An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0161
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Rejection of claim - fit to return to work Dissatisfaction with customer service
Outcome:	0

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant is a member of a voluntary Group Income Protection Scheme via her Trade Union, the policyholder. The policyholder's financial services broker is the Scheme Administrator. The Provider is the Insurer of this Scheme, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant, whose employment duties included making house calls, was assaulted by a customer during one such house call in **December 2016** and was certified as unfit for work. She completed an income protection claim form to the Provider on **28 June 2017** wherein she listed her illness and condition and how it affected her in the work place, as follows:

> *"**Describe in detail your illness/condition:***
> *Following assault @ work during home visit, I suffered torn ligaments to my left arm. I am currently on anti-depression medication and am extremely anxious about returning to work.*
>
> ***How does your condition prevent you from working?***
> *Hand has not regained full strength, cannot write reports as before. Nervous + very anxious about returning to work.*
>
> ***What work related activities does your current condition prevent you from performing?***
> *Home visits, dealing confidently with customers, report writing".*

As part of its assessment of her claim, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on **18 October 2017**. As he concluded that she was fit to return to work, the Provider admitted the Complainant's income protection claim from 24 June 2017, the end of the policy deferred period, to **31 December 2017** only.

The Complainant appealed this decision to only pay income protection benefit up until the end of 2017. As part of its review, the Provider arranged for the Complainant to attend with Consultant Psychiatrist Dr D. for an independent medical examination on **14 March 2018**. As he also concluded that the Complainant was fit to return to work, the Provider upheld its decision by way of correspondence dated **23 April 2018**.

The Complainant says that she remained unfit to work due to co-existing mental health and substance use (alcohol) problems and was voluntarily admitted as an in-patient to hospital from **9 July 2018** to **24 August 2018** for the treatment primarily for a dependence syndrome. In this regard, in her email to this Office dated 26 October 2018, the Complainant advises:

> *"Since my original complaint I became an inpatient of* [named] *Mental Health services for seven weeks* [from 9 July to 24 August 2018]*. This was a voluntary admission where I was being proactive in looking after my mental health. The assault which took place (December 2016)…had a profound effect on my mental health and well-being and I believe the assault was the trigger for the decline in my mental health"*.

In correspondence dated 4 October 2018, her GP Dr A. advised that the Complainant *"has been certified medically unfit to work since 23/12/2016 to date due to low mood, stress and post-traumatic stress disorder post a work related incident"*. [In her later email to this Office dated 8 July 2019, the Complainant indicated that she was returning to work in and around September 2019, *"albeit to a new role where I will be office based and in a new location to avoid the person whom assaulted me"*.]

In the FSPO Complaint Form she completed in April 2018, the Complainant advised, as follows:

> *"I was assaulted in work on the* [date] *2016. I carry out house calls alone…I was put on sick leave and subsequently went on reduced pay. I made an application…to receive income protection, the decision took almost 5 months. I was informed on the 17th of November 2017 that my claim was being allowed from time of application in June* [2017] *and would cease on the 31st of December* [2017]*. The IME* [Independent Medical Examiner] *had suggested I was fit to return to work. I appealed this decision and saw a second IME who seemed to ask more questions, but neither IME seemed to understand the role I work in. I have…been informed that the original decision* [to cease income protection benefit] *has been upheld.*
> *I feel this is unfair as it is not taking into account the role I work in and also the fact that I am undertaking steps in order to get back to work.*

/Cont'd…

> *I do not feel that a twenty minute chat with a person can provide a full picture regarding my health and my role…Since January [2019] I have reduced my antidepressants from 300 mg to 150 mg as they were reducing my alertness, this is with a view to returning to work in the coming months. I have also seen my* [Employer's Chief Medical Officer] *and we have been in contact with the HR department to see if I can be facilitated with a move to a different role/location in order for me to return to work on a phased basis".*

The Complainant also complains about the manner in which the Provider assessed her income protection claim, as follows:

> *"*[The Scheme Administrator] *would assure me that* [the Provider] *would have a decision tomorrow and then the following day I would be told the decision would be in the afternoon and so on it would go…This process has added additional unnecessary stress and a time when I need to be concentrating on getting well. I am a parent of three children and this drawn out process and trying to live on illness benefit has had a detrimental effect on all our lives…I saw the last IME on the 14th of March yet I had to wait almost six weeks for a reply.* [The Provider] *operate a very poor service to their clients"*.

In addition, in her email to this Office dated 26 October 2018, the Complainant also questions the thoroughness and independence of the medical examinations that the Provider had arranged for her to attend, as follows:

> *"I maintain that the insurer's medical experts could not fully assess the effects of the assault in the short interview time (15 to 20 minutes) and also as they are agents of the insurers and paid by them so I believe they cannot be independent in their assessments. During my interviews I came across as competent and well presented, and this was construed to mean I was well, neither Doctor had met me when I was well and therefore could not make this assessment when they were comparing me to other people and not to my former confident self"*.

Similarly, in her email to this Office dated 8 July 2019, the Complainant submits, *inter alia*, as follows:

> *"I wish to state again that I do not feel the medical experts were acting in a truly independent manner.*
>
> *Firstly, they are engaged by* [the Provider] *and therefore have a vested interest in finding in the insurance companies favour. Otherwise they would cease to get referrals from the said company, thus affecting their business.*
>
> *Secondly, I raised my concerns with both doctors around my very high dose of antidepressant medication' (I was on 375 mg of Effexor daily, the highest recommended dose is 300 mg daily, exceeding this dose this had huge side effects in*

/Cont'd…

making me drowsy) and my poor sleep patterns. I also mentioned that I was consumed alcohol most nights in order to unwind/sleep.
Neither Doctor in his professional capacity sought to address this concern, nor did they recommend that I seek treatment, or spend some time in a residential treatment facility to regulate my medication and sleep. Surely these would be red flags to a medical professional? Again I feel that this shows they were conditioned in their examination of me to come to the only favourable conclusion the insurance company would like as an outcome.

Thirdly, I was extremely unwell during the period of making the application and attending the doctors, some two and a half years have passed since the assault and I have still not returned to work. I am returning to work in September, albeit in a new role where I will be office based and in a new location to avoid the person whom assaulted me".

