An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0107
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Delayed or inadequate communication Claim handling delays or issues Disagreement regarding Medical evidence submitted Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint concerns a group income protection scheme with the Provider, against which this complaint is made, of which the Complainant is a member.

The first complaint is that the Provider dealt with the Complainant's claim in an unacceptable manner and unreasonably discontinued the Complainant's claim. The second complaint is that the Provider dealt with the Complainant's complaint in an unacceptable manner.

The Complainant's Case

The Complainant submits that she suffered an injury to her neck and shoulder in **March 2016** and due to the injury which she sustained and the subsequent diagnosis of grade III whiplash, she was required to take sick leave from her employment. The Complainant saw a doctor for pain management for the first time in **January/February 2017**.

The Complainant completed a Claim Form in relation to her income protection on **18 May 2017**.

The Complainant was assessed by a medical professional specialising in occupational medicine on behalf of the Provider on **3 August 2017** who noted that the Complainant's *"MRI scan was pretty unremarkable"* and that her *"pain scores and distress levels appeared generally disproportionate to the findings on examination"* but who nevertheless felt that she was *"genuinely unfit for work…I believe she could be fit to resume work, at least on a part time basis inside a 3-month timeframe"*. Income protection payments were therefore made to the Complainant on the basis of this report.

The Complainant then attended a Consultant Psychiatrist on behalf of the Provider on **2 November 2017** who was *"unable to make a diagnosis of psychiatric illness"* and was *"unable to find pathological symptoms of mental illness"*. The Consultant Psychiatrist also found that *"there was no objective evidence of depression or anxiety of any significance"* and stated that in his opinion the Complainant was fit to return to work.

The Complainant was then reviewed by a Consultant Orthopaedic Surgeon on **26 October 2017** who stated that she *"moves quite comfortably and freely…without any apparent distress…on gentle movement it is apparent that she has a full range of motion in her neck…She has tenderness in her left paraspinal muscles…on gentle passive range of motion, there is no discomfort and no restriction and in fact she can hold her shoulder fully abducted and rotated…Neurological examination does not identify any specific radiculopathy or nerve root weakness or dermatomal reduced sensation…This lady sustained a soft tissue injury to her neck…I do not think this should impact on her occupational activities…I think she would be fit to do this from now on."*

As a result of the reports of the Consultant Psychiatrist and the Consultant Orthopaedic Surgeon, the Complainant's payments of her income protection claim were stopped on **28 February 2018**. The Complainant appealed this decision to stop her payments.

Further to her appeal, the Complainant furnished two letters to the Provider from her GP and Physiotherapist which were supportive of her claim that she was unfit to work.

On **24 April 2018** the Complainant underwent the chronic pain abilities determination (CPAD) assessment, as part of the income protection claims appeal process. This CPAD assessment indicated a significant number of inconsistencies and discrepancies and stated that the Complainant's reported pain levels could not be viewed as a barrier to her working. The Consultant Orthopaedic Surgeon was then requested by the Provider to review the CPAD findings and he stated that it was consistent with his own findings.

On **27 June 2018**, the Provider informed the Complainant that her appeal was not upheld.

The Complainant submits that the CPAD assessment was not carried out in adherence with the schedule outlined by the Provider as a female assistant scheduled to be in attendance during the CPAD assessment, was not present.

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The Complainant submits that the independent medical examiner contracted by the Provider to carry out the CPAD assessment is not a registered physician in Ireland. She further submits that the assessment was carried out negligently by the independent medical examiner and that he was not appropriately qualified to manipulate a patient with her injuries. Furthermore, the Complainant also submits that the CPAD assessment process itself is not valid and points to an unnamed High Court case from **1 May 2014** in support of this contention.

The Complainant submits that directly prior to the CPAD assessment she had experienced a flare up of her pain symptoms following a twenty minute walk to the assessment venue.

The Complainant submits that she tried to explain her level of pain to the medical examiner upon arrival but the medical examiner was disinterested in discussing the state of pain which she was experiencing at that point in time.

The Complainant submits that as a result of the physical exercises, which she endured to the best of her ability during the CPAD assessment, she began to suffer involuntary spasms in her lower neck and could not lift her head which had begun to shake. She states that standing upright *"felt impossible"*. The Complainant submits that the spasms, which she had never experienced prior to that day, continued to get more intense and the medical examiner ended the examination and advised her that a second day of examination, which had been previously scheduled, was no longer required. The Complainant submits that following this CPAD assessment these spasms/tremors continued, for up to fifteen minutes at a time.

