An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2019-0395
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant became a member of a Group Income Protection Scheme by way of her employment. The policyholder is her Employer and the Provider is the insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant has been absent from work since a road traffic accident on **23 September 2014**. She completed an income protection claim form on **15 January 2015** wherein she listed her illness, as follows:

> *"Back/Neck Injuries / Headaches / Right side of leg pain / Right wrist as a result* [of] *lorry hitting my car on way to work …*
>
> *Cannot sit longer then limited amount of time, cannot stand or walk for limited time, only slight relief when lying down on bed.*
>
> *Need to drive to work approx. 1.30 hrs, cannot drive this period as too long and now have panic attacks whilst driving even for short distance. Cannot drive as on strong medication. Have now home help".*

Following its assessment, the Provider was satisfied that the medical evidence supported a valid claim and it commenced income protection payments with effect from **24 March 2015**.

Following a later review of her claim, the Provider concluded that the Complainant no longer satisfied the policy terms and conditions for a valid claim and it ceased payment of her income protection claim on **30 September 2016**. The Complainant appealed this decision but upon review the Provider upheld its decision to cease payment of her claim.

In this regard, the Complainant sets out her complaint, as follows:

> *"*[The Provider] *denied appeal of my claim for continuation of income protection payments, which I had been in receipt of from 23/03/2015 until 23/09/2016.*
>
> *On 23/09/2014 I was driving to work and a lorry rammed into my car carrying me approx. ¼ mile down the road, resulting in my current medical conditions.*
>
> *I was requested to see two of the* [Provider]*'s consultants, who in their opinion stated that I am fit to return to work, there is indeed a conflict of interest (was even advised to consider working standing up, when told of my symptoms).*
>
> *I can assure you, there is nothing I would like more then to be healthy again and to return to work. My finances have reached rock bottom, my savings have totally depleted and I risk losing my home due to being unable to pay my mortgage, not to mention that I am thousands in debt. I now have to rely on social welfare payments to survive, which* [is] *less than half of my salary. This is certainly not by choice. I am certain, that if I was able to return to work, social welfare would certainly not be paying me.*
>
> *As a result of the above, I now suffer from severe back issues, PTSD and depression. I am prescribed strong medication, CBT and hydrotherapy and consultations with numerous specialist*[s]*, plus am attending my GP on a regular basis".*

As a result, the Complainant seeks for the Provider to reinstate her income protection claim from 30 September 2016.

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

Provider records indicate that the Complainant, an account manager, completed an income protection claim form on 15 January 2015 wherein she noted her first date of absence as 23 September 2014 and listed her illness as *"Back/Neck Injuries / Headaches / Right side of leg pain / Right wrist as a result* [of] *lorry hitting my car on way to work"*. Her Employer completed an employer claim form on 17 February 2015 advising that the Complainant was absent from work as a result of *"injuries due to a car accident while driving to work"*.

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A member of the Group Income Protection Scheme can claim income protection benefit during a period of disability, which is defined in the policy conditions, 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"*.

Following its assessment, the Provider was satisfied that the medical evidence supported a valid claim for the Complainant. As the deferred period under the policy is 26 weeks, the Provider commenced income protection payments with effect from 24 March 2015.

Income protection claims are always subject to ongoing review. In this regard, the Provider commenced a claim review by way of its correspondence to the Complainant on 22 April 2016, wherein it asked for a copy of any medical reports relevant to her absence from work. From a review of the reports that she then submitted, the Provider noted that the Complainant had been reviewed by Mr J., Consultant Neurosurgeon on 23 October 2015 for the first time and no further review was arranged. The Complainant also attended Dr E., Consultant Psychiatrist on 23 November 2015 and the next review was scheduled for September 2016.

In order to conduct the claim review, the Provider arranged for the Complainant to attend for two separate independent medical examinations. In this regard, the Complainant attended for examination with Mr P., Consultant Orthopaedic Surgeon on 22 July 2016, who in his ensuing report dated 22 July 2016 advised, *inter alia*, as follows:

> *"*[The Complainant] *went to see an orthopaedic surgeon* [Mr I.] *who advised no orthopaedic intervention or physiotherapy and gave her pain management. She subsequently went to see* [Dr J.] *a neurosurgeon who organized scans of her lumbar and thoracic spine which were completely normal. An MRI scan of her cervical spine certainly showed degenerative changes at the C5/6 C6/7 level with minor disc bulging but no nerve root compression and he contemplated the possibility of nerve root injections into her neck if her neck symptoms were more significant …*
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> *At the time of her accident* [the Complainant] *sustained soft tissue myofascial injuries to her cervical, thoracic and lumbar spine. Her thoracic symptoms have settled but she is still left with mainly residual soft tissue symptoms affecting her lower back. Her MRI scan of her lumbar spine is very reassuring in that she has no significant degenerative changes in her back or discs or facet joints and no nerve root compression. She does have some minor degenerative changes in her cervical spine but her neck symptoms are intermittent and manageable and would not prevent this lady certainly from physically returning back to the workforce …*
>
> *I believe a return back to work would be beneficial and I don't believe her neck or back symptoms are severe enough to prevent a trial return to work at this stage"*.

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In addition, the Complainant attended an examination with Dr D., Consultant Psychiatrist on 4 August 2016 and in his ensuing report dated 11 August 2016 he advised, *inter alia*, as follows:

> *"Symptoms as* [the Complainant] *describes them are mild in nature and understandable in the context of her restricted lifestyle …*
>
> *The main, indeed the only reason she cites preventing her from returning to work is her back pain …*
>
> *It is my opinion that* [the Complainant] *is currently fit to carry out her normal occupation from a psychiatric point of view. The degree of symptoms she describes would not prevent her from carrying out her work …*
>
> *With regard to part time work she said the drive would be so long that this would stop her working for even three or four hours a day …*
>
> *The big barrier to her return to work is the driving. She had thought about selling her home to move nearer to work but it would be much more expensive to buy a property in Dublin near her work"*.