In her later email to this Office dated 13 September 2019, the Complainant submits, *inter alia*, as follows:

"I note [the Provider's] *Legal Counsel states that they fully reviewed the case again, and did not change their view that I was fit to work in early 2018. In my opinion the hierarchy of needs being addressed by the two Psychiatrists I saw (briefly and who based their medical opinion on my physical appearance and attire) was clearly to answer the only question of importance to* [the Provider] - *was I capable of returning to work in any shape or form in order to cease the need for further payments of income continuance. The doctors did not concern themselves with what would be major "red flags" in relation to mental health, not sleeping, poor concentration, alcohol consumption, groggy and disinterested in life. My medication, Effexor 375 mg was exceeding the highest recommended dose and still neither doctor felt the need to recommend further supports and/or residential treatment.*

My own Consultant and her team of specialists concur that further treatment was necessary and indeed essential. I have attended Aware for support around my depression, I have completed a course in compassion focused therapy, and I continue to see a psychoanalyst…I have remained without alcohol in my life, my medication was changed (January 2019) and the result has been amazing. In this year alone I have shed over four stone. I could not have undertaken this recovery if I had returned to work in the mental state I was in …

It has taken me over a year and a half to recover to the point where I am returning to work. I feel where mental health is concerned more care needs to be taken when assessing a person, it is not the same as a broken bone and should not be treated in the same manner – one short visit to a doctor, who is not familiar with your history could not be sufficient to make a qualified assessment.
Both Dr's stated I was pleasant, well dressed, and engaged well. This seems a rather pointless and baseless statement when you consider that neither Doctor had ever met me when I was well".

/Cont'd…

As a result, the Complainant *"would like to have my income protection application allowed and any backdated monies to be paid to me. If possible I would like to be compensated for the unprofessional way in which* [the Provider] *conducted their business with me"*.

The Provider's Case

Provider records indicate that it received an income protection claim from the Complainant on 7 September 2017. In this regard, the Complainant had completed an Employee Claim Form on 28 June 2017 detailing that she was certified as unfit for work from 24 December 2016 as *"following assault @ work during home visit, I suffered torn ligaments to my left arm. I am currently on anti-depression medication and am extremely anxious about returning to work"*. Her GP, Dr A. completed the Practitioner Report on 28 July 2017, confirming the nature and cause of the Complainant's disability as *"PTSD post assault in work – weakness left arm – impacts writing – anxiety, insomnia, low self-esteem"*.

In order to have a valid claim, the Complainant must satisfy the Group Income Protection Voluntary Scheme definition of disability, as follows:

> *"The member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury; upon occurrence of which the benefit under the policy becomes payable, after the deferred period.*
>
> *The member must not be engaged in any other occupation on a part-time or full-time basis, whether or not for profit or reward or remuneration, including benefit in kind".*

The Scheme provides a benefit once the Provider is satisfied that the policy definition of disability is met, payable after the completion of the 26 week deferred period. As the Complainant's absence began in December 2016, any Provider liability would only commence from 24 June 2017. As part of its claim assessment, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 18 October 2017. In his ensuing Report dated 18 October 2017, Dr F. advised, *inter alia*, as follows:

> *"There was no objective evidence of anxiety, tension or agitation …*
>
> *There was no abnormality of the form or stream of thoughts …*
>
> *There was no evidence of memory or concentration difficulties in the assessment …*
>
> *There is no objective evidence of depression or anxiety of any significance at this time, reflecting improvement since she went on sick leave …*
>
> *In my opinion* [the Complainant] *is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature"*.

/Cont'd…

As a result, the Provider wrote to the Scheme Administrator on 23 November 2017 advising that Dr F. had deemed the Complainant fit to resume work and that the claim was to be paid from 24 June 2017, the end of the deferred period, up to 31 December 2017 only.
This was to allow sufficient time for the Complainant to transition back to the workplace. The total claim settlement issued on 15 December 2017 in the amount of €7,672.92. The Provider points out that the decision made was not to cease an in payment claim. Rather, a decision was made to pay a claim retrospectively from 24 June 2017 to 31 December 2017. This was because the claim was submitted late, some 8 months after the initial absence, which meant that it had to be retrospectively assessed. This caused some difficulty, especially in the case of a subjective illness like mental health. Whilst it is at its discretion to decide if a late claim will be assessed, the Provider was, on balance, happy to accept liability and pay the claim for the period 24 June 2017 to 31 December 2017, which it considers was more than fair given the late submission of the claim. In this regard, the Provider was first notified of the claim when it received the Employee Claim Form on 7 September 2017, almost ten months after the Complainant's first date of absence.

The Complainant appealed the Provider decision to pay income protection benefits, only to 31 December 2017. In this regard, the Complainant did not furnish any evidence from a treating psychiatrist, instead she submitted a letter from her GP dated **29 January 2018**, wherein Dr A. advised:-

> *"*[the Complainant] *continues to experience a very short attention span, poor concentration and fatigue. As a result I do not feel she will be able to manage eight hour days"*.

The Provider notes that this statement was not in keeping with the findings of the independent medical examination carried out by Consultant Psychiatrist Dr F. on 18 October 2017, wherein he did not note any concentration or attention issues on formal testing (Rey test). Given that the GP recounted symptoms told to her from the Complainant's subjective viewpoint, this warranted the Provider to arrange for a new independent medical examination in order to get an objective view from a specialist in the field.

As a result, as part of its claim review, the Provider arranged for the Complainant to attend with Consultant Psychiatrist Dr D. for an independent medical examination on 14 March 2018, who in his ensuing Report advised, *inter alia*, as follows:

> *"It is my opinion from a psychiatric point of view that* [the Complainant] *is fit to return to her normal occupation. This is based on the following:*
>
> *She has had effective treatment including psychotherapy and medication which she has found very helpful. Mental state examination was normal showing excellent attention, concentration and memory throughout the interview and there was no objective evidence of pathological depression or anxiety.*

/Cont'd…

There are additional factors adversely affecting her energy and motivation to return to work. She has residual difficulty with sleep and emotion regulation these would be helped by reducing or stopping alcohol and establishing a better daily routine. There have been considerable personnel issues at work including bullying and lone working detailed above.

Her move to [location] *means she would have a long commute which would require her to be away from the family from early morning to early evening thus thwarting her wish to spend time with the children. The commute would also militate against her plans for a quieter rural lifestyle and developing the* [land] *with a poly tunnel and animals. She has had an interest in horticulture since she was a child"*.

Following its claim review, the Provider wrote the Scheme Administrator on **23 April 2018** to advise that it was upholding its original decision.

The Provider later received on **20 August 2018** a letter from Consultant Psychiatrist Dr S. dated 14 August 2018 advising that the Complainant had been admitted as an inpatient to [named] Hospital on 9 July 2018 (until 24 August 2018). In this regard, the Provider notes that the claim appeal decision had issued on 24 April 2018, some three months prior to the Complainant's admission to hospital, and there was no indication at that time of an alcohol-related issue.

