Decision Ref:	2020-0022
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Claim handling delays or issues Disagreement regarding Medical evidence submitted
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant is a member of a Group Income Protection Policy via his Employer, the policyholder. The Provider is the insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant, [profession] was certified as unfit for work from **20 June 2015** and completed an income protection claim form to the Provider wherein he advised, as follows:

> ***"Describe in detail your illness/condition***
> *Diagnosed with depressive illness in January 2014 & prescribed Lexapro & time out/rest to recover from overburden. This diagnosis was following a spell of illness/ injury following a head trauma & back injury outside of work. This injury was followed by a short term job abroad. Doctor diagnosed this condition & cause was a result of many factors which included stress, back injury, head & sinus issues & adverse reaction to anti-malaria medication in 2012/2013.*
>
> ***How does your condition prevent you from working?***
> *Reduced motivation & increased lethargy.*
> *Difficulty in concentrating on a specific task which leads to being easily distracted.*
> *Short term memory difficulties / forgetfulness.*
> *Back injury also deteriorates with prolonged periods at my desk/office.*

> ***What work related activities does your current condition prevent you from performing?***
> *Driving to/from site work.*
> *… Management have restricted me to desk/office work. [Occupation] and duties are no longer permitted to be carried out.*
> *Prolonged spells/duration at my desk leads to increased symptoms of my conditions & back pain"*.

As part of its assessment of this claim, the Provider referred the Complainant to Consultant Psychiatrist Dr F. for an independent medical examination on **29 October 2015**. As his ensuing report deemed the Complainant fit to work, the Provider concluded that the Complainant did not satisfy the Group Income Protection Policy definition of disability and declined his income protection claim on 17 December 2015.

The Complainant appealed this declinature and as part of its review, the Provider referred him to Consultant Psychiatrist Dr D. on **28 June 2016** and Consultant Neurologist Dr X. on **17 August 2016** for further independent medical examinations. As their ensuing reports also deemed the Complainant fit to work, the Provider affirmed its decision to decline his income protection claim on **7 September 2016**.

The Complainant, however, seeks for the Provider to admit his income protection claim.

The Complainant's complaint is that the Provider wrongly or unfairly declined his income protection claim.

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

Provider records indicate that the Complainant, a [occupation], is a member of a Group Income Protection Policy via his Employer, the policyholder. The Complainant completed an income protection claim form to the Provider wherein he noted his illness as *"Diagnosed with depressive illness in January 2014"*.

In addition, the Complainant's GP Dr P. completed a Practitioner Report on **18 November 2015**, wherein he noted the exact nature and cause of the Complainant's disability as *"Depression"*. The Complainant's Employer, as the policyholder of the Group Income Protection Policy, completed an Employer Claim Form to the Provider on 18 August 2015 wherein it noted the Complainant's reason for incapacity as *"Depression"* and the first date of his absence as 20 June 2015.

In order for an income protection claim to be payable, a member of the Group Income Protection Policy must satisfy the policy definition of disability, as follows:

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> *"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 occupation"*.

As the deferred period is 26 weeks and given that the Complainant's absence commenced on 20 June 2015, any Provider liability was not due to commence until 19 December 2015.

As part of the initial claim papers, the Complainant's GP Dr P. included his Consultation Notes, which detailed that the Complainant had attended throughout 2014 and 2015 with, *inter alia*, depression, though the Provider notes that the then most recent entry regarding this diagnosis dated 9 July 2015 stated, *"Depression improved recently"*. The Provider also received a number of reports from Consultant Psychiatrist Dr M., who following his consultations with the Complainant on 18 February, 18 March, 3 June, 15 July, 26 August and 28 October 2015 presented in his Report dated 1 November 2015 an overall picture of improvement with a resumption of work planned for early 2016, as the Complainant was reluctant to resume work beforehand. In this regard, the Provider notes that his own treating doctors did not seem to suggest or indicate that the Complainant's mental illness was of a significant disabling nature and it appeared to have resolved satisfactorily before any Provider liability was due to commence on 19 December 2015.

However, in order to assess the claim fully, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 29 October 2015. During the course of this assessment, the Complainant advised that he suffered a head injury in 2012 but that he did continue to work thereafter and had done so for a significant period. The Complainant also described a very active daily and social activity routine, involving physical gym training, daily [sport] training, driving long distances to the west of Ireland for [sport], fixing [sporting equipment] and his then recent participation in a race in Europe. In his ensuing Report dated 29 October 2015, Dr F. advised, *inter alia*, as follows:

> "[The Complainant] *said that when he returns to work he will need to have a change of working department but initially he will have to go back to the old job. He said he needs a change of job to be more motivated and stimulated.*
>
> [The Complainant] *told me that he used to get frustrated with doing other people's work and having other people taking credit for work he did. He talked of others being "promoted on your back". He feels he was less rewarded than he should have been …*
>
> [The Complainant] *engaged well in the interview and good rapport was established. His behaviour was within normal parameters during the assessment.*
>
> *Mood was not depressed or anxious during the assessment. Affect was euthymic and normally reactive.*

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Thought content was not notably negative or depressive. There was no suicidal ideation.

There was no abnormality of the form or stream of thoughts. There was no evidence of psychosis.

There was no evidence of memory or concentration difficulties in the assessment …

[The Complainant] *has been diagnosed with depression. Currently there are mild symptoms of depression. There appears to have been significant remission of symptoms compared to when he first went on sick leave …*

[The Complainant] *has a full life and there is little evidence that, at this time, there is any negative impact on his normal daily activities by symptoms of a depressive illness. His daily activities indicate that he is functioning at a high level. He is able to participate in his* [description]*-sports leisure activities on a very regular basis …*

His current mental state does not provide objective evidence of symptoms of depression of any significance at this time …

In my opinion [the Complainant] *is now fit to resume his normal occupation on a full-time basis. He is not currently disabled from performing the material and substantial duties of his normal occupation as an* [occupation].

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".

The Provider concluded that this independent medical examination and the collateral evidence provided by the Complainant's treating doctors were not suggestive of a disabling psychiatric complaint at the time its liability was due to commence on **19 December 2015**. As a result, the Provider wrote to the Complainant's Employer, the policyholder, on 17 December 2015 to advise that it was declining the Complainant's income protection claim, as follows:

"Based on the evidenced received I regret to advise we are unable to accept [the Complainant's] *claim. IME* [independent medical examination] *findings suggest that:*

"In my opinion [the Complainant] *is now fit to resume his normal occupation on a full-time basis. He is not currently disabled from performing the material and substantial duties of his normal occupation as an* [occupation].*".*

If [the Complainant] *is unhappy with the decision on his case, there is a facility for him to appeal the decision".*

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Both the Complainant and his Employer appealed this decision in March 2016 and provided contemporaneous medical reports. In this regard, in his letter dated 16 March 2016, Consultant Psychiatrist Dr M. indicated that the Complainant was on antidepressant medication and had responded well to this intervention but was currently unfit for work. The Provider notes, however, that there was no indication from Dr M. of any deterioration in the Complainant's mental health since his previous Report dated 1 November 2015, which had presented an overall picture of improvement. In addition, the Report from Principal Clinical Neuropsychologist Prof N. dated **13 January 2016** did not indicate that the Complainant was unfit for work, though it did note cognitive deficits post head injury in 2012.