The Provider notes that income protection claims are assessed against the claimant's current role with his or her employer and the job description provided; the commute to and from work is not taken into account.

Based on the findings of the independent medical examinations and a review of all medical records received, the Provider concluded that the Complainant no longer met the policy definition of disability and advised her Employer, the policyholder, by way of correspondence dated 16 August 2016 that in order to allow time to make the necessary return to work arrangements for the Complainant, it would pay her claim in full until 30 September 2016.

The Complainant appealed this decision on 15 November 2016 and enclosed correspondence from her GP, Dr C., dated 8 November 2016. The Provider emailed the Complainant on 22 November 2016 to see if she would be submitting any further medical evidence in support of her appeal, to which she responded by email on 23 November 2016 that *"My doctor has covered everything relevant in her letter"*.

As part of the appeal process, the Provider forwarded the letter from the Complainant's GP to Mr P., Consultant Orthopaedic Surgeon to see if the contents of same altered his original decision that the Complainant was fit to return to work, and he advised in his correspondence dated 13 December 2016, as follows:

> *"Many thanks for your letter concerning this lady, I saw her on 27th July 2016. At that time I deemed this lady fit to return back to work on a trial basis initially in a part time capacity with some work accommodation.*

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> *I note her letter from her GP. I certainly don't believe her orthopaedic symptoms are enough to preclude her work. I will leave her treating psychologist and psychiatrist to determine whether her anxiety driving and psychological status is a barrier to go back to work. Otherwise the subsequent information you have sent me doesn't change my opinion of this lady who I believe is orthopedically fit for a trial return back to work as highlighted in my previous report"*.

In addition, the Provider also forwarded the letter from the Complainant's GP to Dr D., Consultant Psychiatrist for comment and he advised in his email of 2 December 2016, *"I have read* [Dr C.]*'s letter of 8th November 2016 and* [the Complainant's] *e-mail about her receipt of a medical card. I have reviewed my own file and report. I have no changes to make regarding my opinion"*.

As a result, the Provider advised the Complainant and her Employer by way of correspondence dated 10 January 2017 that it had affirmed its decision to cease payment of her income protection claim.

The Provider notes that it later received on 3 April 2017 additional medical reports that the Complainant had included as part of her complaint submission to the then Financial Services Ombudsman's Bureau which it had not received at any stage during the claim assessment and appeal process, namely, a report from Mr I., Consultant Orthopaedic Surgeon dated 10 December 2016 and a report from Dr E., Consultant Psychiatrist, dated 31 January 2017, both addressed to a firm of solicitors.

In light of these specialist reports not previously provided, the Provider arranged for the Complainant to attend for two further independent medical examinations. In this regard, the Complainant attended with Dr F., Consultant Psychiatrist on 10 May 2017, who in his ensuing report dated 10 May 2017 advised, *inter alia*, as follows:

> *"*[The Complainant] *has attended* [Dr E.]*, Consultant Psychiatrist, on two occasions for assessment for medico-legal purposes and also for diagnostic and treatment opinion. She does not have further scheduled appointments with* [Dr E.] *…*
>
> [The Complainant] *told me that her main concern about work is driving to and from work. She said that the commute is too long at two hours each way. She cannot afford to move to be closer to work …*
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> *When asked what she needs to change in order for her to return to work she replied that she needs to live nearer to work. She said, "Then I wouldn't have half the problem I have now". She has looked into the logistics of commuting by public transport but it is not practical. She said it would take over three hours each way …*
>
> *Mood was not depressed or anxious. She was normally interactive and reactive. Affect was euthymic and without any restriction. There was no evidence of anxiety, tension or agitation …*

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Current psychological symptoms are mild in severity. The most prominent symptoms in this assessment were physical ones and the consequent restrictions in activities …

There was no objective evidence of depression of mood during this assessment. She was normally interactive and reactive. Affect was not restricted in any way. There was no evidence of anxiety, agitation or tension …

[The Complainant's] *primary problem with work is the difficulty in commuting for two hours to work. She feels that she will not be able to drive for this length of time because of her fears about driving since the road traffic accident. In the workplace, the main problems she would have are related to her physical symptoms …*

In my opinion, from the perspective of psychiatric illness, [the Complainant] *is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that it preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature. It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness"*.

In addition, the Complainant attended for an examination with Prof J., Consultant Orthopaedic Surgeon on 20 June 2017. The Provider notes that this is the second time it referred the Complainant to Prof J., as she previously attended on 17 June 2015 when he at that time found her unfit to return to work. In his ensuing report dated 20 June 2017, Prof J. advised, *inter alia*, as follows:

"[The Complainant] *states that the difficulty for her returning to work is that she has to sit for most of the day. She also states that the car journey is a 2 hour journey so this makes it difficult for her.*

On examination this lady has a full range of motion of her cervical spine. She has no abnormality visible at her thoracic spine. Neurologically her upper limbs are normal.

With regard to her lumbosacral spine she has full range of motion in all directions. She has a negative straight leg raising bilaterally and no neurological deficit.

With regard to the activities of daily living this lady states she is able to drive locally and do her supermarket shopping and carry out the groceries. She can also stand and prepare food and wash up.

This lady has improved significantly as would have been predicted. She still has some residual soft tissue nature low back pain. She has full range of motion, no neurological deficit and no evidence of nerve root compression. This is consistent with a soft tissue back injury. She is functioning well in her daily life and is independent and can drive, cook and shop. Her treatment has improved her situation dramatically.

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I think that with ongoing home exercises and hydrotherapy and analgesia that her situation will continue to improve in her low back.

