Decision Ref:	2018-0113
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a member of a Group Income Protection Scheme, the Provider was the underwriter of this scheme. The Complainant went on work related stress leave on the 9/12/16 and she made an Income Protection claim under the policy by way of claim form dated 27 February 2017. The claim was admitted for the period 22/2/17 to 23/5/17. The Provider ceased paying benefit from 23/5/17 and refused to admit the claim thereafter.

The Complainant's Case

The Complainant states that the Provider accepted that she was unfit to work due to stress since it paid her claim for the period 27/2/17 to 23/5/17. The Complainant contends that the same reasons she was unfit to work for the period February to May 2017 continued after that date and that if she returned to work in May 2017 she would have become very unwell again as the work situation remained unchanged.

The Complainant relies on the medical report of Dr. G dated 30/1/17 which states that; "*she is unfit to attend work*" further the medical report of Dr. G dated 17/5/17 states that she; *"continues to be off work due to work- related stress…..she is still apprehensive about her return to work if the conditions which caused her stress have not changed*".

The Complainant further relies on the medical report of Dr. S dated 22/2/17 which states; *"I believe a return to work at this point in time is likely going to be unsuccessful. I recommend that management and (the Complainant) engage to discuss her concern."*

A further report of Dr. S dated 18/5/17 states that; *"her work concerns have not been addressed by management*".
It is the Complainant's case that the original, accepted illness, was ongoing after 23/5/17.

The Provider's Case

The Provider contends that the Complainant was no longer suffering from a "period of disability" from the 23/5/17. The Provider relies on the Independent Medical Examination report of Dr. F dated 11 April 2017 which states;

> *"There is no current evidence of a significant mental health condition that would render her medically unfit to work in her role. The issues involved here are of an industrial relations and Human Resources management nature rather than medical"*

Further, by letter dated 15 May 2017 Dr. F stated; *"It is an IR/HR issue preventing her returning to work rather than a medical condition*."

The Provider also relies on the report of Dr. S dated 18 May 2017 which states;

> *"I now believe that [the Complainant] is not medically contra- indicated to return to work and I encourage that she considers a phased return to work."*

The Provider believes that by paying three months benefit, it allowed sufficient time for discussions to occur between the Complainant and the Employer so as to resolve the management issues.

The Provider states that the definition for a valid claim under section 1.2.11 of the group Policy Terms & Conditions defines a "period of disability" as *"A period throughout which a Member is totally unable to carry out his/her Normal Occupation due to a recognised illness or accident…."*

It is the Provider's case that the Complainant has not produced medical evidence to support her claim that she was under a "period of disability" after 23/5/17.

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.

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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 22 June 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.

Addressing the Complainant's case that as her claim was accepted for the period 22/2/17 to 23/5/17 the Provider had accepted that she had an illness and that this illness was ongoing and that the Provider should continue to provide cover. The Complainant was diagnosed as having high blood pressure and severe stress by Dr. G on the 30/1/17. This was a recognised medical condition and it was the basis for the Provider admitting the claim for the period 22/2/17 to 23/5/17. In contrast Dr. G's medical report of 17/5/17 states that the Complainant's blood pressure has settled and that the Complainant is "*apprehensive about her return to work if the conditions which caused her stress have not changed*". This report does not set out what medical condition the Complainant is suffering. I consider that the medical reports confirm that the Complainant's condition improved to such an extent that by May 2015 she was not suffering from the illness she had previously been diagnosed with. This improved diagnosis can also be seen from the difference between the 22/2/17 medical report of Dr. S which states that a return to work at this time would not be successful and the 18/5/17 medical report of Dr. S which states that *"(the Complainant) is not medically contra-indicated to return to work*". I conclude that it was not unreasonable for the Provider to conclude that the stress and high blood pressure which the Complainant was diagnosed with in December 2016 was not ongoing after May 2017.

I accept that the Complainant's work situation made her very unwell and forced her to take the unprecedented step of taking sick leave. All of the medical reports agree that the Complainant had serious and continued anxieties about returning to work while her concerns have not been addressed and the work situation remained the same as it was previously.

The policy the subject matter of this claim provides cover for mental health conditions even if work related, to be eligible for this cover the Complainant must show that she is "*totally unable to carry out his/her Normal Occupation due to a recognised illness or*

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accident….” Medical evidence is required to establish that the Complainant has a recognised illness.

The medical report which is strongest in support of the Complainant's contention that she was not fit to return to work in April/May 2017 is that of Dr. F. Dr. F's report dated 11 April 2017 notes that; *"she is not totally disabled from working life but equally given the level of anxiety noted; I believe she would have difficulty resuming work successfully at this time, in the absence of some degree of resolution or management plan for her issues of concern.*

Otherwise, I would fear a prompt recurrence or deterioration in symptoms and/or further ill health and time out of work." The doctor continues by saying that the Complainant should be able to resolve the work place issues within 4 weeks and that she could then return to work.

The Provider's comments in relation to Dr. F's above quoted report are that *"It appears that Dr. F is contradicting herself in her report, whilst she acknowledges that there are IR/HR issues and that there is no significant mental health condition she has also stated that a RTW would be difficult at this time and a resolution to workplace stressors would be appropriate*".
The Provider requested Dr. F to clarify her opinion and by letter dated 15/5/17 Dr. F confirmed that the Complainant was medically fit to return to work and that she had no mental health condition that would impact on her ability to return to work.

I conclude that the primary reasons preventing the Complainant returning to work after 23/5/17 were internal relations and human resource issues which were an ongoing source of anxiety for the Complainant. However, the policy only provides cover for a recognised illness; anxiety is not a recognised medical illness, nor is the policy required to cover absences due to IR/HR issues.

The Complainant informed this office by letter dated 20 April 2018 that she had returned to work from 17 April 2018 stating – *"I didn't want to be off work and was eager to return to work but was unable to do so as the stressors which caused me to be off work were not resolved*".

The Provider responded on 16 May that it believed "*that her return to work in a new post provided further evidence that [the Provider] correctly ceased this claim payment in May 2017 on medical grounds".*

I do not accept the Provider's contention that the fact that the Complainant has now returned to work somehow justifies their decision in May 2017. It does, however, confirm the Complainant's willingness to return to work.

The issue to be decided is whether the decision taken at that time was a reasonable one.

I very much welcome that fact that the Complainant has now returned to work. This has no influence on my decision now as to the decision taken by the Provider in 2017. My

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decision in that regard is based on the evidence that was available to the Provider when the decision was made.

I have read and considered all of the medical reports and weighed up the evidence and submissions provided by both parties. Based on these, I believe it was not unreasonable for the Provider to decide that the Complainant was not suffering from a recognised illness after May 2017.

Therefore 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

17 July 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.*