In order to further consider the claim, the Provider arranged for the Complainant to attend Consultant Psychiatrist Dr D. on 28 June 2016 for a further independent medical examination, who in his ensuing report dated 28 June 2016 advised, *inter alia*, as follows:

> *"There was no evidence of depression or anxiety; he wasn't upset at any stage during the interview. His attention, concentration and memory were normal …*
>
> *The report of* [Professor N.] *Principal Clinical Neuropsychologist.*
>
> [Professor N.] *states that* [the Complainant] *had a mild brain injury when [circumstances of injury redacted] . He states that while there was no loss of consciousness reported, that* [the Complainant] *was "obviously concussed".* [Professor N.] *found that* [the Complainant] *had "a pattern of reduced attentional function in memory". He does have difficulty in coding large volumes of information and visual memory is markedly impaired for his professional chosen experience. It does appear to be a difficulty in handling large volumes of information. A similar pattern was seen in executive functions, reduced working memory, speed and concentration. "Tasks unrelated to this were performed at normal levels, with good levels of language and perception".*
>
> *Comment:* [Professor N.] *doesn't give any specific recommendations and rehabilitation; he recommends a referral to Headway.* [Professor N.]*'s report was based on an assessment carried out in January 2016. The last head injury* [the Complainant] *had was in 2012. Following the head injury, he continued at work for a further three years. There was a gradual deterioration in his functioning from about 2014-2015 due to increasing commitments which he could not manage, leading to depression and anxiety. It seems likely that if there was a significant cognitive impairment due to a series of head injuries, up to 2012, that his function would have been at its lowest in 2012 and if anything, gradually improving over time. Physical or cognitive symptoms with initial onset weeks or months after traumatic brain injury (TBI) or symptoms that progressively worsen over the months or years after injury may have explanations other than TBI.* [Professor N.] *doesn't make any statement on whether* [the Complainant] *is fit for work …*

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It is my opinion that from a psychiatric point of view, [the Complainant] *is fit to return to work. He has had symptoms of anxiety and depression which have now entirely resolved. He is functioning at an extremely high level as described by his activities of daily living. He had difficulties at work as he did not like his placement in* [location]*, he felt there were excessive demands put on him"*.

It is difficult for the Provider to accept the view of Professor N. that the Complainant had been *"obviously concussed"* when the MRI brain scan in 2015 was normal. The Provider is not aware of any CT scan or equivalent scan undertaken shortly after the incident in 2012 which confirmed a concussion and it appears there was no formal neurological examination and evaluation of signs or symptoms shortly after the event in 2012.

Nevertheless, the Provider arranged for the Complainant to attend for a neurology review with Consultant Neurologist Dr X. on **17 August 2016**, who in his ensuing Report dated 31 August 2016 advised, *inter alia*, as follows:

"From my perspective as a Neurologist I will concentrate on [the Complainant's] *head injury which occurred in 2012.*

[The Complainant] *was attending…..[circumstances of injury redacted]. He states he does not remember the events immediately thereafter and possibly for a number of hours. He was however drinking before and after the head trauma. Based on the history* [the Complainant's] *head trauma would be classified as minor/mild. He also suffered a probable whiplash injury to his neck region as a result of the trauma sustained in the pool.*

Imaging studies of his brain which were performed in April 2015 showed no macroscopic brain pathology as a result of the head trauma sustained in 2012. The MRI scan of his neck showed some mild disc dehydration at C2, C3, C4 and C5. This would not be unexpected in a man who has been so active over the years. His imaging studies were also performed approximately 3 years following his head and neck trauma… Following this patient's head trauma he was able to continue working and ran a big project abroad for up to 9 months …

From my standpoint as a neurologist it would be very unusual for neurocognitive deficits following a minor/mild head injury to persist for this length of time following that head trauma. It is highly probable that [his] *difficulties with attention and concentration which were on-going in the assessment performed by* [Professor N.] *in January of this year were more likely related to the patient's mood. It is well known that problems with mood/depression result in difficulties with attention and concentration and hence memory complaints/deficits.*

From the neurological standpoint then I do not feel that any of [the Complainant's] *on-going complaints are as a direct result of the minor/mild head injury sustained in 2012. From the neurological standpoint this patient is fit to return to his previous occupation full time"*.

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On review of all of the medical evidence before it, the Provider remained of the opinion that the Complainant was not medically disabled from performing his duties as a [profession] and its decision to decline his claim remained unchanged. As a result, the Provider wrote to the Complainant's Employer, the policyholder, on 7 September 2016 to advise that it was affirming its decision to decline the Complainant's income protection claim, as follows:

> *"As you know* [the Complainant]*'s claim was declined on the 17/12/2015 following a review of the findings received from the independent medical examination which the member attended on the 29/10/2015.* [The Complainant] *appealed this decision. As part of the appeal, we arranged a further two independent medical examinations on the 28 June 2016 & 17 August 2016. We have now received the findings following the recent medical assessments.*
>
> *Based on the findings of the independent medical examination and a review of all medical records on file including the appeal documents submitted and 2 independent assessments that* [the Complainant] *attended, it is our opinion that* [the Complainant] *does not meet the definition of disability as set out in the policy. I must advise therefore that we are unable to admit this claim"*.

In assessing his claim, the Provider arranged for the Complainant to attend for three different independent medical examinations and each of these examiners, two very experienced mental health professionals and a neurologist, were provided with a copy of the full file inclusive of all the medical evidence submitted by or on behalf of the Complainant. The Provider has no concerns in relation to the ability of these examiners to form an independent opinion as to the Complainant's fitness for work and notes that in forming their opinions, these three doctors had sight of and clearly considered the medical evidence provided by and on behalf of the Complainant in conjunction with their own actual assessments.

The Provider is satisfied based on the extensive medical evidence it received during both its claim assessment and appeal review that the Complainant was not medically disabled from working at that time. In arriving at its decision, the Provider notes that the medical reports furnished by the Complainant's GP Dr P. and his Consultant Psychiatrist Dr M. showed that depression was diagnosed and treated throughout 2014 and 2015, however it is evident from both doctors that there was improvement. In this regard, for example, the then most recent entry in the Complainant's GP's Consultation Notes dated 9 July 2015 regarding this diagnosis stated, *"Depression improved recently"*. In addition, when he was reviewed by Consultant Psychiatrist Dr F. in October 2015, the Complainant was deemed fit for work.