I would regard her as fit to work in a sedentary job in an office. It may be that she needs to stand up every two to three hours and move around for a while. I think that she should be fit to return to work certainly for four hours at a time. I think she could do this for three months and then six hours at a time and back to full duty.

The issue about her commute is a little difficult, however she does describe that she can sit comfortably for two – three hours and her commute is two hours, overall I think she is fit to return to work on a phased basis. Initially for a four hour working day for three months and then increase it. I do not think that by staying out her situation will get better any sooner. I do not think that her returning to work will aggravate her situation and I would regard her as fit to return to work".

The Provider noted that in the course of his report, Prof J. was of the opinion that the Complainant was fit to return to work on an initial phased basis. The Provider asked him to clarify whether this was essential or preferential, to which he advised *"My comments about her phased return are optional. This is not an essential at all. Overall I found that at the review on the 20th June 2017 that this lady was fit for work"*.

In order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. The purpose of the income protection policy is to support employees who demonstrate work disability supported by the objective medical evidence and in this regard the Provider admitted the Complainant's income protection claim from 24 March 2015 through to 30 September 2016. The objective independent medical reports from Mr P., Consultant Orthopaedic, Dr D., Consultant Psychiatrist, Dr F., Consultant Psychiatrist and Prof J., Consultant Orthopaedic Surgeon clearly indicate that the Complainant no longer met the policy definition of disability under the Group Income Protection Scheme.

The Provider acknowledges that the Complainant may have residual symptoms, however the independent examiners have advised that these residual symptoms were not disabling in nature and that the Complainant is fit for work. The Provider paid the claim to allow time for the Complainant to resume work, however she has not done so at any stage. It is apparent that the commute to work is the main barrier to her actually resuming work, however the Provider cannot consider this as a factor when assessing work disability. The Provider can only consider a claim against the policy definition of disability and the weight of independent objective medical evidence indicates that the Complainant is fit to resume her occupation. The Provider is satisfied that when the full medical file is reviewed and on the balance of the medical evidence received, the continuance of the income protection claim for the Complainant is not medically supported.

Accordingly, the Provider is satisfied that as the Complainant no longer met the policy terms and conditions for a valid claim at that time, that it correctly ceased payment of her income protection claim on 30 September 2016, in accordance with the terms and conditions of the Group Income Protection Scheme.

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The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongly or unfairly ceased payment of her income protection claim in September 2016.

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 30 October 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.

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

The complaint at hand is that the Provider wrongly or unfairly ceased payment of the Complainant's income protection claim in September 2016. In this regard, the Complainant became a member of a Group Income Protection Scheme by way of her employment and the Provider is the insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant has been absent from work since a road traffic accident on 23 September 2014. She completed an income protection claim form on 15 January 2015 wherein she listed her illness, as follows:

> *"Back/Neck Injuries / Headaches / Right side of leg pain / Right wrist as a result* [of] *lorry hitting my car on way to work …*

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Cannot sit longer then limited amount of time, cannot stand or walk for limited time, only slight relief when lying down on bed.

Need to drive to work approx. 1.30 hrs, cannot drive this period as too long and now have panic attacks whilst driving even for short distance. Cannot drive as on strong medication. Have now home help".

Income protection policies, like all insurance policies, do not provide cover for every eventuality; rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this instance, **Section 5, 'Claims'**, of the applicable Group Income Protection Policy Conditions provides, *inter alia*, at pg. 8, as follows:

"The benefit shall be payable to the Policyholder at the end of the Deferred Period once we are satisfied that the member meets the definition of Disability".

As a result, in order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. In this regard, the '**Appendix: Glossary of Terms'** section of these Policy Conditions provide, *inter alia*, at pg. 19, as follows:

*"**Disability***

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".

Following its assessment, the Provider was satisfied that the medical evidence supported a valid claim and it commenced income protection payments with effect from 24 March 2015.

The Provider, having later carried out a review of her income protection claim, concluded that the Complainant no longer satisfied the policy terms and conditions for a valid claim and it ceased payment of her claim on 30 September 2016. The Complainant appealed this decision but the Provider upheld its decision to cease payment of her claim.

In this regard, the complaint is that the Provider wrongly or unfairly ceased payment of the Complainant's income protection claim.

All income protection claims are subject to ongoing review. In this regard, I note that the Provider commenced a claim review by way of its correspondence to the Complainant on 22 April 2016, wherein it asked for a copy of any medical reports relevant to her absence from work. The Complainant submitted two medical reports.

In this regard, in his Report dated **23 October 2015**, Mr J., Consultant Neurosurgeon advised, as follows:

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"[The Complainant] *works in admin and advised me that she was involved in an accident last year in September 2014. Essentially she was the driver of a car and an articulated lorry had a collision with her and dragged her for about ¼ mile. Essentially, she ended up with a significant amount of neck pain and lower back pain. Her problem is being that of significant axial neck pain with some degree of pain radiating down the arm, associated with pins and needles in the right hand and she also describes significant mechanical lower back pain. She has had multiple episodes of physiotherapy which she has not found useful and she has been started on a variety of medication including Lyrica and anti-inflammatories etc. She has been on Tramadol, Lyric and K-Pak. Essentially, she has come to a point where the pain syndrome is causing her significant discomfort.*

Clinically she appears to have tenderness over the C4/5 and C5/6 facet joints. Her neck movements are restricted on extension and lateral rotation. She also has trapezius spasm. She also has pain and tenderness in the intrascapular region and in the lower back. Her sacroiliac joint is also tender, her upper limb motor power is normal and reflexes are generally diminished on the right hand side. I could not detect any evidence of myelopathy.