The Complainant submits that these complications which she suffered as a result of the physical exercise exerted during the CPAD has set her recovery process back by eighteen months and it has added to the symptoms which she had been experiencing prior to the assessment. The Complainant submits that the statement made by the medical examiner, in the CPAD assessment report, that she was able to flex her head normally and converse despite being hysterical, is untrue and questionable given the symptoms and emotions she had experienced as quoted above.

The Complainant submits that it was not included in the CPAD report that once the examination was completed she was hunched over in pain and as a result of her not being able to move unaccompanied, she was escorted to the reception area by the medical examiner and that she was left at the reception area without any medical assistance in a distressed state due to her significant pain. The Complainant submits that her request for the medical examiner to call her husband to collect her, due to her state of physical and mental shock, was declined and a taxi was offered instead.

The Complainant submits that she had advised the Provider that she was not fit to work or to carry out any examination including the CPAD assessment and that this advice was corroborated by letters written to the Provider by her Physiotherapist, however, due to the terms and conditions of the policy she had to proceed with the assessment regardless.

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The Complainant submits that prior to the CPAD assessment she had been learning to manage the pain, however due to the assessment she was mostly confined to a bed for three weeks while requiring a taxi to take her to her physiotherapy appointments which have subsequently increased from one appointment a week to two appointments a week, since the assessment took place.

The Complainant submits that seven weeks had passed since the CPAD assessment and she had not received an update from the Provider, with the exception of one email which stated that her claim had not yet been concluded. The Complainant submits that she had to pursue the Provider for the medical reports pertaining to her claim.

The Complainant submits that upon review of the CPAD assessment report, she has found numerous inconsistencies and inaccuracies within the report, including the following:

- The Complainant submits that since she has been living with chronic pain for over two years, she has learnt to move her head and neck without apparent difficulty;

- The Complainant submits that the medical examiner's choice of wording, which was used in his report as an apparent quote by the Complainant to describe how she felt when under medical examination, was incorrect. The Complainant submits that what she had said, which may have been misunderstood due to her foreign accent, as English is not her first language, is that she felt *"ripped apart"* after the medical assessments;

- The Complainant contends that in the CPAD assessment report, the medical examiner noted that she was tearful throughout the testing, however, she submits that she *"became tearful as my pain levels rose due to the tests I was performing"*;

- The Complainant submits that the statement by the medical examiner that she is able to use a microwave is *"100% fabricated"* as she has not owned a microwave in years so it *"would never be in my mind to talk about a microwave"*;

- The Complainant submits that the physical tests she undertook as part of the CPAD assessment took *"far more than 10 minutes"*.

The Complainant submits that the day after the assessment in **April 2018**, she visited her general practitioner. The Complainant submits that this matter has caused her *"immense undue stress both physically and mentally, in addition to my current medical condition"* and that the pain she suffers is massive and constant.

The Complainant has furnished a report from a Chartered Physiotherapist dated **8 February 2018** and has also furnished a report from a Consultant Neurosurgeon dated **30 November 2018**, which the Complainant submits clearly explains her injury and the pain he felt before, during and after her CPAD.

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The Consultant Neurosurgeon's report is based on a second MRI and CT scan conducted in or about **December 2018** which the Complainant undertook post the assessment by the Provider. The Complainant states that the Provider disregarded the Physiotherapist's report.

The Complainant declined to grant the Provider access to the second MRI and CT scan which she undertook, as she *"has no trust they would act properly in this instance"*.

The Complainant submits that she was not made aware of the terms and conditions of the income protection policy until after she had formally made her complaint pertaining to this matter.

Ultimately, the Complainant wants the Provider to reinstate her claim and pay the claim in full.

The Provider's Case

By way of response, the Provider submits that in **August 2017**, it admitted the Complainant's income protection claim relating to her absence from work and in accordance with the policy terms and conditions, the claim was subject to ongoing review.

The Provider submits that as part of its claim review process, it arranged for the Complainant to attend two medical assessments in order to re-evaluate if her medical condition would still be deemed to be eligible as a disability as defined under the policy.

The Provider submits that this review included the assessment of the Complainant by a Consultant Orthopaedic surgeon and a Consultant Psychiatrist. The Provider submits that following the evaluation of these two medical consultants, the Complainant was reported to be fit to carry out her normal occupation as a technical service advisor for her employer.

The Provider submits that as a result of the findings by these two medical consultants, it made the decision to discontinue the Complainant's income protection claim and this information was communicated to her on **17 January 2018**.

The Provider submits that following an appeal by the Complainant and a letter received from the Complainant's Physiotherapist which outlined the pain suffered by the Complainant in addition to communication from the Complainant's GP that she is unfit for work; the Provider made the decision to review the Complainant's claim eligibility once again. The Provider submits that the best form of assessment was deemed to be CPAD, which was carried out by a third party medical examiner.