Whilst it acknowledges that the Complainant has a diagnosis of depression, the Provider notes that the symptoms described were mild in nature, due to sufficient recovery and were not of such severity as to be disabling. In this regard, the diagnosis of an illness does not automatically equate to work disability and it appears that the Complainant had recovered sufficiently to resume work before the policy deferred period expired on 19 December 2015, when any Provider liability was due to commence.

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In addition, there is no clinical evidence or tests which support an organic cause for the cognitive issues complained of by the Complainant and his brain MRI in April 2015 was entirely normal. Whilst it has been commented that his cognitive issues could be related to his mental health, the Provider notes that neither Consultant Psychiatrist Dr F. nor Dr D. were able to uncover any particular issues related to the Complainant's attention, concentration and memory on mental state examination and Dr F. performed a memory Rey Test and the Complainant scored normally. In any event, even if there is some organic/mood-related component to his cognitive complaints, the Provider notes that it did not prevent the Complainant from working for a significant period following the incident in 2012 and did not prevent him from delivering significant workplace projects.

Furthermore, the Provider notes that the cervical and lumbar spine MRIs that the Complainant had in April 2015 were normal, apart from some mild disc dehydration and mild degenerative changes and neither revealed any nerve root compression which might explain the back pains the Complainant has complained of. It is clear the Complainant is a very active individual not only in his normal everyday life, but he has competed in a number of sporting events/ activities over the years, post injury event in 2012. Events such as [sports] carry a health and accident risk, however his health complaints did not seem to prevent him from performing in such events. The Provider strongly contends that a disabling physical or mental illness not just prevents an individual from working, but also has a significant impact on their ability to perform normal activities of daily living and recreation/competitive activities. In this regard, the Provider deems that the Complainant's self-reported level of activity would not be commensurate with a disabling medical illness.

Finally, the Provider also notes that other non-medical factors may have been a possible contributing factor to the Complainant's absence from work. In this regard, Dr F. advised in his Report dated 29 October 2015 that the Complainant had stated his frustration on several issues within his Employer and felt he needed a change of job for motivation and stimulation. Similarly, his GP Consultation Notes show that the Complainant had commented on 7 May 2014 of his dislike of the office environment. In this regard, it is not uncommon in cases of illness absence that where displeasure of the job and employer culture exists, motivation is affected and it is the Provider's experience that this invariably leads to an elongation of illness absence beyond the stage that is necessary.

In conclusion, the Provider carefully and fully considered all medical evidence before it, including the evidence furnished by the Complainant's own treating doctors. The Provider remains satisfied that the overall weight of objective evidence was not suggestive of a disabling psychiatric or physical complaint at the time its liability was due to commence in December 2015. Accordingly, the Provider is satisfied that the Complainant did not satisfy the policy definition of disability for a valid claim and thus that it correctly declined his income protection claim, in accordance with the terms and conditions of the Group Income Protection Policy of which he is a member.

Decision

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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 8 January 2020, 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 declined the Complainant's income protection claim. In this regard, the Complainant is a member of a Group Income Protection Policy via his Employer, the policyholder. The Provider is the insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant, a [profession] was medically certified as unfit for work from 20 June 2015 and completed an income protection claim form to the Provider wherein he listed his illness and condition as *"Diagnosed with depressive illness in January 2014 & prescribed Lexapro & time out/rest to recover from overburden".* As part of its assessment of this claim, the Provider referred the Complainant to Consultant Psychiatrist Dr F. for an independent medical examination on 29 October 2015. As his ensuing report deemed the Complainant fit to work, the Provider declined his income protection claim on 17 December 2015. The Complainant appealed this declinature and as part of its review, the Provider referred him to Consultant Psychiatrist Dr D. on 28 June 2016 and Consultant Neurologist Dr X. on 17 August 2016 for further independent medical examinations. As their ensuing reports also deemed the Complainant fit to work, the Provider upheld its decision to decline his income protection claim on 29 June 2018.

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In this regard, the Complainant complains that the Provider wrongly or unfairly declined his income protection claim and he seeks for it to admit his claim for the period that he was medically certified as unfit to work.

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 regard, **Section IV, 'Claims'**, of the applicable Group Income Protection Policy Conditions provides, *inter alia*, at pg. 12:

> *"The benefit shall be payable to the claiming member 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 '**Interpretation**' section of these Policy Conditions provides, *inter alia*, at pg. 4:

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

I note that the Complainant was certified as unfit for work from 20 June 2015 and completed an income protection claim form to the Provider wherein he advised, as follows:

> *"**Describe in detail your illness/condition***
> *Diagnosed with depressive illness in January 2014 & prescribed Lexapro & time out/rest to recover from overburden. This diagnosis was following a spell of illness/ injury following a head trauma & back injury outside of work. This injury was followed by a short term job abroad. Doctor diagnosed this condition & cause was a result of many factors which included stress, back injury, head & sinus issues & adverse reaction to anti-malaria medication in 2012/2013.*
>
> ***How does your condition prevent you from working?***
> *Reduced motivation & increased lethargy.*
> *Difficulty in concentrating on a specific task which leads to being easily distracted.*
> *Short term memory difficulties / forgetfulness.*
> *Back injury also deteriorates with prolonged periods at my desk/office.*
>
> ***What work related activities does your current condition prevent you from performing?***
> *Driving to/from site work.*
> *… Management have restricted me to desk/office work.* [occupational duties] *are no longer permitted to be carried out.*
> *Prolonged spells/duration at my desk leads to increased symptoms of my conditions & back pain"*.

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In addition, the Complainant's GP Dr P. completed a Practitioner Report on 18 November 2015, wherein he noted the exact nature and cause of the Complainant's disability as *"Depression"*. The Complainant's Employer, as the policyholder of the Group Income Protection Policy, completed an Employer Claim Form to the Provider on 18 August 2015 wherein it noted the Complainant's reason for incapacity as *"Depression"* and the first date of his absence as 20 June 2015. As the policy deferred period is 26 weeks, I am satisfied therefore that taking into account the deferred period referenced in the policy, any Provider liability for this claim would only have been due to commence from **19 December 2015**.

I note that the Complainant's GP included his Consultation Notes, which include a number of entries regarding depression, as follows:

"28/01/2014 P76 DEPRESSIVE DISORDER Agitated depression x months, Getting progressively worse. Not suicidal … General advice. Psychotherapy recommended. Start Lexapro %mg od x 1/52 …

03/02/2014 P76 DEPRESSIVE DISORDER Depression has not deteriorated over past week. Tolerating SSRI. Attended psychotherapist last week. Continue Lexapro 5mg od x 2/52 then review progress ….

