**Decision Ref:** 2019-0171

**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

This complaint is in respect of an income protection insurance policy held by the Complainant's employer, which the Provider refused to pay out on when the Complainant was out of work for a period of time after the sudden death of her partner.

### The Complainant's Case

The Complainant was employed by a third party (the "TP") and is a member of the TP's Income Protection Scheme held with the Provider against which this complaint is made. On **1 January, 2014** she became a member of an Income Protection insurance policy with the Provider (the "Policy").

The Complainant was out of work from **8 March, 2016**, due to severe bereavement reaction following the death of her partner. She submitted a claim form to the Provider on **10 August, 2016**.

The Provider requested her to attend an appointment with a Consultant Psychiatrist on **29 November, 2016**, in order to determine her eligibility to receive income protection benefit under the Policy. On foot of the Consultant Psychiatrist's report, the Provider denied her claim on **20 December, 2016**.

The Complainant appealed this decision on **13 March, 2017**. As part of the appeal, she was required to attend with another Consultant Psychiatrist, who was nominated by the Provider, on **17 May, 2017**. By letter dated **21 June, 2017**, the Provider indicated that the Complainant's appeal was denied. That decision was based on the fact that the medical report compiled during the appeal found the following:

> "*In my opinion* [Complainant] *is currently fit to carry out her normal occupation. She is not suffering from a disabling psychiatric illness that prevents her from performing the material substantial duties of her normal occupation.*"

The Complainant submitted in her complaint form to this Office that she was unhappy that her consultations with the Consultant Psychiatrist lasted only fifty minutes. She states that she had submitted a substantial amount of documentation from her GP, an Occupational GP and her Cognitive Behavioural Therapist, all of which confirmed she was unfit to work and these should have been relied on instead.

The Complainant states that she feels that the initial assessment carried out by the Consultant Psychiatrist nominated by the Provider did not assess her in a manner so as to come to the conclusion that she was fit for work. She states that the questions asked of her in the assessment were inappropriate and only a few questions were relatable, such as questions which asked about her moods throughout the day etc., however, she advises that she was unable to give a "yes" or "no" answer to these questions. She does not feel that the assessment was adequate.

The Complainant maintains that seeing the second Consultant Psychiatrist in respect of her appeal, some eight months after the initial assessment, did not result in an accurate reflection of her welfare at the time she lodged her claim.

The Complainant wants the Provider to admit the claim.

**<u>The Provider's Case</u>**

The Provider states that on the basis of the Consultant Psychiatrist's reports, the Complainant was deemed fit to attend work.

Page 13 of the Policy provides:

> "*We will pay benefit from the end of the deferred period when we are satisfied that the medical evidence supports the definition of disability and you have complied with the terms of the policy*
>
> *…*
>
> *The policy has been taken out by you [the employer] to provide cover in the event that a member is unable to perform the material and substantial duties of their normal occupation.*"

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Page 3 of the policy defines "benefit" thus:

> *"The regular income payable, after a deferred period, if following medical assessment we are satisfied that the member meets the definition of disability."*

At page 4 of the policy, "disability" is defined as:

> *"The member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury…"*

"Material and substantial duties" is defined, at page 5, as:

> *"The duties that a member is normally required to do in order to perform their normal occupation and which cannot be omitted or modified by you or the member."*

The Provider says that the Complainant was not disabled within the meaning of the Policy and, accordingly, she was not entitled to receive a benefit under the Policy. On **9 December, 2016**, the Provider received a report from a Consultant Psychiatrist compiled on foot of the initial claim. That report found, among other things, the following in relation to the Complainant:

> *"Apart from not going to work there are no major restrictions or limitations on her normal activities."*
>
> *"She is engaged in no treatment. She had two or three sessions of counselling after her bereavement. She has not been referred to a psychiatrist or prescribed any medication."*
>
> *"It is my opinion that she is currently fit to carry out her normal occupation as her symptoms are not of a nature or severity that would prevent her from working. It is an important part of getting through the bereavement that she rebuild her life and returning to work, although difficult, will be an essential part of the process."*

The Provider received a report from a Consultant Psychiatrist that was compiled during the course of the appeal on **25 May, 2017**. That report found:

"Complainant] *has satisfactory daily activities.*"

"[The Complainant] *is grieving for her partner. Whilst it is understandable that she may feel unable to work whilst she is grieving, it is not in the interests of her mental health that she does not return to work. She will benefit from returning to work as it will be part of normalisation and rebuilding of her life without her partner.*

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*Whilst this is undoubtedly a difficult thing to do, a prolonged period of absence from work following a significant bereavement is likely to contribute to delaying normal progression of the grieving process."*

That report concludes:

"*In my opinion,* [the Complainant] *is currently fit to carry out her normal occupation. She is not suffering from a disabling psychiatric illness that prevents her from performing the material and substantial duties of her normal occupation."*

The Provider asserts that, on the basis of those two reports, it was justified in its finding that the Complainant was not disabled within the meaning of the Policy.