The Provider is satisfied that the Complainant's claim was assessed in line with the terms and conditions of the Group Income Protection Voluntary Scheme that she is a member of and the claim was paid from 24 June 2017, the end of the deferred period, to 31 December 2017. The Complainant was reviewed by two separate psychiatric consultants – Dr F. on 18 October 2017 and Dr D. on 14 March 2018 - and both deemed her fit to work. The appeal evidence received from the Complainant's GP, Dr A. seemed to suggest self-reported complaints, however on formal psychiatric evaluation the Complainant did not appear to have any memory, attention or concentration issues.

In addition, the Provider also notes that is clear from the independent medical examination reports that there are workplace issues. In this regard, Dr F. advised that the Complainant was apprehensive about returning to work because she recognised that she may be in the same situation as she was when she was assaulted and felt that she did not have appropriate support from management.

Her previous experience of bullying in the workplace has made her doubt that management will deal with her workplace issues appropriately. Furthermore, in his Report following his independent medical examination of the Complainant on 14 March 2018, Dr D. states:

"[The Complainant] *said she is not sure about going back to work. She would love to have the routine of work but when she was working she had no time for herself. She feels that she cannot go back to the job and feels that maybe it's "not for me". She thinks she might get a job as a part time carer and spend the rest of her time doing her outdoor pursuits, such as her gardening, growing things ion the poly tunnel,*

/Cont'd…

looking after the animals and walking. She said her work and life were at race speed and she is feeling burnt out".

The Provider notes that the evidence suggests that the Complainant would like a change of career and lifestyle and that this is stemmed by the work issues in the past. In addition to this, the Provider notes that the Complainant and her family have moved to [location] and to return to work now would involve a long commute and time away from her family.

With regard to any perceived delay in its assessment of the Complainant's claim, the Provider was first notified of the claim when it received the Employee Claim Form on 7 September 2017, almost ten months after the Complainant's first date of absence. Whilst it is at its discretion to decide if a late claim will be assessed, the Provider was, on balance, happy to accept liability and pay the claim from 24 June 2017 to 31 December 2017, which it considers was more than fair given the late submission of the claim. The Provider notified the Scheme Administrator on 23 November 2017 of its decision to admit the claim for the stated period, which was less than three months after claim notification. In addition, the Provider received the appeal documentation from the Scheme Administrator on 13 February 2018 and sent its appeal final decision letter on 24 April 2018. In this regard, the Provider does not consider that there were undue delays in the assessment of the Complainant's claim or appeal.

Notwithstanding that the objective medical evidence before it at that time indicated that the Complainant was fit to work, the Provider agreed, despite late notification, to admit the income protection claim retrospectively from 24 June 2017 to 31 December 2017 only, and the Provider was satisfied that the Complainant continued to be fit for work and therefore did not satisfy the policy definition of disability, as set out in the applicable terms and conditions of the Group Income Protection Voluntary Scheme that she is a member of, when it affirmed its decision on appeal, on 24 April 2018.

Whilst the Complainant has submitted further medical evidence dated after April 2018, the Provider is not in a position to retrospectively assess the claim based on new evidence received. It can only consider evidence presented during the assessment or appeal of the claim, which must be time appropriate. The Provider was advised that the Complainant's admission to [named] Hospital from 9 July 2018 to 24 August 2018 was a voluntary admission for the treatment primarily for a dependence syndrome, which had never been disclosed as an issue in any of the previous correspondence to the Provider. This admission was three months after the appeal had closed, therefore it cannot have any bearing on the Provider's original claim assessment.

Similarly, whilst the Complainant talks about how she tried to gather sufficient evidence to support her claim whilst she was an in-patient in hospital, the Provider notes that she was an in-patient in hospital in July 2018, at which time the claim had been assessed, appealed (with evidence submitted) and its final decision on the appeal had been issued three months previously. In this regard, the Provider notes that there was no opportunity for the Complainant to appeal again after April 2018.

/Cont'd…

Having said that, the Provider acknowledges that the Complainant had issues in July 2018. The Provider has fully reviewed the matter again and it remains satisfied with its original decision and does not believe that it has any further liability on this matter. However, it does recognise that the Complainant underwent some intensive treatment in an in-patient environment and as a result, by way of correspondence dated 3 September 2019, the Provider advised that it is prepared to make an ex-gratia payment in respect of the period from 9 July 2018, the date of her admission to hospital, to 30 September 2018 as a full and final settlement of this dispute, which is 84 days of benefit, totalling €5,325.72.

Whilst the Complainant has since declined this offer, the Provider notes that the offer remains open to her to accept.

The Complaint for Adjudication

The Complainant's complaint is that the Provider wrongfully or unfairly ceased benefit payments to the Complainant only from 31 December 2017, in circumstances where she says that she continued to be certified as unfit to work thereafter.

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 **20 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.

/Cont'd…

Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

The complaint at hand is that the Provider wrongly or unfairly admitted the Complainant's income protection claim only for the period from 24 June 2017 to 31 December 2017, in circumstances where she says that she continued to be certified as unfit to work thereafter.

In this regard, the Complainant is a member of a voluntary Group Income Protection Scheme via her Trade Union, the policyholder. The policyholder's financial services broker is the Scheme Administrator. The Provider is the Insurer of this Scheme, responsible for the underwriting of applications for cover and assessing claims.

I note that the Complainant, whose employment duties included making house calls, was assaulted by a customer during one such house call in December 2016 and was certified as unfit for work. She completed an income protection claim form to the Provider wherein she listed her illness and condition and how it affected her in the work place, as follows:

> *"**Describe in detail your illness/condition:***
> *Following assault @ work during home visit, I suffered torn ligaments to my left arm. I am currently on anti-depression medication and am extremely anxious about returning to work.*
>
> ***How does your condition prevent you from working?***
> *Hand has not regained full strength, cannot write reports as before. Nervous + very anxious about returning to work.*
>
> ***What work related activities does your current condition prevent you from performing?***
> *Home visits, dealing confidently with customers, report writing".*

In addition, the Complainant's GP Dr A. completed a Practitioner Report on 28 July 2017, wherein she confirmed the nature and cause of the Complainant's disability as

"PTSD post assault in work – weakness left arm – impacts writing – anxiety, insomnia, low self-esteem" and advised, *"I hope she will return to work in the next 3-6 months"*.

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 Voluntary Scheme Policy Conditions provides, *inter alia*, at pg. 10:

> *"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"*

/Cont'd…

As a result, in order for an income protection claim to be payable, a claimant must satisfy the policy definition of disability and the **'Interpretation'** section of these Policy Conditions provides, *inter alia*, at pg. 4:

> *"**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 occupation on a part-time or full-time basis, whether or not for profit or reward or remuneration, including benefit in kind"*.