OPINION

[The Complainant's] *MRI scan shows degenerative changes in the cervical spine and mildly in the lumbar spine. There does not seem to be any significant nerve root compression on the right hand side. I have had a long discussion with her. I have advised her about the soft tissue component to the injury and the fact that it could take time to heal. I have advised her there is a natural healing process with it. I have also made recommendations for further soft tissue release work and perhaps a TENS machine. I have also offered her cervical and lumbar facet joint injections and I have spoken to her at length about that. She is not keen on that, in view of the fact that she has got a few relatives in England and America that have had some adverse outcomes with the injections. I have also advised her that if she preferred she could get trigger point injections but she is not keen on that either. She has advised me that she may go and meet* [K.] *in Harley Street and I have advised her that I have no objections to that. If she ever wants to come back and see me I would be more than happy to review her"*.

The Complainant also attended with Dr E., Consultant Psychiatrist on 7 November 2015, who in a letter to the Complainant's GP dated **23 November 2015** advised, *inter alia*, as follows:

"[The Complainant] *outlined in detail her experience of a road traffic accident, during which she had expected to be seriously injured or killed. Since then, she reports persistent pain and discomfort, which is greatly limiting her life, and which is contributing to her difficulties driving. Consequently, she has been unable to return to work, and is missing out on leisure and social activities. She has become reliant on a carer to drive her, and to help her with household tasks.*

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Following my assessment, I considered that [the Complainant] *was suffering from a combination of post-traumatic stress disorder, and depressive disorder, both of which were at least moderately severe. She described flashbacks and intrusive memories of the accident, associated with marked hypervigilance and anxiety, and avoidance behaviours. She also reported persistently low mood with fears for the future, and acknowledged some suicidal ideation, although she denied suicidal intent. During a brief telephone call to her mother in the UK, her mother outlined her concerns about* [the Complainant's] *depression, and explained that she had been encouraging her to consider returning to the UK.*

I suggested to [the Complainant] *that she might benefit from CBT therapy, and especially if the therapist is also trained in EMDR, a technique used to reduce intrusive memories. This would especially be helpful with* [the Complainant's] *anxiety symptoms. I am not sure how open she is to this treatment, and whether it is available in* [her locality]*, but it may be available through the local mental health services, or the primary care psychological set-up.*

As this letter concluded abruptly at the end of the page, this office wrote to the Provider on 10 July 2019 requesting a copy of the missing page which appeared to follow. When the Provider responded on 17 July 2019, it confirmed that it also only held one page of the letter and therefore could not supply the missing page. This office then sought the missing page from the Complainant, who furnished other copy reports from the same Consultant Psychiatrist, but the missing page was not amongst the details made available.

It is clear that at the time when the Provider made its decision to cease benefit payments to the Complainant, the contents of the missing page could not have been taken into account. The role of this office is to review the decision of the Provider in the consideration of the medical information which was available to it at the time when the decision was made to cease benefit payments. Consequently, the additional medical report from Dr. E. dated February 2018, which was recently made available to this office by the Complainant, is not relevant in that regard, as the contents were not in existence in 2016 and were therefore not considered by the Provider, in the context of its review of the claim.

The Complainant also submitted to the Provider the results of three MRI scans dated **2 October 2015**. In this regard, the results of the MRI of the thoracic spine were, as follows:

"No fracture or destructive bone lesion. Thoracic cord is normal.

No focal disc herniation.
No exit foramen encroachment. No evidence of demyelination. No canal stenosis. Thoracic aorta is of calibre.

Conclusion: Normal thoracic spine MRI. No obvious fracture".

The results of the MRI of the lumbar spine were, as follows:

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"Normal lumbar curvature. No fracture or destructive bone lesion. Lower thoracic cord and conus is intact. No focal disc herniation.

Conclusion: Normal lumbar spine MRI. Normal SI joints. No exit encroachment identified".

The results of the MRI of the cervical spine were, as follows:

"No fracture or destructive bone lesion. Craniocervical junction region is intact. Disc protrusions are present at C5-6 and C6-7 levels impinging on ventral aspect of theca but causing no obvious cord compression.

Upper thoracic cord is normal.
Axial imaging frame the presence of a small central disc protrusion at C5-6 with no significant exit foramen encroachment or canal stenosis. A small central and slight left-sided disc protrusion is also seen at C6-7 again no significant canal stenosis or exit foramen encroachment.
Conclusion: Small central disc protrusions noted at C5-6 and C6-7. No fracture. Normal cervical cord".

I note that in order to conduct the claim review, the Provider arranged for the Complainant to attend for two separate independent medical examinations. In this regard, the Complainant attended for examination with Mr P., Consultant Orthopaedic Surgeon on **22 July 2016**, who in his ensuing report dated 22 July 2016 advised, *inter alia*, as follows:

"[The Complainant] *is now one year and ten months since a traumatic high speed road traffic accident. Obviously the nature of the accident certainly was traumatic in relation to the patient psychologically. It is clear she developed post-traumatic stress and depression which she is on multiple medication for under the direction of her treating psychiatrist with it seems a reasonably good recovery apart from anxiety which has persisted and which she states prevents her from being able to drive on motorway again.*

At the time of her accident [the Complainant] *sustained soft tissue myofascial injuries to her cervical, thoracic and lumbar spine. Her thoracic symptoms have settled but she is still left with mainly residual soft tissue symptoms affecting her lower back. Her MRI scan of her lumbar spine is very reassuring in that she has no significant degenerative changes in her back or discs or facet joints and no nerve root compression. She does have some minor degenerative changes in her cervical spine but her neck symptoms are intermittent and manageable and would not prevent this lady certainly from physically returning back to the workforce.*

Her main disability relates to her ongoing back symptoms which on assessment today are related the myofascial structures of her back and possibly the facet joints at L4/5 with no signs of any discogenic or neuropathic pain on assessment today.

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On assessment today this lady's symptoms of back pain and discomfort are evident in terms of either sitting or standing for any prolonged period with stiffness in her back but no obvious neurological signs of assessment today.