The Provider submits that the findings of the CPAD assessment report undertaken on **24 April 2018** noted a significant number of inconsistencies and discrepancies regarding the level of pain reported by the Complainant at the time of the assessment and that the *"reported pain levels cannot be viewed as barriers to preventing* [her] *from working"*.

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The Provider submits that the Complainant was not medically disabled as defined under the policy and her appeal of the declination of her claim was therefore not upheld.

In relation to the non-attendance of the female assistant, the Provider accepts that it did advise the Complainant that a female assistant would be present but that this was because it had mistakenly thought that the CPAD assessment was to take place at the Complainant's home. It accepts and regrets that it did not adequately communicate the non-attendance of the female assistant to the Complainant.

The third party medical examiner, through the Provider, furnished this Office with further comments in relation to this matter and stated that the Complainant was advised prior to and during testing that she would not be expected to undertake any test/s she felt unable to complete and that she could stop performing any of the tests at any time. The medical examiner stated that this has and always will be his practice with respect to individuals undertaking the CPAD assessment. Furthermore, he states that this is clearly explained in the pre-test Consent Form given to the Complainant. He states that he would never insist that any individual continue with testing if he/she did not wish to do so and this is proven by the fact that as soon as the Complainant wished to terminate the assessment he agreed to do so. The Provider appointed medical examiner has submitted that he would never refuse to call a spouse or any other individual that a client wished to have called for assistance.

The medical examiner disputes the allegation that he was negligent during the CPAD assessment. He supports this by reference to his 30 years in medical practice and his undertaking of over 4,500 assessments. He also stresses that as an independent medical examiner he is completely free from any bias, whether that be from the individual or the company who instructed him. He is adamant that the numerous inconsistencies in the CPAD report indicated that the Complainant attempted to simulate weakness and disability during CPAD testing. Furthermore, he states that the Complainant is incorrect to state that he manipulated her at any time during the assessment.

The medical examiner stated that the CPAD protocol was devised by a group of professionals, who are experts in the field, and was published in the Irish Medical journal in **2008**. He states that the Complainant has misunderstood the Irish High Court case she mentioned and cites from the particular judgment in support of the CPAD process.

The Provider submits that the reports furnished to this Office by the Complainant's physiotherapist and Consultant Neurosurgeon were provided long after the original claim decision was made and based on the information available to the Provider at the time it believes it made the correct decision. It does not believe that the evidence provided to it retrospectively should be applied to its decision. In any event, the Provider states that the MRI report from **2016** provided by the Complainant's doctors at the outset of this claim states that there is *"no disc protrusion, no encroachment on the exit formina"* and confirmed minor disc degeneration which supported a diagnosis of a whiplash injury.

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The Provider states that this does not support the Consultant Neurosurgeon's opinion that the *"MRI scan done…in 2016…does confirm that she seems to have a small disc protrusion on the left side at the C5/6 level which I think is causing some degree of forminal compression. This certainly could explain the symptoms that this lady is experiencing down the left arm"*.

Furthermore, the Provider stated in its letter to this Office dated **11 June 2019**, that it is prepared to review the further tests carried out by the Consultant Neurosurgeon on behalf of the Complainant, namely the MRI of the cervical spine and the CT scan of the brain, if she will provide these.

The Provider also stated that it is prepared to engage with the Consultant Neurosurgeon and seek his comments, however, if the Complainant does not permit the Provider to do this then it could not give any further consideration to the claim and its opinion will remain unchanged.

The Provider states that the Complainant's employment ceased as of **28 January 2019** and therefore her entitlement to cover ceased with effect from that date and the Provider has no liability beyond that date.

The Provider submits that it met its obligations under the terms and conditions of the policy in paying the claim until **February 2018** and is satisfied that after an extensive review of the claim and the Complainant's medical condition that the Complainant is able to work. The Provider believes the findings of the CPAD and the assessments and opinion of the medical professionals & consultants it appointed to assess the Complainant are valid.

In respect of the complaint that the Provider dealt with the Complainant's complaint in an unacceptable manner, the Provider states that it communicated with the Complainant by e-mail in the 7 week period between the CPAD assessment and the final decision relating to this on **27 June 2018**. Furthermore, the Provider states that claims of this nature are complex and it took a period of time for the Consultant Orthopaedic Surgeon to review the findings of the CPAD on behalf of the Provider and for the Provider to assess and gather that information.

The Provider has proposed a formal settlement offer to the Complainant of €500 as a full and final resolution to this complaint.