In this regard, Section IV, 'Claims', of the Policy Conditions provides, *inter alia*, at pg.11:

> *"We will arrange any such independent examinations with any physician chosen by us as may be reasonably required to assess our liability under the claim"*.

As part of its claim assessment, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 18 October 2017. I note that in his ensuing Report dated 18 October 2017, Dr F. advised, *inter alia*, as follows:

> *"**History of illness***
>
> [The Complainant] *told me she suffered a physical assault during a visit to a client's home on* [date]*`2016. She was assaulted by the client's husband, who tried to stop her from leaving the property. She sustained a torn ligament in her left arm. He blocked her car. He was irate and annoyed that a … was in the house …*
>
> [The Complainant's] *injury was to her left arm, her dominant arm, she could not lift up her child. She could not lift pots in the kitchen. She had to have extensive physiotherapy.*
>
> [The Complainant] *told me that her father was physically abusive and quick-tempered. She said, "I've worked hard to leave my youth behind… It was disempowering that somebody would do this to me". She has a resurgence of reminders of the issues she had with her father when growing up.*
> *Her sleep was disturbed. She was anxious. She said, "It made me feel undervalued… Really worthless… And scared… And frustrated because I'd worked so hard to put all that stuff behind me" …*
>
> [The Complainant] *told me that she was bullied at work by a male colleague.* [The Complainant] *was manager of the office and this man refused to do anything she asked. She said he was passive-aggressive. He accused her of delusions of grandeur in an email he sent to their managers, an investigation cleared her but he was not*

/Cont'd…

reprimanded. She told me that she became depressed as a result of this bullying. She had psychotherapy …

She was on sick leave between December 2013 and February 2014 because of stress at work, including bullying. She was on maternity leave from August 2014. From October 2014 to December 2015 she was on sick leave due to bullying.

Current symptoms

[The Complainant] *told me that her mood is not great and she still struggles. She said she is not getting as much happiness out of things as she used to. She said her fuse is shorter and she is more irritable. She did not describe diurnal mood variation.*

Sleep has improved in the last three weeks since she has been taking the sedating antidepressant mirtazapine …

Her energy levels are low and she has a tendency to nap during the day.

Her motivation is poor compared to usual.

Treatment

[The Complainant] *is currently prescribed the antidepressant venlafaxine 300 mg daily. She has been on this dose for one year. This is a high dose of this antidepressant.*

She told me that [Dr X.]*, the CMO at work, suggested augmentation with the sedating antidepressant mirtazapine because of her sleep problems. She started mirtazapine 15 mg at the end of September, is now taking 30 mg at night …*

[The Complainant] *has been having psychotherapy…for the past two years. She started in 2014 when she had been bullied in the workplace. This therapy consists of talking and meditation. Initially she attended weekly and now she attends every two weeks …*

Work / occupational issues

[The Complainant] *said she is apprehensive about returning to work. She has not been back in the office since the assault happened. She is nervous about it. She wonders what has been said in the office.*

She is apprehensive having to visit clients in their own homes. She said her management will not be supportive and are not known for flexibility. She has considered a change of location and has discussed this with the occupational health physician. She said, "I don't want to go back to work in that environment" …

/Cont'd…

[The Complainant] *felt that she was bullied by a colleague three years ago. She feels she was "fobbed off" by the investigation into the bullying issue. She said she has had seven managers and they come and go. She said that emails are not acknowledged …*

[The Complainant] *said she would like to get back to work by New Year…She said, "I'm sick of being sick" …*

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 18/10/2017, was in the mild severity range.*

Hamilton Anxiety Rating Scale (HAM-A)

The Hamilton Anxiety Rating Scale is a clinical rated instrument that measures the severity of anxiety symptoms. It is completed based on a comprehensive psychiatric interview. It is not in itself a diagnostic instrument for anxiety and a diagnosis should not be based on the scoring in the HAM-A alone.

The HAM-A score for [the Complainant]*, based on the psychiatric interview on 18/10/2017, was not indicative of an anxiety disorder of significance.*

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 18/10/2017.*

His total score of eight 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 may be of clinical significance.

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

/Cont'd…

Mental state examination on 18/10/2017 *…*

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

She was spontaneous and normally interactive during the assessment. Mood was not depressed. There was no restriction of affect. There was normal affective reactivity. At time she became emotional when talking about the problems in the workplace but this was within normal limits of mood as a normal reaction to adverse situations in life. There was no objective evidence of anxiety, tension or agitation.

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

Diagnosis:
The diagnosis is an adjustment disorder. The stressor necessary for this diagnosis was the injury suffered by [the Complainant] *when she was assaulted in the course of her work in December 2016*

Circumstances of development of illness:
[The Complainant] *understandably developed an intense emotional reaction to having been assaulted in the workplace in December 2016.*

Current symptoms:
… Current symptoms are mild in severity.

Level of function and effects of illness on ability to carry out normal activities:
There is no evidence that [the Complainant] *is disabled from carrying out normal activities in her life outside of the workplace …*

Current mental state:
… There is no objective evidence of depression or anxiety of any significance at this time, reflecting improvement since she went on sick leave.

Goals towards a return to work:
[The Complainant] *told me that she hopes to return to work by the New Year. However, she has not set herself any definite goals.*

/Cont'd…

Reasons cited for being unable to work:
… [The Complainant] *is apprehensive about returning to work because she recognises that she may be in the same situation as she was in when she was assaulted. She feels that she does not have appropriate support form management, her previous experience of bullying in the workplace has made her doubt that her management will deal with difficult workplace issues appropriately.*

Degree of disability / fitness for work:
In my opinion [the Complainant] *is currently fit to carry out her normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing her from performing the material and substantial duties of her normal occupation. Any residual symptoms are not disabling in nature*.

It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness.

Prognosis:
The prognosis should be reasonable".

As a result, I note that the Provider wrote to the Scheme Administrator on 23 November 2017 to advise that it had concluded from the results of this independent medical examination that the Complainant was fit to work. In order to allow sufficient time for her to transition back to the workplace, I note that the Provider decided to admit the Complainant's income protection claim from 24 June 2017, the end of the deferred period, up to 31 December 2017 only, in the amount of €7,672.92.

The Complainant appealed the Provider decision to only pay income protection up to 31 December 2017. In this regard, I note that in correspondence dated 29 January 2018, the Complainant's GP, Dr A. advised, as follows:

"This is to confirm that I don't believe [the Complainant] *is medically fit to return to work at this stage. She continues to experience a very short attention span, poor concentration and fatigue. As a result I do not feel she will be able to manage eight hour days.*

Some of the above symptoms may be medication related so our plan is to gradually reduce her medication in combination with regular psychotherapy and exercise and I hope that she will be fit to return to work in the next six to nine months".