From a day to day point of view she has ongoing activity pain but functions reasonably well apart from sitting or standing and is able to drive short distances and do light household activities …

[The Complainant] *I believe has reached the end cycle in terms of her treatment following her traumatic road traffic accident from a psychological and physical point of view, She is on multiple medication, physiotherapy, cognitive behavioural therapy and pain management programme and there is little further treatment that can be helpful at this stage. I believe a return back to work would be beneficial and I don't believe her neck or back symptoms are severe enough to prevent a trial return back to work any this stage. I do not believe such a return back to work would be deleterious to her back symptoms to any great degree.*

I feel that she will have a significant benefit from a psychological point of view if she returns back to work part time. She might require some accommodation work with a stand up desk so that will allow her to change her position and I certainly feel she should return back in a part time capacity 20 hours per week for a protracted period of maybe six to eight weeks. There will be an issue of the commute to work irritating her back symptoms but I still feel this could be accommodated by part time working duties.

Therefore I feel this lady certainly has residual low back pain which is myofascial in nature with possibly an overlay with facet joint pain with no discogenic or neurological pain on assessment today. The mainstay of treatment is conservative and I feel this lady has an appropriate period of time and rehabilitation to help her physical symptoms and she is stable from a psychological point of view that she now should consider a phased return back to workforce. I believe with some accommodation from her employer in terms of part time work practices and ergonomic assessment of her work practices should be reasonable to allow her to get back to her relatively sedentary job".

In addition, the Complainant attended an examination with Dr D., Consultant Psychiatrist on 4 August 2016 and in his ensuing report dated 11 August 2016 he advised, *inter alia*, as follows:

*"**Patient's Perception of what's stopping her from Working***

She said that the drive to work would be very difficult because of her back pain. She also says that she can't sit down for long periods. After a while she needs to lie down for a couple of hours and therefore it wouldn't be feasible to work. With regard to part time work she said the drive would be so long that this would stop her working for even three or four hours a day …

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Back to Work Plans

She said she doesn't know when she'll be able to go back. She thought when she had the accident she'd be off for a few days. The big barrier to her return is the driving. She had thought about selling her home to move nearer to work but it would be much more expensive to buy a property in Dublin near her work …

Mental State Examination

She looked well and she was cooperative with the history and examination. Her speech was normal in rate, tone and volume and she was quite animated during the interview. She showed no overt stress except from transiently when talking about some of her difficulties. She wasn't overtly depressed or anxious. Her attention, concentration and memory were good and she has very good insight …

[The Complainant] *has an adjustment disorder, in that she's not able to take an interest or enjoyment in her usual activities because of the restrictions imposed by her injuries sustained in the road traffic accident …*

Symptoms as [the Complainant] *describes them are mild in nature and understandable in the context of her restricted lifestyle …*

The main, indeed the only reason she cites preventing her from returning to work is her back pain …

It is my opinion that [the Complainant] *is currently fit to carry out her normal occupation from a psychiatric point of view. The degree of symptoms she describes would not prevent her from carrying out her work"*.

I note that the Provider, based on the findings of the independent medical examinations and a review of all medical records received, concluded that the Complainant no longer met the policy definition of disability and it advised her Employer, the policyholder, by way of correspondence dated 16 August 2016 that in order to allow time to make the necessary return to work arrangements for the Complainant, it would pay her claim in full until 30 September 2016.

The Complainant appealed the Provider's decision to cease payment of her income protection claim and submitted correspondence in support of her appeal to the Provider from her GP, Dr C. dated 8 November 2016 that advised, *inter alia*, as follows

"I feel that [the Complainant] *is not medically fit to return to her previous employment role as she is unable to sit for prolonged periods of time due to her neck and back pain. She can get very uncomfortable and even during consultations in the surgery she would often have to stand up and move around to relieve her symptoms which wold make working in an office base job difficult and disruptive to both* [the Complainant] *and other employees.*

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> *With regards to* [the Complainant's] *mental health she has reduced concentration and memory due to depression which would affect her ability to complete important tasks effectively and efficiently and would also increase her risk of making errors.*
>
> [The Complainant] *also suffers with frequent panic attacks which are triggered by driving or travelling as a passenger in a vehicle. As a result of her anxiety, she has developed avoidance behaviour and drives short distances into* [the local town] *only if absolutely necessary as she can become quite distressed.* [The Complainant] *lives in a rural area and the transport links are limited causing difficulty commuting to Dublin to her previous workplace.*
>
> [The Complainant] *is making every attempt to aid her rehabilitation however her progress over the past 2 years has been slow. In my opinion,* [the Complainant] *is not currently medically fit to return to her job as an Account Manager and it is difficult to predict whether or not she will be able to return to employment as a result of her physical and psychological injures sustained from the accident"*.

I note that the Provider forwarded this letter to Mr P., Consultant Orthopaedic Surgeon to see if its contents altered his original decision that the Complainant was fit to return to work, and he advised in correspondence dated 13 December 2016, as follows:

> *"Many thanks for your letter concerning this lady, I saw her on 27th July 2016. At that time I deemed this lady fit to return back to work on a trial basis initially in a part time capacity with some work accommodation.*
>
> *I note her letter from her GP. I certainly don't believe her orthopaedic symptoms are enough to preclude her work. I will leave her treating psychologist and psychiatrist to determine whether her anxiety driving and psychological status is a barrier to go back to work. Otherwise the subsequent information you have sent me doesn't change my opinion of this lady who I believe is orthopedically fit for a trial return back to work as highlighted in my previous report"*.

In addition, I note that the Provider also forwarded the letter from the Complainant's GP to Dr D. M., Consultant Psychiatrist for comment and he advised in his email of 2 December 2016, *"I have read* [Dr C.]*'s letter of 8th November 2016 and* [the Complainant's] *e-mail about her receipt of a medical card. I have reviewed my own file and report. I have no changes to make regarding my opinion"*.