<u>The Complaints for Adjudication</u>

The complaint for adjudication is that the Provider dealt with the Complainant's claim in an unacceptable manner and unreasonably discontinued the Complainant's claim, and that the Provider dealt with the Complainant's complaint in an unacceptable manner.

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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 on 10 February 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.

Following the issue of my Preliminary Decision, the Complainant made a further submission under cover of her letter and enclosures to this Office (received 2 March 2020), a copy of which was transmitted to the Provider for its consideration.

The Provider has not made any further submission.

Having considered the Complainant's additional submission, together with all of the submissions and evidence furnished to this Office by the parties, I set out below my final determination.

The Complainant was a member of a group income protection scheme with the Provider.

I note that for the purposes of this policy disablement is defined as:

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

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I note that Section IV of the policy entitled 'Claims' states that benefits are payable to the policyholder at the end of the deferred period once the Provider is satisfied that the *"member meets the definition of disability"*. Furthermore the 'Claim Review' portion of Section IV of the policy states that *"payment is conditional on the claiming member continuing to satisfy the definition of disability and* [the Provider] *will conduct a periodic assessment of the member's ability to carry out the material and substantial duties of their normal occupation. The frequency of these reviews will be determined by the medical evidence available."*

The Complainant completed a Claim Form in **May 2017** and she provided correspondence from her GP advising she suffered a Grade III whiplash injury following an accident. I note that her complaints were primarily pain related and were *"typical of a soft tissue claim"*.

This resulted in an initial assessment by specialist in occupational medicine offering an opinion that the Complainant as unfit to work. I note that following on from this opinion, the Complainant's claim for income protection was paid until **February 2018** at which time the claim was stopped due to medical advice of a Consultant Orthopaedic Surgeon and a Consultant Psychiatrist. On appeal, and following further reports from her GP and her Physiotherapist being received, the Complainant was assessed by a third party medical examiner by way of CPAD assessment. I note that this CPAD assessment was reviewed by the Consultant Orthopaedic Surgeon on behalf of the Provider and a decision was made on **27 June 2018** to reject the Complainant's appeal.

The Complainant's initial assessment by a specialist in occupational medicine found that she was *"genuinely unfit for work…I believe she could be fit to resume work, at least on a part-time basis inside a 3-month timeframe"* and after her re-assessment and failed appeal, the Complainant has furnished this Office with an extremely brief note from her GP dated **5 February 2018** stating that she *"remains medically unfit to reattend work until further notice"* and a relatively brief report from her physiotherapist dated **11 April 2018** stating that it *"will be a number of months at the earliest before she will improve enough to return to work"*.

The Complainant has also furnished the Provider with a report of a Consultant Neurosurgeon dated **30 November 2018** which doesn't offer an opinion as to the Complainant's ability to work but does provide a medical explanation for the symptoms the Complainant states she is experiencing.

The situation in this complaint is similar to the position faced by the Court in ***Holohan v Friends First Life Assurance Company Ltd [2014] IEHC 676***. This is the judgment, which was referenced by both the Complainant and the Provider in their submissions but not explicitly named. In ***Holohan***, the court was faced with *"the difficult task of assessing the expert evidence which has been adduced on behalf of the plaintiff and the defendant"* (paragraph 68) and there was *"a genuine difference of approach between the evidence of* [the medical professionals]*…as to the appropriate approach to take in the plaintiff's case"* (paragraph 69).

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Similar to this complaint, in ***Holohan*** the Complainant's CPAD testing results disclosed *"inconsistencies"* (paragraph 75) and the Court had *"concerns in respect of the results thereof"* (paragraph 77). Most importantly, in ***Holohan*** the Court addressed the issue of CPAD testing and stated that it *"accepts the validity"* (paragraph 77) of same.

The key difference between ***Holohan*** and the present complaint is that in ***Holohan***, the Court was presented *"with a cohort of medical evidence presented on behalf of the plaintiff which is very persuasive and which on the balance of probabilities, the court accepts"* (paragraph77) whereas, in this complaint, the Complainant has furnished the Provider and this Office with one very limited GP's report, one relatively brief physiotherapist's report and one report from a Consultant Neurosurgeon (lacking the crucial scans) which does not specifically state that the Complainant is unfit for work.

In comparison, the detailed reports and medical evidence submitted to this Office on behalf of the Provider from a specialist in occupational medicine, a Consultant Psychiatrist, a Consultant Orthopaedic Surgeon and the CPAD Assessment all indicate that the Complainant is fit to return to work and does not suffer from a disability preventing her from doing so.