05/03/2014 P76 DEPRESSIVE DISORDER Depression exacerbation by resolving viral URTI. Not suicidal … General stress management advice. Continue Lexapro 5mg od x 2/52 then increase Lexapro to 10mg od if he has not improved …

19/03/2014 P76 DEPRESSIVE DISORDER Depression improving slowly … Continue Lexapro 5mg od x 1/12 …

16/04/2014 P76 DEPRESSIVE DISORDER Depression much improved. Attending psychotherapist. Continue Lexapro 5mg od x 1/12. General discussion re- work/life balance …

07/05/2014 P76 DEPRESSIVE DISORDER Depression static. Unable to go to work recently due to lethargy & dislike of office environment. Feels he is not productive at present. …Plan: Increase Lexapro to 10mg od x 1/12. Continue psychotherapy …

09/06/2014 P76 DEPRESSIVE DISORDER Depression improved since Lexapro increased. Tolerating SSRI well … Continue psychotherapy & Lexapro 10mg od x 2/12 then review …

21/07/2014 P76 DEPRESSIVE DISORDER Depression resolved. Has made decision re-work & career future which he is satisfied with … Wean off SSRI slowly …

24/09/2014 P76 DEPRESSIVE DISORDER Mood dipped when weaned off SSRI but normal since resumed Lexapro 10mg daily …

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07/11/2014 *P76 DEPRESSIVE DISORDER Depression exacerbation off SSRI recently with alcohol ingestion. Resume Lexapro 10mg od x 1/12. Continue psychotherapy.*

16/12/2014 *P76 DEPRESSIVE DISORDER Depression stable. Continue Lexapro 10mg od x 1/12. Refer to* [Consultant Psychiatrist Dr M.] …

06/01/2015 *P76 DEPRESSIVE DISORDER Depression stable …*

09/07/2015 *P76 DEPRESSIVE DISORDER Depression improved recently. Continue Lexapro 20mg od. To attend* [Consultant Psychiatrist Dr M.] *for review soon"*.

In addition, enclosed with the Practitioner Report were a number of reports from Consultant Psychiatrist Dr M., following his consultations with the Complainant on 18 February, 18 March, 3 June, 15 July, 26 August and 28 October 2015. In his then most recent Report dated 1 November 2015, I note that Dr M. advised, *inter alia*, as follows:

"I met again with [the Complainant]*…on 28/10/2015.*

I had previously met with him on 26/08/2015. I did not note any disimprovement in his mental state and I had recommended he continue with the current treatment plan including pharmacotherapy with Escitalopram 15mg daily …

When reviewed [the Complainant] *reported he has been reasonably well in the intervening period. He said he felt better than he had when previously seen. He described an improvement in his mood state. He described his reactivity as improved. He did not describe any particular new difficulties with his sleep, appetite, energy, concentration and motivation …*

He reported he met with [Dr J.] *at* [his Employer's] *Occupational Health Department the previous week and that they had agreed that he would aim to return to work I January/February of 2016.*

[The Complainant] *reported his physical health status was stable …*

It was easy to establish and maintain a rapport with [the Complainant]. *His speech was coherent and rational with a normal rate and normal volume. His mood state was subjectively and objectively brighter than when previously seen. He was not subjectively depressed at interview … He reported a degree of rumination on work related matters … He was alert. He was orientated. He was cognitively grossly intact. In terms of his self-appraisal he saw his mood state as having a trajectory of improvement associated with some of the behavioural measures that he had engaged with. He remains ambivalent about his prescribed pharmacotherapy …*

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[The Complainant]*'s mental state had not disimproved since last reviewed at the end of August 2015.*

There appears to be a trajectory of improvement in his mental state and specifically his mood state associated with his engagement with the recommended behavioural interventions and his current pharmacotherapy.

I note reluctance on [the Complainant's] *part to consider a phased return to work until January or February of 2016 …*

I have recommended that continue the Escitalopram at its current dose of 15mg daily.

I have stressed that as this is the best he has been in terms of his mental state since we have started working together that it would be premature to consider a discontinuation of his prescribed medications at this point in time.

We have agreed ongoing and routine review at the end of January 2016".

In addition, also enclosed were three Radiology Reports. In this regard, the MRI Lumbar Spine Report dated **7 April 2015** states, as follows:

"Findings:
Normal vertebral body alignment, height and marrow signal is preserved.
The central canal and neural exit foramina are patent at all levels with no cord or nerve root impingement. The cord ends at L1 and the conus and cauda equina are within normal limits.
The facet joints show evidence of mild degenerative changes at L4-5 with no pars defect.

Impression:
No cord or nerve root impingement".

The MRI Cervical Spine Radiology Report dated **7 April 2015** states, as follows:

"Findings:
Normal vertebral body alignment, height and marrow signal is preserved.
There is mild disc desiccation from C2-3 to C4-5 without a disc bulge or prolapse and the central canal and neural exit foramina remain patent at all levels.
The brainstem, cervical and upper thoracic cord are normal with no intrinsic cord lesion or compression. No evidence of nerve root impingement. No fracture or dislocation.

Impression:
No cord, nerve root impingement or intrinsic cord lesion".

The MRI Brain Radiology Report dated **7 April 2015** states, as follows:

/Cont'd…

"Findings:
There is no haemorrhage, infarction or space-occupying lesion.
The grey-white matter interface is preserved and the ventricular and basal cisterns are within normal limits. The extra-axial structures are normal.
Diffusion weighted imaging and gradient echo sequences are normal.
Normal central T2 intervascular flow voids.
The visualised facial sinuses are clear.

Impression:
Normal examination".

In order to assess the claim fully, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 29 October 2015, who in his ensuing Report dated 29 October 2015 advised, *inter alia*, as follows:

*"**Background***

[The Complainant] *last worked in his profession as a* [profession] *with* [his Employer] *in June 2015. He has worked with* [his Employer] *since March 2006 and has been in his present role since June 2011.*

[The Complainant] *has been on sick leave because of a depressive illness.*

History of illness

[The Complainant] *told me that [circumstances of injury redacted]. He does not know if he lost consciousness. He does not remember anything further until he woke the next morning. However, he was told by other guests [nature of event redacted] that he had continued drinking and was in great form and the rest of the evening. He did not have any treatment is* [location].

Two days later he returned to [Location redacted] and went to [name of hospital redacted] Hospital where he was admitted for investigations. He had a spinal x-ray but no head CT or MRI scan. He was diagnosed with whiplash and compressed vertebrae. He was off work for two or three weeks. He had a brain MRI some time later which was normal.