As part of its claim review, I note that the Provider then arranged for the Complainant to attend with Consultant Psychiatrist Dr D. for an independent medical examination on **14 March 2018**, who in his ensuing Report advised, *inter alia*, as follows:

/Cont'd…

*"**Current Treatment:***

[The Complainant] *has had extensive psychotherapy over the last two and a half years, which she has found very helpful. She is currently reducing her Venlafaxine and is down from 300 mg to 225 mg daily. She continues on Mirtazapine. She has had Diazepam PRN in the past. She attends* [Dr J.], *psychiatrist …*

Past Psychiatric History:

In 2006 after her separation from her husband she took an overdose of medication as she was overwhelmed by emotion. She was admitted to [named] *Hospital for three weeks. She was off work for about six months. She has had no other episodes of deliberate self-harm. She suffered from depression having being bullied in July 2014 …*

Personnel Issues:

She said there were significant problems at work…She was bullied at work by a male colleague. She was a manager in an office and this man refused to do anything asked. He accused her of delusions of grandeur in an email he sent to their managers. An investigation cleared her but he was not reprimanded. She became depressed as a result of this bullying. She had psychotherapy …

She said she has no interest or motivation in going back to work. She feels she had been mistreated by her employer. There was no appreciation and no 'well done' from her employer, even though she was a very conscientious worker. When she moved to the...office in [location] *there were files piled up to the ceiling and it was extremely busy. She said it was a fire fighting operation. She said their target was to have 20 clearances per week, which is feasible if the clients come into the office and have all their documentation, however, this rarely happened. She feels she does not have the motivation or concentration to go back to work and it is a high pressure job with very difficult targets she has concerns over her safety if she goes back to work as she has been assaulted…Her left arm has still not fully recovered and she still has a deadness if she writes even a little.*

Back to Work Plans:

She said she is not sure about going back to work. She would love to have the routine of work but when she was working she had no time to herself. She feels that she cannot go back to that job and feels that maybe it is 'not for me'. She thinks she might get a job as a part time carer and spend the rest of her time doing her outdoor pursuits, such as gardening, growing things in the poly tunnel, looking after the animals and walking.

/Cont'd…

> *She said her work and life were at race speed and she is feeling burnt out. In her old job she was threatened to be shot, people kicked screens and thumped things and then she was expected to say 'Next please'. She feels burnt out. She does not feel confident. She feels vulnerable to assault …*
>
> ***Mental State Examination:*** *…*
>
> *There was no objective evidence of pathological depression or anxiety …*
>
> *What is* [the Complainant's] *prognosis with respect to her current condition?*
> [The Complainant's] *prognosis is good, she currently has a conflict between her new lifestyle in* [location] *and whether or not to return to work, which is difficult for her to resolve and accounts for her current levels of emotional difficulty …*
>
> *It is my opinion from a psychiatric point of view that* [the Complainant] *is fit to return to her normal occupation. This is based on the following:*
>
> *She has had effective treatment including psychotherapy and medication which she has found very helpful. Mental state examination was normal showing excellent attention, concentration and memory throughout the interview and there was no objective evidence of pathological depression or anxiety.*
>
> *There are additional factors adversely affecting her energy and motivation to return to work. She has residual difficulty with sleep and emotion regulation these would be helped by reducing or stopping alcohol and establishing a better daily routine. There have been considerable personnel issues at work including bullying and lone working detailed above. Her move to* [location] *means she would have a long commute which would require her to be away from the family from early morning to early evening thus thwarting her wish to spend time with the children. The commute would also militate against her plans for a quieter rural lifestyle and developing the* [land] *with a poly tunnel and animals"*.

Following its claim review, I note that the Provider informed the Scheme Administrator by letter dated 23 April 2018 that it was upholding its original decision, as follows:

> *"Based on the evidence received, we are upholding our decision in respect of* [the Complainant's] *claim. IME* [Independent medical examination] *findings on both occasions indicate that* [the Complainant] *is currently fit to carry out her normal occupation"*.

I note that the Complainant has complained about the medical examinations she attended at the request of the Provider with Consultant Psychiatrist Dr F. on 18 October 2017 and with Dr D. on 14 March 2018, and has repeatedly questioned the thoroughness and independence of these assessments. I note that Section IV, **'Claims'**, of the applicable Group Income Protection Voluntary Scheme Policy Conditions provides, *inter alia*, at pg.11:

/Cont'd…

> *"We will arrange any such independent examinations with any physician chosen by us as may be reasonably required to assess our liability under the claim"*.

I am thus satisfied that the Provider, as the Insurer, is entitled to gather medical evidence and to arrange, as part of its assessment of an income protection claim or appeal, for a claimant to attend for independent medical examinations in order to assist it in making an informed decision. In this regard, I accept the Provider position that such specialist examiners, as medical professionals, are entitled to form their own opinions and conclusions and the Provider is entitled to rely upon the weight of the objective medical evidence before it, in determining whether a claimant satisfies the policy definitions for a valid income protection claim.

In this regard, I note that the Complainant herself failed to furnish the Provider with any medical reports from a treating specialist as part of her claim or appeal, instead relying only upon the Practitioner Report completed by her GP, Dr A. on 28 July 2017 (wherein the GP advised that she expected the Complainant to be fit to return to work in 3 – 6 months' time) and a short letter from her GP dated 29 January 2018 (wherein the GP then advised that she expected the Complainant would be fit to return to work in 6 – 9 months).

Having considered the weight of the objective medical evidence before it, and which I have cited from at length, I am satisfied that it was open for the Provider to conclude that the Complainant did not satisfy the policy definition of disability in November 2017, though I note that it decided to pay her income protection claim from 24 June 2017, the end of the deferred period, up to 31 December 2017 only, to allow her sufficient time to transition back to the workplace. Similarly, I am satisfied that on 23 April 2018, it was open for the Provider to conclude from the weight of the medical evidence before it when it was assessing her appeal, that the Complainant did not satisfy the policy definition of disability, particularly as the Complainant had not made any report available from a consultant psychiatrist or similar treating physician.

As a result, I am satisfied that in April 2018, the Provider assessed the Complainant's income protection claim and subsequent appeal in accordance with the terms and conditions of the Group Income Protection Voluntary Scheme which she was a member of.