As a result, the Provider advised the Complainant and her Employer by way of correspondence dated 10 January 2017 that it had affirmed its decision to cease payment of her income protection claim.

The Complainant subsequently initiated a complaint with this Office and she included, *inter alia*, two medical reports with her complaint papers, namely, a report from Mr I., Consultant Orthopaedic Surgeon dated 10 December 2016 and a report from Dr E., Consultant Psychiatrist, dated 31 January 2017, both addressed to a firm of solicitors. This Office forwarded these reports to the Provider as part of its processes.

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In this regard, I note that in his Report dated **10 December 2016**, Mr I., Consultant Orthopaedic Surgeon advised, *inter alia*, as follows:

> *"As compared to my last examination, she has remained symptomatic although she has improved slightly and there are good days and bad days, but her symptoms are not settling and at this stage as she…progress into chronic pain situation phase I would strongly recommend that she should be seen by a pain specialist and I would recommend* [Dr D.]*, Consultant Pain Specialist who will be able to* [offer] *her treatment, as well as long-term prognosis regarding her as I believe that, she will be symptomatic for some time to come and the long-term prognosis will be guarded as her symptoms are not settling down"*.

I note that in her Report dated 31 January 2017, Dr E., Consultant Psychiatrist, dated **31 January 2017** advised, *inter alia*, as follows:

> *"**Work:***
>
> *At the time of follow-up assessment,* [the Complainant] *had been unable to return to work…She explained that her inability to work especially related to being unable to cope with sitting or standing for long periods. She also reflected that the journey to work was a concern for her, and explained that it would take her three hours to travel to work by public transport. She reflected that she was not physically or mentally ready to return to work at the time of follow-up assessment …*
>
> ***Driving:***
>
> *At the time of follow-up assessment,* [the Complainant] *reported that her ability to drive to* [the local town] *had improved since the previous assessment. She was also able to drive her dogs to a local walking area.*
> [The Complainant] *reported being fearful if she had to drive on a motorway, and especially of lorries. She reported becoming acutely anxious if she saw a lorry approach, associated with hyperventilation, and a need to hold on. She remained largely avoidant of driving on motorways …*
>
> ***Formulation:***
>
> *At the follow-up assessment, I considered that* [the Complainant] *had experienced a modest improvement in the intrusive symptoms of Post-Traumatic Stress Disorder, with less frequent ruminations about the accident and less nightmares related to it. She had increased her level of activity, and was managing to drive to* [the local town]*, and to walk her dogs, with assistance. However, she remained highly avoidant and anxious, and had developed symptoms of agoraphobia. She was inclined to pack any anxiety-provoking behaviours into one day, and by doing so, avoided frequent exposure to anxiety.*

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Although the improvement in [the Complainant's] *PTSD had been only modest, there had been a better improvement in her depressive symptoms since the previous assessment. At the time of assessment,* [the Complainant] *reported ongoing anhedonia, but in general, her persistent Depressive Disorder was in the milder range of severity.*

In addition to the PTSD and Depressive Disorder outlined, [the Complainant] *described significant and realistic concerns for her future. She reported being inclined to ruminate on the change in her career and future prospects, with concerns about her financial position, and she outlined a severe financial struggle. She reflected on being unable to see herself returning to work, and was finding it hard to contemplate necessary decision-making in relation to a possible return to the UK. She explained that she was inclined to avoid making decisions, as she did not consider herself in a stable condition to do so. In the context of her changed circumstances and her worries about the future, I considered that* [the Complainant] *was also suffering from an Adjustment Disorder.*

Following her follow-up assessment, [the Complainant] *allowed me to contact her counsellor and CBT therapist,* [Ms M.]*, who reported an initial improvement in* [the Complainant's] *symptoms, but with a set-back since* [the Complainant] *had suffered a panic attack when driving on the motorway, and with a reduction in the frequency of sessions.*

At the time of assessment, [the Complainant] *had engaged with CBT therapy, and was also on high dose antidepressant medication, which had benefitted her to some extent. I considered the* [the Complainant's] *prognosis for recovery from her psychological symptoms must remain guarded, given the modest improvement to date, and her difficulties with returning to work"*.

In light of these reports, I note that the Provider, which advises that it had not received these reports at any stage previously during its claim assessment and appeal process, then arranged for the Complainant to attend for two further independent medical examinations. In this regard, the Complainant attended with Dr F., Consultant Psychiatrist on 10 May 2017, who in his ensuing report dated **10 May 2017** advised, *inter alia*, as follows:

*"**Treatment***

[The Complainant] *told me that she has been having CBT with* [Ms M.]*…since January 2016. She attends every three weeks. She said that this is helping her a good deal.*

She has attended [Dr E.]*, Consultant Psychiatrist, on two occasions for assessment for medico-legal purposes and also for diagnostic and treatment opinion. She does not have further scheduled appointments with* [Dr E.]*.*

She told me that she has been referred to the HSE psychiatry services and has been waiting for two months for an appointment.

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[The Complainant] *is prescribed the antidepressant venlafaxine at high dose, 300 mg daily. She said that the higher dose of this medication has helped her mood. She is also prescribed the sleeping tablet zopiclone 7.5 mg nocte.*

[The Complainant] *is prescribed a number of medications for pain, Kapake two tablets BD, pregabalin 75 mg TDS, tramadol 200 mg daily and paracetamol 500 mg TDS.*

She told me that she attended a pain specialist in [named] *University Hospital about one month ago. She said that she is awaiting recommendations from that assessment.*

She finished physiotherapy at the end of 2016.