However, after further consideration following a review on the file, the Provider advises that it is prepared to make a payment to the Complainant for the period following the end of the deferred period, being **6 September, 2016**, to the date that the Complainant attended for the independent assessment, in **29 November 2016**, as on that date she was deemed fit to return to work. The Provider therefore offers the sum of €2,404.57 payable on foot of the Policy.

**<u>The Complaint for Adjudication</u>**

That the Provider wrongly denied the Complainant's claim on the basis that she did not fall within the definition of "disability" under the Policy.

**<u>Decision</u>**

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.

The Complainant in her post Preliminary Decision submission of 7 May 2019, requested an Oral Hearing.

However, 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

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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 16th April 2019, 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.

Following the issuing of my Preliminary Decision, the Complainant made a further submission by letter dated **7 May 2019**, a copy of which was transmitted to the Provider for its consideration. The Provider under cover of its letter dated **9 May 2019**, advised this Office that it did not wish to make any further submission.

In arriving at my Decision, I have carefully considered the evidence and submissions, including the Complainant's post Preliminary Decision submission, put forward by the parties to the complaint.

The Policy defines "benefit", as:

> *"The regular income payable, after a deferred period, if following medical assessment we are satisfied that the member meets the definition of disability."*

By the terms of that definition, the Provider reserves the right to determine, following medical assessment, whether the Complainant meets the definition of disability.

The medical opinions furnished to the Provider by the Complainant and those relied on by the Provider reach opposite conclusions in respect of the fitness of the Complainant to work. The reports relied on by the Provider to deny the Complainant's claim were compiled by Consultant Psychiatrists whereas those relied on by the Complainant to support her claim were general practitioners.

The Provider in assessing the Complainant's claim had her assessed by a Consultant Psychiatrist who found that the Complainant was fit to carry out her normal occupation.

When the Complainant appealed this decision, the Provider had her assessed by a second Consultant Psychiatrist who also found that the Complainant was fit to carry out her normal occupation.

In her post Preliminary Decision submission dated 7 May 2019, the Complainant included a submission from her mother which queried how the Consultant Psychiatrist's decisions were taken at a higher regard over a family GP, cognitive behavioural therapist and occupational doctor. In that regard, I must point out that the reports of both consultant Psychiatrists appear quite comprehensive. The report of Dr. A sets out the history of the Complainant's illness, her current symptoms, her treatment, her daily routine, the work occupational issues, her history of psychiatric illness, her family history, and her personal history. I note

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that this assessment also included a Montgomery-Asberg Depression Rating Scale. This is a clinician-rated instrument that assesses the range of symptoms that are most frequently observed in patients with major depression. It is completed based on a comprehensive psychiatric review. It is not a diagnostic instrument but considered a measure of illness severity. I note that the Complainant's score in this assessment, based on the psychiatric interview on 17 May 2017, was in the moderate severity range. I note the consultant also undertook a Hamilton Anxiety Rating Scale. This is a clinician-rated instrument that measures the severity of anxiety symptoms. It is completed based on a comprehensive psychiatric interview. It is not itself a diagnostic instrument for anxiety and a diagnosis should not be made based on the scoring alone. The Complainant's score in this assessment was in the mild severity range. The conclusion of Dr. A was:-

> "*In my opinion [the Complainant] is currently fit to carry out her normal occupation. She is not suffering from a disabling psychiatric illness that prevents her from performing the material and substantial duties of her normal occupation.*
>
> *[The Complainant] is grieving for her partner. Whilst it is understandable that she may feel unable to work whilst she is grieving, it is not in the interests of her mental health that she does not return to work. She will benefit from returning to work as it will be part of normalisation and rebuilding of her life without her partner. Whilst this is undoubtedly a difficult thing to do, a prolonged period of absence from work following a significant bereavement is likely to contribute to delaying normal progression of the grieving process."*