He went on a short-term work assignment to [location] *in October 2012. He was initially supposed to go for just three weeks but it turned into a three-month posting. He was annoyed with* [his Employer] *for this, feeling badly treated by being told this would be only three weeks and it ended up being three months. His girlfriend was at home in Ireland and was not happy with this.*

He returned to work in Ireland in early 2013. His back injury had been causing some problems abroad. He told me that his motivation started to drop off but it was not having a noticeable effect on his work and he was still delivering on his projects.

/Cont'd…

He had a series of sinus infections. He attributed his work problems to the effects of poor sleep secondary to sinusitis. He said, "Things started to get on top of me".

In January 2014 he was prescribed the antidepressant escitalopram. He said, I wouldn't have thought I was depressed… Maybe just overloaded… I was struggling to get into work". He found it difficult to get motivated in the morning. He had low energy levels. He was feeling more tired than usual. He said there were also problems in his relationship.

From November 2014 he went on a three-day week because he was finding that when working five days weekly he was using the weekend for recovery. By taking annual leave days instead of sick days he had used up all his annual leave. He said he was waking feeling exhausted and many days he was not able to go into work until lunchtime. He said he was getting frustrated with work.

In January 2015 there was deterioration. He met some friends for a [specific] *holiday in* [location]. *He said, "I just wasn't myself… I wasn't enjoying it… I wasn't enjoying their company". Increasingly he felt he was not coping at work. He was indecisive at work and at home. He felt that his brain was overloaded.*

[The Complainant] *said that he had been struggling to get to work for two to three years for what he now realises were mood difficulties.*

In the background there was an adverse reaction to antimalarial medication, Malarone, in 2012/2013. He said this had led to disturbing dreams and poor sleep.

Current symptoms

Since being off work [the Complainant] *feels there has been some improvement in his mood. However, he still has days on which he feels more tired than normal.*

[The Complainant] *told me that the last three or four weeks he has felt not too bad. He said he is getting back into a routine with physical activity. He does not describe persistent depression of mood or diurnal mood variation. He said that he is more irritable than usual.*

Motivation has improved. He said he is motivated to start things.

His sleep has improved but he still feels tired the morning. He has a more regular sleep pattern. He does not describe early morning waking.

His appetite is normal. His weight is stable. His libido is normal. He said his energy levels are lower and he feels tired in the mid-afternoon.

Treatment

/Cont'd…

[The Complainant] *started on the antidepressant escitalopram in January 2014. He currently takes 15mg daily. He thinks it probably has helped.*

He has attended [Dr M.]*, consultant psychiatrist…since June 2015.* [Dr M.] *had increased the dose of the antidepressant to 20mg daily but there were side effects of tiredness and forgetfulness so he reverted to 15mg daily. He last attended* [Dr M.] *this week and his next appointment is at the end of January 2016.*

He has an appointment pending with [Dr N.]*, clinical neuropsychologist…for a full range of neuropsychological testing.*

[The Complainant] *has been attending…a counsellor…for the past 18 months. He is attending weekly. From his description, this is not a CBT type of intervention.*

Daily routine

[The Complainant] *told me that he gets up between 9 and 10 AM. After breakfast he walks the dog for 30 to 60 minutes, depending on the weather. He then does some work fixing* [sporting equipment].

In the afternoon he goes training in the [sport] *club for one to two hours. He does gym work or cardio work in the water. Most of the time he meets somebody that he can train with.*

He shares the housework with his girlfriend and usually does an hour of this during the day.

He might meet a friend for coffee or dinner. He sometimes has dinner with his parents. If his girlfriend is at home they may go out for dinner or cook it together. [The Complainant] *told me that he cooks in the evenings and enjoys preparing food. He told me that he makes three meals a day.*

His main social activities are [sport] *and meeting friends. He goes* [sport] *at least once weekly. He drives to* [location] *to go* [sport] *and occasionally stays overnight.*

He watches television in the evening. He listens to music. He said he used to read a lot but he has lost interest and books do not engage him. He said he is also easily distracted because of poor concentration.

He has recently been to [location] *for a week to participate in an* [sport] *race. He said he underperformed because he was not in the right place to race.*

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Work / occupational issues

[The Complainant] *told me that he wants to go back to work. He is worried by the thoughts of going back to where he was mentally when he was at work. He said he had been happy in his work up to the last two years.*

It is difficult for him to face returning. He worries about what he will say to people at work about why he has been off.

He said that when he returns to work he will need to have a change of working department but initially he will have to go back to the old job. He said he needs a change of job to be more motivated and stimulated.

[The Complainant] *told me that he used to get frustrated with doing other people's work and having other people taking credit for work he did. He talked of others being "promoted on your back". He feels he was less rewarded than he should have been.*

[The Complainant] *told me that he intends returning to work towards the end of January or February 2016. He said that he intends to return initially for three days weekly gradually phase back into full-time working.*

Medical History

[The Complainant] *has problems with his back, which date back to when he was a professional* [sportsman] *before he went into* [profession]. *He told me that MRI scans have shown that there are inflammatory changes in his spine. He has physiotherapy for this. The back problems are aggravated by the injuries suffered in the swimming pool accident in 2012. He has recurrent sinus infections. He gets occasional ear infections secondary to* [sport] *and swimming. He currently has an injury to his right shoulder, secondary to* [sport] …

Montgomery-Åsberg depression rating scale (MADRS)

The Montgomery-Åsberg depression rating scale 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 interview. It is not a diagnostic instrument but is considered a measure of illness severity.

The MADRS score for [the Complainant], *based on the psychiatric interview on 29/10/2015, was 8. This score is at the lower end of the range of mild depressive symptoms.*

Beck Depressive Inventory (BDI-II)

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The Beck Depression Inventory is a self-administered questionnaire consisting of 21 statements which is used to assess depressive symptoms. It is not in itself a diagnostic instrument for depressive illness and a diagnosis should not be made based on the scoring in the BDI alone. It was completed by [the Complainant] *as part of the psychiatric assessment on 29/10/2015.*

[The Complainant] *endorsed symptoms that scored into the range of symptoms of depression of moderate severity. There was some inconsistency between the severity of symptoms endorsed in the BDI and the severity of symptoms elicited in the clinical interview (as reflected in the lesser severity score in the MADRS).*

SIMS questionnaire

This is a 75-item multiaxial self-administered screening measure, which may help in determining if there is symptom overstatement. It was completed by [the Complainant] *as part of the psychiatric assessment on 29/10/2015.*
His total score of 12 was not elevated.

Rey Test

The Rey 15 item memory test comprises five sets of three items which the patient is instructed to remember when shown for 20 seconds. Although apparently a complex memory task, it is in fact easy to remember and reproduce the items. Scores of less than nine in the absence of specific brain dysfunction suggest falsification.