She has weekly hydrotherapy treatment in [location] *…*

Work / occupational issues

[The Complainant] *told me that her main concern about work is driving to and from work. She said that the commute is too long at two hours each way. She cannot afford to move to be closer to work.*

She said that she could not sit still for long periods of time at work because she gets low back pain. She said she can sit for a maximum of two to three hours and then has to lie flat for about an hour.

When asked what she needs to change in order for her to return to work she replied that she needs to love nearer to work. She said, "Then I wouldn't have half the problem I have now". She has looked into the logistics of commuting by public transport but it is not practical. She said it would take over three hours each way.

She has discussed working for home with her manager but has been told that they cannot set a precedent …

[The Complainant] *told me that she cannot envisage driving to work. She has a long commute to work, two hours each way. She would be unable to work from home in her position.*

[The Complainant] *has not yet set any goals towards a return to work. She hopes to be able to return to work eventually and said that this is what keeps her going. She is afraid of making a decision about work that will have long-term negative consequences. She said that she is not strong enough to make decisions about work at this time …*

Mood was not depressed or anxious. She was normally interactive and reactive. Affect was euthymic and without any restriction. There was no evidence of anxiety, tension or agitation …

/Cont'd…

Current psychological symptoms are mild in severity. The most prominent symptoms in this assessment were physical ones and the consequent restrictions in activities …

There was no objective evidence of depression of mood during this assessment. She was normally interactive and reactive. Affect was not restricted in any way. There was no evidence of anxiety, agitation or tension. The most notable aspect of symptomatology during the assessment was her need to stand up and move because of her back pain.

[The Complainant] *said she wishes to return to work but has not set any goals towards a return to work …*

[The Complainant's] *primary problem with work is the difficulty in commuting for two hours to work. She feels that she will not be able to drive for this length of time because of her fears about driving since the road traffic accident. In the workplace, the main problems she would have are related to her physical symptoms.*

In my opinion, from the perspective of psychiatric illness, [the Complainant] *is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that it preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature. It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness"*.

In addition, I note that the Provider had arranged for the Complainant to attend with Prof J., Consultant Orthopaedic Surgeon on 16 May 2017. However, following her attendance with Dr F. on 10 May 2017, the Complainant presented at her GP, Dr C. the following day, who advised the Provider in her correspondence dated 11 May 2017, as follows:

"[The Complainant] *has been attending for independent medical examinations with your organisation as part of an appeals process regarding* [her] *ability to return to work.*

Following the accident, [the Complainant] *suffers with anxiety and depression for which she is receiving medication. She also suffers from chronic back pain which is exacerbated by prolonged sitting.*

[She] *attended* [named] *Hospital for the initial medical examination yesterday (Wednesday 10th May 2017) with* [Dr F.] *and is due to attend for a second examination on Tuesday 16th May 2017 with Orthopaedic Consultant* [Prof J.].

[She] *attended the surgery today visibly upset with a deterioration in her mental state. Following the trip to Dublin yesterday she has been extremely anxious and has been suffering with anxiety attacks. She reports difficulty sleeping and also lower*

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back pain due to the long car journey to Dublin. [She] *does not feel that she would be physically or mentally able to attend another examination in such a short time frame.*

I am enquiring if it would be possible to postpone the examination on Tuesday 16th May to a later date".

As a result, the Provider rearranged for the Complainant to attend for examination with Prof J. on 20 June 2017. I note that this is the second time that the Provider referred the Complainant to Prof J., as she previously attended on 17 June 2015 when he had found her unfit to return to work. In his ensuing report dated **20 June 2017**, Prof J. advised, *inter alia*, as follows:

"[The Complainant] *states that the difficulty for her returning to work is that she has to sit for most of the day. She also states that the car journey is a 2 hour journey so this makes it difficult for her.*

On examination this lady has a full range of motion of her cervical spine. She has no abnormality visible at her thoracic spine. Neurologically her upper limbs are normal.

With regard to her lumbosacral spine she has full range of motion in all directions. She has a negative straight leg raising bilaterally and no neurological deficit.

With regard to the activities of daily living this lady states she is able to drive locally and do her supermarket shopping and carry out the groceries. She can also stand and prepare food and wash up.

This lady has improved significantly as would have bene predicted. She still has some residual soft tissue nature low back pain. She has full range of motion, no neurological deficit and no evidence of nerve root compression. This is consistent with a soft tissue back injury. She is functioning well in her daily life and is independent and can drive, cook and shop. Her treatment has improved her situation dramatically. I think that with ongoing home exercises and hydrotherapy and analgesia that her situation will continue to improve in her low back.

I would regard her as fit to work in a sedentary job in an office. It may be that she needs to stand up every two to three hours and move around for a while. I think that she should be fit to return to work certainly for four hours at a time. I think she could do this for three months and then six hours at a time and back to full duty.

The issue about her commute is a little difficult, however she does describe that she can sit comfortably for two – three hours and her commute is two hours. Overall I think she is fit to return to work on a phased basis. Initially for a four hour working day for three months and then increase it, I do not think that by staying out her situation will get better any sooner. I do not think that her returned to work will aggravate her situation and I would regard her as fit to return to work".

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I note that the Provider subsequently asked Prof J. to clarify whether the phased return to work that he refers to in his Report was essential or preferential, to which he advised *"My comments about her phased return are optional. This is not an essential at all. Overall I found that at the review on the 20th June 2017 that this lady was fit for work"*.

