr S., in her correspondence to the Complainant’s Employer dated 10 August 2015 and the Practitioner Report she completed on 17 December 2015.

In this regard, I note that in its correspondence to this Office dated 3 January 2018, the Provider submits, as follows:

“[The Provider] have nothing further to add except that we believe [Dr S.]’s written comments per the GP form dated 17 December 2015, have to be taken at face value. These comments were clear and objective and we cannot accept the Complainant’s interpretations.

Finally, we have no concerns with the validity of the medical assessment carried out by [Dr D.] who is a Consultant in the field of Psychiatry. We believe he made a fair and honest assessment of [the Complainant] and gave his professional opinion which he is entitled to do”.

I note that the Complainant contends that one of the reasons the Provider declined her claim was because she had returned to work, although I note that she had not returned to work but rather had returned to being on the payroll by way of using her accrued annual

/Cont’d...

leave. The Complainant considers that the recording of the telephone call between the Complainant and the Provider on 3 May 2016 bears this out insofar that the Complainant submits in her email to this Office on 17 April 2018, as follows:

"This [telephone call on 3 May 2016] is the conversation I specifically referred to...when I said it was clear that [the Provider] used the fact of my telling them I was returning to work, to deny my claim. That is, that if I was going back then somehow that confirmed that I had never really been ill in the first place..."

[The Agent] then says, "but you have returned to work". In her mind...because she is working on the first (incorrect) premise, that my inability to attend work at that time was due to a workplace dispute and not the actual illness caused by what I had been subjected to at work, my 'returning to work' meant (to her as the claims handler) that I clearly was not and had not been ill. She clearly links the two things".

Recordings of these calls have been submitted in evidence.

I do not find that the content of these calls support the Complainant's contention. It would appear to me that the Complainant has taken the Agent's phrase *"But you've returned to work"* in isolation and out of context. In this regard, I note from a recording of the telephone call between the Complainant and the Provider on 3 May 2016, the following exchange:

Agent: *So, basically, on the basis that there was no underlying psychiatric illness that caused you to actually be unable to work it was attributed to the industrial relations matter that was ongoing -*

Complainant: *So if somebody [indiscipherable] suffers anxiety attacks and is on medication for depression, that's not an underlying illness?*

Agent: *Well it was more attributed to your ongoing -*

Complainant: *No, it was caused by that, that is what triggered it. That is what triggered the illness. The illness was there. That's what triggered it ... [my Employer]'s independent doctor even recommended that I not go back to work with that line manager because of, because the whole thing had been caused by her bullying of me -*

Agent: *- and the opinion on file was if that was to be resolved there wouldn't be an issue with you returning to work, so that was also a reason as well*

Complainant: *What do you mean there wouldn't be an issue with me returning to work?*

Agent: *If your situation within the workplace was to resolve there wouldn't be an issue there -*

/Cont'd...

Complainant: *But it hasn't been resolved. It hasn't been resolved.*

Agent: *But you've returned to work.*

Complainant: *No. I'm been paid at the moment. I'm using up my holiday time. And I got to go now and have a series of mediations with this person to try and see if there is a way that the situation of working together can be resolved.*

Agent: *Ok -*

Complainant: *So what you're saying is basically that [the Provider] have waited all these months to make a decision but because I say now that I'm well enough to go back to work, now you say ok, well I'm not going to pay your claim. I don't accept that at all.*

Agent: *Well no, it was actually on the basis of what we received in the IME [Independent Medical Examination] and that wasn't received until -*

Complainant: *But you just said "and it was also if I'm going back to work well then there can't be anything wrong with me" -*

Agent: *Well no, that's not what, that's not what was communicated -*

Complainant: *But that is what you just said. That that was another reason.*

Agent: *It was based, the basis of your inability to work was on the basis, was that you actually had an ongoing dispute with your employer.*

Complainant: *No, the basis of it was that I was ill and that has been triggered by the situation with my line manager".*

Similarly, I note that the Provider wrote to the Complainant's Employer on 29 April 2016 to advise that it had declined the Complainant's claim, as follows:

"Based on the evidence received throughout the claims assessment, I regret to advise we are unable to consider [the Complainant]'s claim for Income Protection benefits. [Independent Medical Examination] findings indicate that [the Complainant] is currently fit to carry out her normal occupation. There is no objective evidence or diagnosis of disabling illness that is preventing her from performing the material and substantial duties of her normal occupation. The main obstacle regarding her inability to work [is] related to a work place dispute and she has now informed [the Provider] of her return to work with [the Employer]. There is no evidence to suggest she had a disabling medical illness preventing her from working".

/Cont'd...

Whilst this correspondence does note that the Complainant *“has now informed [the Provider] of her return to work with [the Employer]”*, I accept that when taken in context this does not indicate that her return to work is the reason for declining the claim at hand but rather that the reason for the declinature is that *“There is no objective evidence or diagnosis of disabling illness that is preventing her from performing the material and substantial duties of her normal occupation”*.

Finally, the Complainant complains that the Provider delayed unduly in assessing her claim. In this regard, I note that the Provider first became aware of the claim when it received an Employer Claim Form completed by the Complainant’s Employer on 15 October 2015 and a Claim Form completed by the Complainant on 18 November 2015. At this time, the Provider requested that the Complainant’s treating doctor complete a Practitioner Report to provide further information, which was completed on 17 December 2015 and which the Provider received over the Christmas period. As part of its claim assessment, the Provider then arranged for the Complainant to attend an independent medical examination with Dr D., a Consultant Psychiatrist, which took place on 1 February 2016.

The Provider then delayed in making a decision at this time in order to obtain the Report from Dr C-M., the Specialist in Occupational Health that the Complainant’s Employer arranged for the Complainant to attend for assessment on 18 February 2016. I note that the Provider received this Report on 24 March 2016 and forwarded it to Dr D. for review, who upon review subsequently provided the Provider with an additional report dated 27 March 2016. The Provider did not then communicate its decision to decline the claim until it wrote to the Complainant’s Employer on 29 April 2016.

In this regard, I note that the Provider does acknowledge that there were some service delays on its behalf incurred during the claims process which was due to a high volume of claims at that time and it has apologised to the Complainant for this.

Having considered the circumstances of the complaint in full, the Provider, in its email to this Office dated 5 December 2107, advised *“we would like to place an offer of €5k on the record in full and final settlement of the claim”*...

Given that I accept that it was reasonable for the Provider to conclude from the evidence before it that the Complainant did not meet the policy definition of disablement, I consider this offer to be an acceptable offer in respect of the delays that the Complainant experienced.

On the basis that this offer remains available to the Complainant, and for the reasons set out above, I do not uphold this complaint.

Conclusion

My Decision pursuant to **Section 60(1)** of the **Financial Services and Pensions Ombudsman Act 2017**, is that this complaint is rejected.

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 September 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) ensures compliance with the Data Protection Regulation and the Data Protection Act 2018.