[The Complainant] *scored 15 in this test.*

Mental state examination on 29/10/2015 *…*

[The Complainant] *engaged well in the interview and good rapport was established. His behaviour was within normal parameters during the assessment.*

Mood was not depressed or anxious during the assessment. Affect was euthymic and normally reactive.

Thought content was not notably negative or depressive. There was no suicidal ideation.

There was no abnormality of the form or stream of thoughts. There was no evidence of psychosis.

There was no evidence of memory or concentration difficulties in the assessment.

Conclusions / Opinion

/Cont'd…

Diagnosis:
[The Complainant] *has been diagnosed with depression. Currently there are mild symptoms of depression. There appears to have been significant remission of symptoms compared to when he first went on sick leave.*

Circumstances of development of illness:
[The Complainant] *gives a history of having developed symptoms of depression over a two to three year period. The head injury he suffered in June 2012 may have been a relevant aetiological factor (there is an increased risk of depression in a person who has experienced significant head trauma).*

Current symptoms:
… Current symptoms are mild in severity. From the history obtained, [the Complainant] *had more severe symptoms but there has been improvement on appropriate treatment. His level of functioning also appears to have improved.*

Level of function and effects of illness on ability to carry out normal activities:
[The Complainant] *has a full life and there is little evidence that, at this time, there is any negative impact on his normal daily activities by symptoms of a depressive illness. His daily activities indicate that he is functioning at a high level. He is able to participate in his* [specific]*-sports leisure activities on a very regular basis …*

Current mental state:
… His current mental state does not provide objective evidence of symptoms of depression of any significance at this time.

Goals towards a return to work:
… [the Complainant] *is concerned about how he will explain his absence from work to colleagues, which is a common problem in people have been off work for a significant period with mental health problems. He is contemplating returning to work in early 2006.*

Degree of disability:
[The Complainant] *is recovering from depression. At this time his depressive illness is not disabling and his current psychiatric symptoms are not disabling in nature.*

Fitness for work:
In my opinion [the Complainant] *is now fit to resume his normal occupation on a full-time basis. He is not currently disabled from performing the material and substantial duties of his normal occupation as an* [occupation].

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.

Future treatment recommendations:

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[The Complainant] *is on appropriate treatment and it is essential that he continues on antidepressant medication for as long as his treating psychiatrist recommends. It is essential that he adheres to treatment recommendations, including continuation of antidepressant treatment for a significant time into the future, so that the risk of recurrence of depression can be minimised"*.

I note that the Provider concluded from the results of this independent medical examination and the reports provided by his treating doctors that the Complainant was not suffering from a disabling psychiatric complaint at the time its liability was due to commence on 19 December 2015. As a result, the Provider wrote to the Complainant's Employer, as the policyholder, on 17 December 2015 declining his income protection claim.

The Complainant appealed this decision in March 2016 and provided two contemporaneous medical reports. In this regard, in his Report dated 13 January 2016, Principal Clinical Neuropsychologist Prof N. advised, *inter alia*, as follows:

"[The Complainant]*…sustained a mild brain injury [circumstances of injury redacted]. He attended a local A&E Department and then was discharged home. He was then subsequently deployed to* [location] *with* [his Employer]. *He noticed an alteration in his mental state and alcohol use was in excess of the normal recommended limits. I note from your referral that an MRI brain scan was reported as normal. Unfortunately, there has been no significant improvement in his mental health …*

[The Complainant] *told me that the accident occurred in* [location]. *He said that he experienced a whiplash type injury. He said that following the accident he continued at the party but has no clear memories until the following morning, although he does acknowledge that he continued drinking and partying, which may have contributed to his difficulties [circumstances of injury redacted] and he feels that there is a gap of approximately two or three hours before his memories return. He drove 400km to the airport the next day and returned home to [Location Redacted]. He had no further follow-up or neurological reviews or x-rays. He is currently off work due to significant back pain. He told me that he was sent to* [location] *for three months following the injury, which he found very difficult. He said that he is not the same now. He said that his "head" is not great and he told me that he has depression and mild sleep apnoea. His fitness is improving and he feels, that he is starting to get better. He said that he has some on-going forgetfulness, which, he feels might relate to distractibility and absent-mindedness. Unfortunately, his relationship also broke down during this period of time.*

He told me that he had high cholesterol and high blood pressure in the past and this is managed by his GP. He is taking Lexapro for his mood and he also attended a counsellor. He has been out on sick leave since June 2015. He told me that he has a long history of multiple bangs to the head as he has been involved in significant active sports all his life but did have a bad bang to the lead with laceration at age 16 but has numerous other head injuries [sports named]. *He does not think that he ever lost consciousness but he does feel that he may have had concussions in the past.*

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Neuropsycholgical Examination

General Intellectual Ability:

I estimated his intellectual ability to fall at least within the upper end of average range, with an estimated Premorbid Verbal IQ of 102 and Performance IQ of 13. In terms of his current intellectual function, his scores fall within this range. He has normal levels of vocabulary and visual reasoning. His intellectual ability appears to be broadly consistent with premorbid estimates.

Memory:

In terms of memory, his immediate and delayed recall of complex prose passage lay within the average range, with no loss of information over time.
On a word list learning test, his immediate recall fell below average range and was slightly lower than expected which was mostly attributable to poor concentration and attention. Delayed recall was better and lay within an average range and recognition prompts improved his performance substantially.

His copy of a complex figure was weak and lay below the 1st percentile, which is surprising, given his occupation. Immediate and delayed recall scores were also poor and lay at the 2nd percentile, although there was no significant decrement in information over time, it does appear to have related to poor concentration preparation of the material. I have seen this type of difficulty in previous concussions and it appears to relate to the complexity of the material and the attention demands involved.

Executive Functions:

In terms of executive functions, semantic fluency was good and lay within normal limits but verbal fluency was weak and lay below the low average range which, again, was lower than expected for his overall level of function and ability.

I also administered the Delis Kaplin version of the Stroop test. His colour naming lay within the low average range, word reading lay within the average range, but his performance dropped to within the impaired range for inhibition. It improved again for inhibition with complex attention and it does appear that he could benefit from intentional application of attention but automatic attentional performance seems to be impaired.

Psychomotor Speed:

Psychomotor speed lay within the low average range.

Short-term working memory was also impaired and lay within the borderline range.

Language/Perception:

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Language was intact, with no evidence of any impairments and perception was also intact for colour, spatial and number perception, as well as functional word reading.