I note that the Complainant later attended Dr D., Consultant in Pain Management on 1 November 2017, and in his ensuing Report to a named firm of Solicitors dated **1 November 2017** he advised, *inter alia*, as follows:

> *"Presenting complaints:*
>
> ***Pain 1***
>
> *Site:* *Axial neck pain*
> *Type:* *Dull ache, occasionally sharp pain*
> *VAS:* *3 out of 10 currently. This is since* [Mr J., Consultant Neurosurgeon] *carried out injections in October 2017. Previous to that, her pain score was 3 to 8 out of 10.*
> *Increased by:* *Cold*
> *Decreased by:* *Heat*
> *Currently,* [the Complainant] *has a very low level of pain in her neck.*
>
> ***Pain 2***
>
> *Site:* *Low back pain*
> *Type:* *Constant, dull ache, occasionally sharp pain*
> *VAS:* *9 out of 10, all the time. Previous to injections in her back by* [Mr J.], *her pain score in her back was 7 to 10 out of 10.*
> *Increased by:* *Cold weather, sudden movement, prolonged standing*
> *Decreased by:* *Heat*
> *Initially, after the accident, for the first year,* [the Complainant] *had interscapular pain, but this has now resolved ….*
>
> **VAS = Visual Analogue Pain Scale …*

Opinion and prognosis:

> [The Complainant] *is a very distressed patient. Her prognosis at this stage is extremely guarded. She has had diagnostic blocks and her neck pain has been palliated, but they had no impact whatever on her lumbosacral pain. She will need to go back to* [Mr J.] *for further review. I think it would be valuable if she attended a pain management programme, perhaps the one they have in the Royal National Hospital for Rheumatic Diseases, in Bath which is a residential programme. There are none available in the Republic of Ireland, and the patient is unable to travel several hours a day, to and from her home to a pain management programme in Dublin, Galway or Limerick.*

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[The Complainant] *has had new MRIs of her cervical, thoracic and lumbar spines. The MRI of her cervical spine shows multilevel prolapsed discs at C5-6 and C6-7. The MRIs of her thoracic and lumbar spines are essentially normal. I have suggested to her that she should return to* [Mr J.] *for review, with regard to her lumbosacral spines.*

[The Complainant] *has chronic pain syndrome, which is a mixture of pain, disability and psychosocial distress. She needs to attend a pain management programme, preferably residential, given the remoteness of where she lives. None are available in this country, so this could be accessed through the Treatment Abroad Scheme. Long-term, her outlook has to be extremely guarded, as she has no social support and the slightest minor injury could predispose her to having to enter sheltered accommodation.*

[The Complainant] *is very distressed, and incapable of accessing any pain management programme in this country, and would have to go aboard for one, perhaps to the Royal National Hospital for Rheumatic Diseases, Bath. Alternatively, it may benefit her to attend the Rehabilitation Programme in her Musculoskeletal Unit in* [named institution] *Dublin"*.

The Complainant later furnished this Office with a copy of the Report from Dr D. by email on **22 June 2018**. This Office forwarded this Report to the Provider as part of the complaint process, and I note that in its correspondence dated 3 July 2018 the Provider advised, *inter alia*, as follows:

"During the course of [the Complainant's] *absence, I note that she also attended* [Mr J.]*, Consultant Neurosurgeon and* [Mr D.]*, Consultant Neurologist who formed the same opinion as* [Mr P.]*, Consultant Orthopaedic Surgeon and* [Prof J.]*, Consultant Orthopaedic Surgeon in that her injuries were likely due to soft tissue injury.*

Following a review of [Dr D.]*, Consultant Pain Management, we acknowledge that the Complainant may have residual symptoms however the independent examiners have advised these are not disabling in nature and* [the Complainant] *is fit for work.* [The Provider] *paid a claim to allow time for* [the Complainant] *to resume work, however she has not done so at any stage.*
Please note also [Mr P]*, Consultant Orthopaedic,* [Dr D.]*, Consultant Psychiatrist,* [Dr F]*, Consultant Psychiatrist and* [Prof J.]*, Consultant Orthopaedic Surgeon all carried out objective tests. You will note that the assessment with* [Dr D.] *details self-reported symptoms only.*

It is apparent that the commute to work is the main barrier to [the Complainant] *actually resuming work, however,* [the Provider] *cannot consider this as a factor when assessing work disability.* [The Provider] *can only consider a claim against the definition of disablement. The weight of independent objective medical evidence indicates* [the Complainant] *is fit to resume her pre-disability occupation"*.

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I note that a claimant must satisfy the policy conditions in order to have a valid income protection claim. In this regard, the '**Appendix: Glossary of Terms'** section of the applicable Group Income Protection Policy Conditions provide, *inter alia*, at pg. 19, as follows:

> *"**Disability***
>
> *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"*.

Income protection insurance decisions are based on objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets the policy definitions for a valid claim. Having considered the weight of the objective evidence before it, and which I have cited from at length, I am satisfied that it was reasonable for the Provider to conclude in late 2016, from the medical evidence it received that whilst the Complainant may have had some residual symptoms, these did not prevent her from performing the material and substantial duties of her normal occupation.

Though these symptoms may make the lengthy commute to the workplace difficult for the Complainant, due either to the longevity of the commute itself (approx. 2 hours) or the fear and anxiety of driving on motorways following her accident, or both, I am satisfied that it was reasonable for the Provider to conclude that this aspect of the Complainant's difficulties did not render the Complainant incapable of performing her normal insured occupation as an account manager in her workplace. In this regard, I am satisfied that the difficulties surrounding her commute to work was not a factor that the Provider was required to consider when assessing whether the Complainant was fit to perform the material and substantial duties of her normal occupation, once at the workplace.

As a result, given the terms outlined in the policy document, I am satisfied that it was reasonable for the Provider to conclude that the Complainant no longer satisfied the policy definition of "Disability" within the terms and conditions, for a valid income protection claim. Consequently, in ceasing payment of her claim on 30 September 2016, the Provider acted in accordance with the terms and conditions of the Group Income Protection Policy.

It is my Decision therefore, on the evidence before me that this complaint cannot be upheld.

/Cont'd…

Conclusion

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

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

21 November 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.