I particularly note that the initial assessment of the specialist in occupational medicine furnished by the Provider dated **3 August 2017** states that the Complainant *"could be fit to resume work, at least on a part time basis inside a 3-month timeframe"*. The Complainant then attended a Consultant Psychiatrist on behalf of the Provider on **2 November 2017** who was *"unable to make a diagnosis of psychiatric illness"* and was *"unable to find pathological symptoms of mental illness"*. The Consultant Psychiatrist also found that *"there was no objective evidence of depression or anxiety of any significance"* and stated that in his opinion the Complainant was fit to return to work. The Complainant was then reviewed by a Consultant Orthopaedic Surgeon on **26 October 2017** who stated that the Complainant *"moves quite comfortably and freely…without any apparent distress…on gentle movement it is apparent that she has a full range of motion in her neck…She has tenderness in her left paraspinal muscles…on gentle passive range of motion, there is no discomfort and no restriction and in fact she can hold her shoulder fully abducted and rotated…Neurological examination does not identify any specific radiculopathy or nerve root weakness or dermatomal reduced sensation…*

This lady sustained a soft tissue injury to her neck…I do not think this should impact on her occupational activities…I think she would be fit to do this from now on." Furthermore, the findings of the CPAD assessment report undertaken on **24 April 2018** noted that the *"reported pain levels cannot be viewed as barriers to preventing* [her] *from working"* and this CPAD assessment report was then reviewed by the Consultant Orthopaedic Surgeon who stated that it was consistent with his own findings.

It is not my role to determine whether or not the Complainant fits the definition of disability. It is my role to determine if the decisions arrived at by the Provider was reasonable based on the information and medical assessments available to it at the time it made those decisions. Neither is it my role to investigate the qualifications or integrity of a medical professional.

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Therefore I offer no view on the Complainant's contention that the medical examiner who conducted the CPAD assessment conducted it negligently, nor that the medical examiner was unqualified to conduct the examination or *"manipulated"* the Complainant in such a way that exacerbated what remained of her existing injuries.

In my Preliminary Decision I expressed that any complaints or allegations regarding medical professionals are a matter for the Medical Council.

The Complainant, in response to this, stated in her post Preliminary Decision submission:

> *"The FSPO are already aware that the medical council of Ireland is unable to investigate [named individual] as he is unregistered in Ireland yet you say 'complaints or allegations regarding medical professionals are a matter for the medical council'. This matter is a crux of my complaint which was brushed over in the preliminary decision report"*

I note the Complainant's position. However, I must reiterate that it is not my role, nor am I in a position as an independent and impartial adjudicator of complaints against financial service providers, to offer an opinion on, or to adjudicate on matters outside of the remit of the ***Financial Services and Pensions Ombudsman Act 2017***. Therefore, I am unable to comment on, or investigate the status of a medical professional, and I can only adjudicate on the complaints against the Provider detailed above.

I accept the Complainant's assertion that her difficulties with English may have resulted in some of her statements to the medical examiner being misunderstood but I note that any such misunderstandings were minor and in any event were incidental to the substantive findings in this decision. I further note that while it is unfortunate that the Provider did not adequately communicate the non-attendance of the female assistant to the Complainant, no prejudice or damage was suffered by the Complainant as a result of this.

On balance, I do not find it was unreasonable for the Provider to discontinue the Complainant's claim based on the medical reports available to it at the time.

In respect of the secondary complaint that the Provider dealt with the Complainant's complaint in an unacceptable manner, no evidence has been presented to me to support this contention. It is accepted by both parties that the Provider communicated with the Complainant by e-mail in the 7 week period between the CPAD assessment and the final decision relating to this on **27 June 2018**. I accept that claims of this nature are complex and it took a period of time for the Consultant Orthopaedic Surgeon to review the findings of the CPAD on behalf of the Provider and for the Provider to assess and gather that information.

I note the Provider has stated that it is prepared to review the further tests carried out by the Consultant Neurosurgeon on behalf of the Complainant, namely the MRI of the cervical spine and CT scan of the brain, if she will furnish these to the Provider. The Provider also stated that it is prepared to engage with the Consultant Neurosurgeon and seek his comments.

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However, the Complainant declined to grant the Provider access to the second MRI and CT scan which she undertook stating that she "*has no trust they would act properly in this instance*". I also note that the Provider has offered the Complainant a settlement offer of €500.

It was not, in my view, very helpful for the Complainant not to provide access to these medical records and it is a matter for her to now decide if she wishes to engage with the Provider in relation to its settlement offer.

Having considered the evidence in its entirety, and the offers made by the Provider, I believe its conduct in relation to the Complainant was not unreasonable. For this reason, I do not uphold this complaint.

Conclusion

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

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

31 March 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.