Conclusions

[The Complainant] *is a very pleasant ** year old gentleman who suffered [circumstances of injury redacted]. He does not feel that he lost consciousness but he does have a significant period of post-traumatic amnesia, exacerbated by alcohol intake following the injury. He has noted a significant decrement in mood and cognitive functioning since the accident and also suffers back and neck pain. He is off work at the present but is motivated to improve his circumstances as well as improving his physical fitness. It does appear that he suffered a mild head injury with post concussive state. He also reports significant multiple head injuries in the past although none with loss of consciousness.*

In terms of cognitive functioning, intellectual ability appears to be consistent with premorbid estimates, although there is a pattern of reduced attentional function in memory. He does have difficulty encoding large volumes of information and visual memory is markedly impaired for his professional chosen experience. It does appear to be difficult handling large volumes of information. A similar pattern was seen in executive functions, with reduced working memory, speed and concentration. Tasks unrelated to this were performed at normal levels, with good levels of language and perception.

Overall, it does appear that he continues to suffer from cognitive deficits associated with the head injury which include reduced attention, reduced motor speed and concentration. These are most likely being exacerbated by the effects of pain and low mood and may also, to some extent, reflect the effects of previous head injuries. I spent some time talking with him today about the management of these and I also felt that he could do with a referral to Headway which I will complete and I will see him in the near future for further feedback and discussion of his cognitive difficulties".

In addition, in his letter dated 16 March 2016, Consultant Psychiatrist Dr M. advised, as follows:

"[The Complainant] *is currently on antidepressant medication and had responded well, to date, to this intervention.*

He has been assessed on my referral to [Dr N.]*, Principal Neuropsychologist, and his report confirms cognitive deficits post head injury…*

I confirm that [the Complainant] *is currently unfit to re attend work".*

I also note that the Complainant's Employer, the policyholder, by way of letter dated 7 March 2016, appealed the Provider's decision to decline the claim and enclosed a recent Report from its Chief Medical Officer, Dr J. dated 13 January 2016, which advised, *inter alia*, as follows:

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"[The Complainant] *attended* [the policyholder's] *Occupational Health for further medical review on 11/01/16 …*

At review today [the Complainant] *describes further gradual improvement in his symptom profile and parallel progression of functional activity routines. He describes most of his symptoms as having improved well although he continues to describe intermittent episodes where he has significant symptomatic deterioration for short periods and this in turn impairs his functional activity.*

In addition [the Complainant] *also describes having further investigation in relation to a couple of other medical queries which may have an impact on his underlying psychological status. One of these investigations has revealed a separate medical issue which is due to be addressed over the coming months. He is due to have another significant investigation process later this week …*
[The Complainant] *remains on sick leave certified as suffering with Depression. His symptomatic pattern suggests a gradual incremental improvement but with persisting transient deterioration in his profile and functional activity routines. He acknowledges that these transient episodes are becoming less frequent and less debilitating. He equally acknowledges that a return to work in the near future is appropriate and he is focused on achieving this over the short term.*

My overview is that [the Complainant] *has improved well from a psychological perspective but I would still have concerns in relation to the sustainability of his work fitness particularly in light of the pattern of attendance that persisted for a significant period prior to him going on sick leave. I have emphasised to* [the Complainant] *that whilst accommodation such as a phased return to work would be available to him this would have to be in the context of a defined phasing period beyond which he would be expected to achieve and maintain a full-time working capability. As yet I remain unconvinced that he is fit to achieve a sustainable pattern on this basis.*

I am also conscious that the parallel medical issues alluded to above may have some impact upon his capability.

I would therefore advise that [the Complainant] *remains in my view unfit to initiate a return to work"*.

As part of its appeal assessment, I note that the Provider arranged for the Complainant to attend Consultant Psychiatrist Dr D. on 28 June 2016 for a further independent medical examination, who in his ensuing report dated 28 June 2016 advised, *inter alia*, as follows:

*"**Reason for absence on sick leave:***

In January 2014, [the Complainant] *was prescribed anti-depressants as he was thought to be depressed. He said himself he wouldn't have thought he was depressed but was perhaps just overloaded. He was finding it difficult to get into work and to get motivated. He had poor energy. He was finding it difficult to cope with all the*

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demands, his relationship with his girlfriend, his own family and his [sport] *club and activities. He said overall his commitments had become too much for him. In November 2014, to reduce his commitments, he went on a three day week. He would wake up late and find it difficult to go into work; he would go in late and then work late. He could work very well on a good day but at other times he would be much less productive. He had a number of intermittent absences and has been on continuous sick leave since June 2015 …*

Current Daily Routine:

He gets up before 10 o'clock in the morning in order to keep a routine. He feeds his dog, then he takes the dog for a walk. He might then do some work in his workshop. He does regular intensive training for [sport]*. He does this four or five times a week. He does sessions of up to 12 kilometres at a time. Sometimes on his own, sometimes in a group.*
*He does intensive training, including speed intervals, where his heart rate might go above 190 or longer sessions at 65% maximum heart rate. He enjoys these activities and is the current national champion in the over-** age group ….. He also enjoys* [sport] *regularly at* [location]*. Up to last year he used to go on the very big* [detail]*, for example, at* [location]*, where he confines himself to less dramatic* [detail] *at the moment in order to avoid any further head injuries. He meets friends regularly for a coffee and goes out and socialises in the pub. He enjoys all these activities. He also does yoga. He said in general his day is busy.*

He also goes cycling very regularly. He said that in general training makes his head a lot clearer. He said if he has to do anything computer related, he is less motivated and finds it hard to get his head around it …

Mental State Examination:

… There was no evidence of depression or anxiety; he wasn't upset at any stage during the interview. His attention, concentration and memory were normal …

Review of Documents:

The letter from [Dr M.]*, Psychiatrist notes that* [the Complainant] *has been treated with anti-depressant medication and has responded well.* [Dr M.] *refers to* [Dr N.'s] *report which found cognitive deficits "post head injury".* [Dr M.] *states that* [the Complainant] *is currently unfit to attend work but doesn't provide any evidence for this.* [Dr M.] *doesn't make any recommendations for rehabilitation to promote a return to work.*

The report of [Professor N.]*, Principal Clinical Neuropsychologist.*

[Professor N.] *states that* [the Complainant] *had a mild brain injury [circumstances of injury redacted]. He states that while there was no loss of consciousness reported, that* [the Complainant] *was "obviously concussed".* [Professor N.] *found that* [the

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Complainant] *had "a pattern of reduced attentional function in memory". He does have difficulty in coding large volumes of information and visual memory is markedly impaired for his professional chosen experience. It does appear to be a difficulty in handling large volumes of information. A similar pattern was seen in executive functions, reduced working memory, speed and concentration. "Tasks unrelated to this were performed at normal levels, with good levels of language and perception".*