The Provider also received a comprehensive report from Dr. B, Consultant Psychiatrist dated 29 November 2016. This report set out the Complainant's current physical symptoms, past psychiatric history, past medical history, personal history, current daily routine, patient's perception of what's stopping her from work, back-to-work plans, treatment. It also contains the results of a structured inventory of malingered symptomatology. This is a 75 item, Multi-Axial Scale assessing exaggeration of psychiatric symptoms. The Complainant scored 8 in this. The consultant's conclusion was that the Complainant was "*currently fit to carry out her normal occupation, as her symptoms are not of a nature or severity that would prevent her from working. It is an important part of getting through the bereavement that she rebuild her life and return to work, although difficult, will be an essential part of the process*".

I note under the heading "*Treatment*" in this report the consultant states that the Complainant "*attended a counsellor 2 or 3 times about a month after her bereavement but did not go back*." The Complainant in her post Preliminary Decision submission of 7 May 2019 states: "*I do not believe that on the 2 occasions that I attended the consultant psychiatrists as the* [Provider] *requests, that the time spent with me was adequate to appreciate and understand the depth of grief I was experiencing and the affect it was having on my day to day life. Especially, in comparison to my GP, the occupational doctor for* [my employer] *and the Cognitive Behavioural Therapist's opinions, whom I was regularly attending".* The Complainant also draws attention to what she terms "*incorrect information submitted by the Provider*" and attached supporting documentation to show that she received counselling on more than 2 occasions, as stated by the consultant psychiatrist,

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following the death of her partner. In that regard, the Complainant has provided a letter from a clinic, stating that she attended the clinic on 23 occasions in 2014, 7 occasions in 2015, 10 occasions in 2016, 6 occasions in 2017, 1 occasion in 2018 and 1 occasion in 2019. The consultant's report in question is dated 29 November 2016. I note the report from the Complainant's clinic indicates that she attended that clinic on 9 occasions between 31 March 2019 and the date of the report. This information does not appear to accord with the consultant's statement. I do not believe, however, that it undermines the entirety of the consultant psychiatrist's report. Furthermore, I note the second consultant psychiatrist's report dated 17 May 2017 states:-

> "[Complainant] *has been attending counselling with a* [CBT therapist]. *She had originally seen* [CBT therapist] *for about a year on a monthly basis up to a year and a half before* [her partner] *died. She said this was because of anxiety and "a bit of depression". She saw* [CBP therapist] *weekly for 2 months after* [her partner's death]. *She returned to* [CBP therapist] *for further counselling before Christmas and had been attending every 1 – 4 weeks. This has elements of bereavement counselling. She has also spoken to her GP about her grief."*

While I fully understand both the Complainant and her mother's disappointment that the claim was not admitted by the Provider, I have not been presented with any evidence that the Provider acted unreasonably in accepting the assessment of two consultant psychiatrists that the Complainant was fit for work and did not meet the conditions necessary under the Policy for payment.

That said, I note that the deferred period ended on 6 September 2016 and, were the claim admitted; this would have been the commencement date for payment. I note that the Provider did not schedule an appointment for the Complainant to be reviewed until 29 November 2016, and therefore the Provider was not in a position to determine whether the Complainant was suffering from a disablement during the period 6 September 2016 to 29 November 2016. Therefore, I find that for this period of time, it was not appropriate for the Provider to decline to pay the Complainant.

However, by email dated **6 February, 2018**, sent to this Office during the course of investigation, the Provider offered to pay the Complainant for the period between the date on which a benefit could have become payable under the Policy, being **6 September, 2016**, and the date on which the Complainant was independently medically assessed at first instance, being **29 November, 2016**. This offer was made on the basis that due to the late submission of the Complainant's claim, in the Provider's view, the Provider was not able to carry out an independent medical assessment prior to the expiration of the deferred period. This being a period that the Provider is not obliged to pay a claimant under the Policy. That offer was refused by the Complainant.

While I understand the very difficult situation the Complainant was in and I sympathise with her situation, for the reasons outlined above, and on the basis that the sum of €2,404.57 offered by the Provider to the Complainant to cover the period **6 September 2016 - 29 November 2016** remains available to the Complainant, I do not uphold this complaint.

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**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**

20 June 2019

**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.**