I note, however, from the documentary evidence furnished by the Provider that some 11 weeks later, it received an email from the Scheme Administrator dated 13 July 2018, as follows:

> *"We received the below email from* [the Complainant]. [Her] *claim appeal had been turned down and she had not returned to work. She is now an inpatient in* [named psychiatric hospital]. *How can we proceed with the claim appeal process. Can* [the Complainant's] *consultant complete a med. Cert as requested in her email?"*

In this regard, the email from the Complainant referred to by the Scheme Administrator was attached, also dated 13 July 2018, and it advised, as follows:

/Cont'd…

> *"I am currently an in-patient in* [named psychiatric] *hospital in* [location]. *This is part of* [named] *Health Services. You may recall* [the Provider] *refused my claim for Income Continuance from Dec 17. My doctor treating me is* [Dr S.] *and she has advised me I will require a stay of five to six weeks. Can you arrange for* [the Provider] *to send an assessment form to her?"*

I am disappointed to note that there is no evidence furnished by the Provider, indicating that it responded in any way to this query from the Complainant, or indeed to the query raised by the Scheme Administrator as to how the claim process could be progressed.

In addition, I note that the Provider confirmed that it later received on 20 August 2018 a letter from Consultant Psychiatrist Dr S. dated 14 August 2018, which advised, as follows:

> *"This is to confirm that the above named was admitted to* [named psychiatric] *Hospital on 9th July 2018 and will remain an inpatient until further notice"*.

Again, there is no documentary evidence furnished by the Provider indicating that it addressed this matter at that time, in any manner, or that it acknowledged the communication received.

Furthermore, I note that contained in the documentary evidence furnished by the Provider is a Discharge Summary indicating that the Complainant was discharged from the said [named psychiatric] Hospital on 24 August 2018, and advising, *inter alia*, as follows:

> *"**Case Formulation***
>
> *1st voluntary admission of this mother of 3 children, separated from husband but living with current partner…Referred by GP with low mood, anxiety, and alcohol misuse.*
>
> *History of previous inpatient treatment in* [hospital] *following overdose of tablets 12 years ago, denies this was a suicide attempt. No thoughts of self-harm/suicidal ideation currently, wants to do better.*
>
> *Reports anxiety in multiple situations, panic attacks every week.*
> *Drinking bottle of wine every evening. No withdrawal symptoms currently.*
>
> *Multiple complex psychosocial stressors …*
>
> ***Presenting Complaint***
>
> *TRIGGERs*
> - *Was assaulted at work, ended up with torn ligaments in Dec 2016, hasn't worked since.*
> - *Was bullied at work while pregnant with her 3rd child, this set off current bout of depression.*
> - *Home life can be stressful with kids.*

/Cont'd…

- *Friend…is in nursing home with dementia, finds this very upsetting.*
- *Tense relationship with parents.*

MOOD

- *Has been on antidepressants x 2 yrs, no improvement.*
- *On Venlafaxine 150 mg, Mirtazapine 15 mg.*
- *Previously trailed on Lexapro, but no improvement.*
- *Has done a lot of psychotherapy and counselling in the past.*
- *Feels she is stressed with the children.*
- *Has gained a lot of weight since her 3rd child was born 3 yrs ago.*
- *Was bullied while pregnant with last child and feels this has triggered everything.*
- *Feels she is low most of the time.*
- *Mood is worst in the evening when she is stressed about dinner.*
- *Sleep: using alcohol and Mirtazapine to help her sleep.*
- *Concentration: poor, memory okay.*
- *Appetite: comfort eating.*
- *Anhedonia.*
- *Low self-esteem (longstanding).*
- *No current thoughts of self-harm/suicidal ideation/passive death wish – not hopeless.*
- *History of overdose 12 years ago "to stop my brain racing, not to kill myself", went to* [hospital A] *and* [named hospital] *x 3 weeks.*

ANXIETY

- *Has always been an anxious person.*
- *Triggered by home life with her own kids, grew up in a tense household, father was physically abusive to all his children.*
- *Trying to please everyone, lets things get on top of her.*
- *Work not a stressful environment when she is well.*
- *Panic attacks: a few a week, when she feels under pressure with kids.*
- *Socially anxious.*

ALCOHOL

- *'Self-medicating" – problem x 18 months.*
- *Drinks a bottle of wine every evening.*
- *Last alcohol- free day was 2 weeks ago.*
- *Denies any physical withdrawal symptoms.*
- *Gets cravings.*
- *No increase in tolerance.*
- *Argues with partner re: alcohol use.*
- *Feels she is dependent.*
- *Denies primacy.*
- *Drinks to reduce anxiety symptoms.*
- *No secrecy/hiding it.*
- *No drink driving.*
- *Reports blackouts most nights.*
- *Has injured herself a few times from falling drinking, eg chipped heel bone.*
- *Drinking despite harm.*

/Cont'd…

No history of elation.
No history of psychosis …

Past Psychiatric History

- *Was on antidepressants x 4 years from 2004 – 2008, postnatal depression after birth of 1st daughter.*
- *2005 took overdose, 3 week admission to* [hospital].
- *Seeing a Psychotherapist x 18 months until October.*
- *Did CBT while in* [named] *Hospital*
- *Has done meditation …*

Mental State at Discharge:

Kempt. Not clinically depressed. Pleasant. Nil suicidal. Nil psychotic. Orientated in person, place, and time. Has insight".

I also note from the documentary evidence before me, the more recent Report from Ms Y., Dual Diagnosis Therapist at [named] Mental Health Services dated 28 May 2019, wherein she advises, as follows:

"[The Complainant] *was admitted to* [named] *University Hospital on the 9th July 2018, initially under the care of* [Consultant Psychiatrist Dr S.] *for the treatment of depression and anxiety.* [The Complainant] *was suffering from very low mood, lack of motivation, broken sleep, early awakening patterns and panic attacks. These are all symptoms of a severe depressive episode; she had been bullied in work and assaulted in the past year. These events had taken their toll on* [the Complainant's] *mental health. During her initial consultations with her treating psychiatrist,* [Dr S.] *expressed a concern that* [the Complainant] *was using alcohol as a coping mechanism,* [The Complainant] *agreed to undertake Alcohol Dependency assessments, these assessments highlighted a dependency issue and* [the Complainant] *was treated under the Dual Diagnosis Programme, which treats a depression diagnosis and a secondary dependency issue.*

[Dr S.] *was keen to remove alcohol from the equation and assess the depression/anxiety issue afterwards.* [The Complainant] *fully engaged with the four-week residential programme and has benefited from being alcohol free since her admittance to* [named] *Hospital.*

I am [the Complainant's] *Addiction Counsellor and had worked with* [the Complainant] *daily during the period she was an inpatient in* [named] *Hospital, where she completed the Dual Diagnosis programme. Upon discharge in late August,* [the Complainant] *attended a full day programme, held on a weekly basis for three months.* [The Complainant] *continues to attend an aftercare programme facilitated by me on a fortnightly basis. I can confirm that* [the Complainant] *has embraced this opportunity to turn her life around.*