Comment: [Professor N.] *doesn't give any specific recommendations and rehabilitation; he recommends a referral to Headway.* [Professor N. P*'s report was based on an assessment carried out in January 2016. The last head injury* [the Complainant] *had was in 2012. Following the head injury, he continued at work for a further three years. There was a gradual deterioration in his functioning from about 2014-2015 due to increasing commitments which he could not manage, leading to depression and anxiety.*
It seems likely that if there was a significant cognitive impairment due to a series of head injuries, up to 2012, that his function would have been at its lowest in 2012 and if anything, gradually improving over time. Physical or cognitive symptoms with initial onset weeks or months after traumatic brain injury (TBI) or symptoms that progressively worsen over the months or years after injury may have explanations other than TBI. [Professor N.] *doesn't make any statement on whether* [the Complainant] *is fit for work …*

[The Complainant] *has had a depressive disorder which has now entirely resolved …*

His current mental state is normal …

He does not currently meet the criteria for any psychiatric disorder …

There are no restrictions or limitations on his normal activities of daily living. …

[The Complainant] *has had psychotherapy which was appropriate. He is on medication which is appropriate …*

It is my opinion that from a psychiatric point of view, [the Complainant] *is fit to return to work. He has had symptoms of anxiety and depression which have now entirely resolved. He is functioning at an extremely high level as described by his activities of daily living. He had difficulties at work as he did not like his placement in* [location], *he felt there were excessive demands put on him …*

As there is a question of traumatic brain injury and sleep apnoea, opinions from the doctors who diagnosed and treated these conditions would be appropriate …

[The Complainant] *is very motivated to return to work. His symptoms have resolved with time and appropriate treatment. He has learned to manage his commitments and to look after himself. A factor delaying his return to work might be his desire to be as good as he used to be, rather than just well enough to return to work"*.

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In addition, the Provider also arranged for the Complainant to attend for a neurology review with Consultant Neurologist Dr X. on 17 August 2016, who I note in his ensuing Report dated 31 August 2016 advised, *inter alia*, as follows:

> *"From my perspective as a Neurologist I will concentrate on* [the Complainant's] *head injury which occurred in 2012.*
>
> [The Complainant] *was attending a….. [circumstances of injury redacted] He states he does not remember the events immediately thereafter and possibly for a number of hours. He was however drinking before and after the head trauma. Based on the history* [the Complainant's] *head trauma would be classified as minor/mild. He also suffered a probable whiplash injury to his neck region as a result of the [circumstances of injury redacted]*
>
> *Imaging studies of his brain which were performed in April 2015 showed no macroscopic brain pathology as a result of the head trauma sustained in 2012. The MRI scan of his neck showed some mild disc dehydration at C2, C3, C4 and C5. This would not be unexpected in a man who has been so active over the years. His imaging studies were also performed approximately 3 years following his head and neck trauma.*
>
> *Following this patient's head trauma he was able to continue working and ran a big project abroad for up to 9 months …*
> *From my standpoint as a neurologist it would be very unusual for neurocognitive deficits following a minor/mild head injury to persist for this length of time following that head trauma. It is highly probable that difficulties with attention and concentration which were on-going in the assessment performed by* [Professor N.] *in January of this year were more likely related to the patient's mood. It is well known that problems with mood/depression result in difficulties with attention and concentration and hence memory complainants/deficits.*
>
> *From the neurological standpoint then I do not feel that any of* [the Complainant's] *on-going complaints are as a direct result of the minor/mild head injury sustained in 2012.*
> *From the neurological standpoint this patient is fit to return to his previous occupation full time"*.

Following its review, I note that the Provider remained of the opinion that the Complainant was not medically disabled from performing his duties as a [profession] and its decision to decline his claim, remained unchanged. As a result, the Provider wrote to the Complainant's Employer, the policyholder, on 7 September 2016 to advise that it was affirming its decision to decline his income protection claim.

In order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability. In this regard, the 'Interpretation' section of the applicable Group Income Protection Policy Conditions provides, *inter alia*, at pg. 4:

/Cont'd…

*"**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".

In this regard, in assessing his income protection claim relating to his absence from work in 2015 due to depression and other possible causes arising from a head injury sustained in 2012, I note that the Provider referred the Complainant for independent medical examinations with Consultant Psychiatrists Dr F. on 29 October 2015 and Dr D. M. on 28 June 2016, as well as a neurology review with Consultant Neurologist Dr X. on 17 August 2016.
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 definition for a valid claim. Having considered the weight of the objective evidence before it, and which I have cited from at length and which included medical reports provided by his own treating doctors, I am satisfied that it was reasonable for the Provider to conclude that the Complainant did not satisfy the policy definition of disability, in December 2015, when any liability it may have had in this matter, was due to commence.

As a result, I am thus satisfied that the Provider declined the Complainant's income protection claim and subsequent appeal in accordance with the terms and conditions of the Group Income Protection Policy of which he was a member.

I note that in its correspondence to this Office dated 6 June 2019, the Complainant's Employer, the policyholder, advised that *"*[the policyholder] *in the treatment of* [the Complainant's] *case with* [the Provider] *have at all times relied upon the medical advice of our own Chief Medical Officer who determined that* [the Complainant] *was not fit to work in line with associated claim period"*. In addition, in its later correspondence to this Office dated 4 July 2019, the policyholder submitted, *"*[our] *Chief Medical Officer is a highly experienced occupational physician who is in regular contact with* [the Complainant's] *treating physicians and assessed him on frequent basis…it would be highly unusual for an employer such as* [the policyholder] *not to follow the medical opinion of its own Chief Medical Officer"*.

In this regard, in its correspondence to this Office dated 26 June 2019, I note that the Provider submits, *"On the 1 April 2014* [the Employer] *chose* [the Provider] *as their Group Risk Income Protection provider. As* [the policyholder's] *Insurer, we not only provide a level of cover, we are* [the policyholder's] *disability advisors with regard to long term absentees from the workplace. This is our field of expertise. We are surprised that* [the policyholder] *has chosen their own CMO's opinion over that of* [the Provider]*, specialist disability advisors. Never the less, this is a matter for* [the policyholder]*".*

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I accept the Provider's position that as the Insurer, it is entitled to gather medical evidence and arrange assessments in order to assist it in making an informed decision and that it must assess all claims against the Group Income Protection Policy terms and conditions and that any claim decision is a decision for the Insurer to make, based on all of the medical evidence before it. As stated, I am satisfied having considered the weight of the objective evidence before it, and which I have cited from at length and which included medical reports provided by the Complainant's own treating doctors, that it was reasonable for the Provider to conclude that the Complainant did not satisfy the policy definition of disability in December 2015, when any liability it may have had in this matter was due to commence. Likewise, I am satisfied that having considered the matter further on appeal, during 2016, the Provider was entitled to form the opinion which it did, that the Complainant did not meet the definition of disability within the meaning of the policy.

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

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

30 January 2020

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.