/Cont'd…

She is also attending an afternoon programme on Compassion Focused Therapy as recommended by her treating Psychiatrist, this is an eighteen-week course. This will teach [the Complainant] *not to be so hard on herself, as this contributed to her Mental Health issues in the past.*

When [the Complainant] *was admitted to* [named] *Hospital she was in a very poor state mentally and physically. She was unmotivated, suffering from a very low mood, tearful, overweight, distracted, unable to engage in prolonged conversations and extremely agitated at times. She was not sleeping at night and often woke at 1 and 2 am, this was verified by our night staff and reported to her treating physician. Non-addictive sedative medication was prescribed and increased in dosage until* [the Complainant] *was managing to sleep. This medication left* [the Complainant] *very lethargic and unable to drive during the early part of the day due to the half-life of the drug in her system, she was taking 45 Mg of Mirap on a nightly basis on discharge.*

Over the period of seven weeks while [the Complainant] *was an inpatient she continuously actively engaged with the services provided by the Hospital; Social Work Department, Psychiatry, attending lectures on well-being, AWARE groups and Alcoholics Anonymous meetings, and group therapy.* [The Complainant's] *medication was increased to allow her to sleep and a higher dose of Anti-depressants were prescribed. Upon discharge* [the Complainant] *was taking 375 Mg of Venlafaxine, this combined with Mirap @ 45 mg, would not allow for a return to work due to the sedating effects of the Mirap.*

It is my professional opinion that [the Complainant] *was unfit for work at the time of admission and for a considerable period before her admittance. She was suffering from a dual diagnosis and her life was chaotic because of this. Her depression and anxiety combined with her blaming herself for being bullied/assaulted in work led to a decline in her health over a period of two to three years. Her decision to seek help was correct decision but not without its challenges.* [The Complainant] *was aware that she was not coping, but her method of coping by "relaxing or tuning out" with Alcohol was ill advised. After she was bullied in work* [the Complainant] *was disillusioned with her employer due to their lack of action against stopping the bullying. This disillusionment worsened when she was assaulted in work and there was no contact or concern shown by management, thereby reducing her resilience.*

I am delighted to say that [the Complainant] *has recently being engaging with her employer who are facilitating a transfer to an office in* [new location], [the Complainant] *is aiming to be back in work in September this year. This return to work will be on a phased basis initially but will help further* [the Complainant's] *recovery.* [The Complainant] *has managed to reduce and come off Mirap completely and is enjoying sleeping naturally at night, she has recently reduced her antidepressant medication and is managing this in conjunction with her Psychiatrist.*

/Cont'd…

> *Stress would have greatly exacerbated* [the Complainant's] *illness and it is unfortunate her employer was not able to be more supportive at the time of the assault. Financial hardship would also have contributed to* [the Complainant's] *mental health issues, and unfortunately she was not in the best state to represent herself. As a person,* [the Complainant] *is bright, intelligent, friendly and outgoing. This was not the person who came into hospital in July 2018. There is a huge difference in* [the Complainant] *that comes to group today and the broken person that was introduced to me in July 2018. This recovery has taken months of hard work and I am delighted to be able to say that* [the Complainant] *is doing much better today than she has done in the past".*

I am conscious that neither the letter of 14 August 2018 from Dr. S. (the Complainant's Consultant Psychiatrist) nor the Discharge Summary dated 24 August 2018, nor indeed the report from Ms. Y. dated 28 May 2019, were available to the Provider in April 2018, when it considered the Complainant's appeal against its decision to cease benefit payments under the policy, with effect from December 2017.

The Provider has advised this Office that when its claim appeal decision issued to the Scheme Administrator on **23 April 2018**, prior to the Complainant's admission to hospital on 9 July 2018, there was no indication at that time of an alcohol-related issue. In this regard, however, I note that the Provider is not correct. Rather, I note that following his independent medical examination with the Complainant on 14 March 2018, Consultant Psychiatrist Dr D. advised the Provider in his ensuing Report that:-

> *"There are additional factors adversely affecting her energy and motivation to return to work. She has residual difficulty with sleep and emotion regulating these would be helped by reducing or stopping alcohol and establishing a better daily routine".*

The Provider is however correct, that as the claim appeal decision issued to the Scheme Administrator on **23 April 2018**, there was no specified avenue for the Complainant to appeal again after that time. For that reason, the Provider maintains that although the Complainant submitted further medical evidence dated after the appeal was closed, it was not in a position to retrospectively assess the claim based on new evidence received, as it can only consider evidence presented during the assessment or appeal of the claim, which must be time appropriate. Given the particular circumstances however, I do not accept this.

In reviewing the file I note that the Provider issued its decision on appeal on 23 April 2018. It subsequently came to light however some 11 weeks later, that the Complainant was an in-patient in a mental health services facility. Given the proximity of the Complainant's hospital admission, to the Provider's assessment of her appeal on her claim, based upon "*PTSD Post Assault at Work, weakness left arm – impacts writing*" (described as including symptoms of "*anxiety, insomnia and low self-esteem*") and given the very limited medical evidence made available by the Complainant to the Provider up to that time, I believe that it was unreasonable for the Provider, not to revisit the matter.

/Cont'd…

I take the view that the Provider ought to have recognised the significance of this development and ought reasonably to have revisited its decision, to ensure that it was satisfied to stand over the position which it had determined on appeal. In my opinion the period which had elapsed of 11 weeks, in the overall scheme of things, was suitably proximate to the Provider's assessment of the appeal, as to warrant a more reasonable approach by the Provider at that time, rather than a definitive position that because such medical evidence had been received on a date which post-dated the determination made by the Provider on appeal, it would not be reviewed in any manner.

Given that relative shortness of time between the Provider having issued its appeal decision on 23 April 2018 and the Complainant being admitted as an inpatient of [named] Mental Health Services, from 9 July to 24 August 2018, it is my view, notwithstanding that it was under no contractual obligation to do so, that it would have been appropriate and fair for the Provider to have considered a further review of the Complainant's claim at that time, and it is regrettable that it failed to do so. In this regard, I believe that it was unreasonable for the Provider not to consider at that juncture, whether the Complainant's admission to hospital on 9 July 2018, albeit a voluntary admission, was potentially arising from the illness that was central to her income protection claim which the Provider had previously admitted into payment in the period between 24 June and 31 December 2017, and in respect of which the Complainant had, up to that point, offered only very limited medical evidence..

The Provider has since acknowledged that the Complainant had issues in July 2018 and that she underwent some intensive treatment in an in-patient environment and as a result, by way of correspondence dated **3 September 2019**, the Provider advised that it was prepared to make an ex-gratia payment in respect of the period from 9 July 2018, the date of her admission to hospital, to 30 September 2018 as a full and final settlement of this dispute, which is 84 days benefit totalling €5,325.72. Whilst the Complainant declined this offer, I note that the Provider has advised that it remains open to her to accept. In my opinion however, in the overall circumstances, this offer is inadequate.

I am conscious in this regard that ***Section 60(2)(c)*** empowers this office to find a complaint to be upheld, substantially upheld or partially upheld on the following ground:-

> *"Although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice, or standard is, or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the Complainant;"*

Whilst I am mindful that the Provider had acted correctly in its assessment of the claim in late 2017, and indeed in conducting the necessary steps to reconsider the claim in April 2018, on foot of the Complainant's appeal, nevertheless, I am satisfied that it ought reasonably to have reviewed the claim assessment upon receiving this new and very significant information regarding the Complainant, via its Scheme Administrator in July 2018.

/Cont'd…

Although there may not have been a regulatory or contractual requirement to do so, in my opinion, it was unreasonable and unjust to the Complainant to effectively ignore the very significant communication which had been received, particularly bearing in mind the limited medical information it had received from the Complainant's medical advisors, up to that time, and also taking into account the nature of the Complainant's medical issues.

Since the Preliminary Decision in this matter issued on 20 February 2020, both parties have made additional submissions. The Provider has acknowledged that the communication received by it in respect of the Complainant's admission to a psychiatric hospital was indeed proximate to its assessment of the Complainant's appeal for payment of benefits. The Provider points out however that the proximity in time between the assessment of the appeal and the communication in question "*does not automatically mean that the latter was prima facie relevant to the former*".

In that regard, it has referred to the letter from the psychiatric services dated 14 August 2018 which confirmed that the Complainant had been admitted on 9 July 2018 and would remain an in-patient until further notice. The Provider points out in that regard that the communication was

> "*entirely bereft of any medical evidence of any character, let alone such evidence as would lead the reader to conclude that there was a possibility that the Complainant then met the definition of disability under the policy in question*."

The Provider goes on to say in a letter of 12 March 2020 (incorrectly dated 2019) that:-

> "*If the communication from* [the psychiatric hospital] *on 14 August 2018 in respect of the Complainant's admission thereto had been supported with appropriate medical evidence, which the Complainant had submitted to us, supported her then meeting the definition of disability under the policy terms; then, given the proximity in time to the appeal, I can confirm that* [the Provider] *would, in the interests of fair procedures and natural justice, have given due consideration and regard to same; and revisited our decision in respect of the appeal accordingly, had we deemed it necessary to do so in light of such new evidence, notwithstanding that we were under no obligation to do so*".

It is noted in that regard that the Provider does not disagree that given the proximity between the Complainant's admission to the psychiatric hospital, and the decision taken by the Provider on foot of her appeal, it would have been reasonable for the Provider to have reconsidered the Complainant's appeal; the Provider takes the view however that it could not do so without receiving supporting medical evidence which it could then assess against the definition of disability under the policy terms. The Provider points out that the notification from the psychiatric services dated 14 August 2018 was not evidence at all, but merely a notification. The FSPO agrees with the Provider in this regard. The letter of 14 August 2018 was indeed a notification to the Provider of the development in question, following on the Complainant's advice to the scheme administrator in July, that she had been admitted to the unit.

/Cont'd…

The Provider also points out that it did not come into possession of any additional medical evidence regarding the Complainant's condition until May 2019 and it does not believe that, at that late stage, this created an obligation on its part to revisit the appeal at that point, more than a year after the appeal had been determined. The FSPO accepts the Provider's submission in that regard.

It is however, disappointing that in July/August 2018, when the Provider received notification as to this very significant development regarding the Complainant's admission to the named psychiatric hospital, it did not, in my opinion, take adequate steps to revisit the position at that juncture.

It is notable that on **13 July 2018**, in an email to the Scheme Administrator, the Complainant asked that the Provider would send an assessment form to the doctor who was treating her. 11 days later, the Scheme Administrator replied to the Complainant by email to advise that the Provider had confirmed that it would "*be happy to consider up to date medical evidence from your specialist*".

The Complainant points out that she was in a difficult position. She explains that when she spoke to her treating consultant, she was told that the doctor required the insurer to request the medical information, in the first instance. The Complainant was advised by her doctor that this was in line with data protection protocols in order to protect patient confidentiality. The Complainant has submitted that:-

> "[Dr. S] *would not and legally could not send details of my medical diagnosis or further personal information without a written request from* [the Provider] *explicitly seeking this information. I can understand why this would be her professional stance, as she said this is the norm. I did speak wit*h [the Scheme Administrator] *at the time and* [it] *insisted* [the Provider] *would not write requesting this medical information. I was in a Catch 22 situation as* [the Provider] *refused to write to* [Dr. S.] *seeking this information as they insisted the case was closed. I could neither make them seek the information nor could I insist that* [Dr. S.] *release the information without a written request. Even though I was the patient and quite unwell I was not in a position to further the matter, no matter what I tried."*

The Provider has indicated that it was not aware at any time that the Complainant's physician was refusing to release any relevant medical evidence at the time; it also contends that no request was made that the Provider contact Dr. S. in order to request the relevant medical details, notwithstanding the Complainant's email to the Scheme Administrator on 13 July 2018.

Having considered all of the evidence, I take the view that from July/August 2018, the Provider was on clear notice that the Complainant had been admitted to a psychiatric hospital as an inpatient. The Provider agrees that this development was proximate to the outcome of its determination of her appeal and in my opinion, noting the terms of the Complainant's request to the Scheme Administrator on 13 July, for the Provider to send an assessment to her treating consultant, I believe that the Provider, taking into account all of the circumstances, should have been more proactive in securing up to date medical information.

/Cont'd…

Whilst the Provider made it clear through its Scheme Administrator that it was willing to assess any medical information received, I don't believe that it was reasonable of the Provider to require the Complainant, who was clearly very unwell, to herself solve the difficulty which was created by the opposing positions taken by the Provider and her treating doctor, in the context of GDPR concerns.

The Provider is correct that the notification in August 2018 was simply that: there was little medical evidence available. I believe that the Provider however, has a case to answer for failing, in the context of that significant development, to procure the necessary up to date medical details regarding the Complainant's position in order to satisfy itself that the determination made on appeal in April 2018, continued to be sound.

It would have been helpful in that regard if the Provider had communicated clearly to the Complainant regarding its requirements, and any suggested solution, as it appears that the limited emails and telephone calls with the Scheme Administrator in July 2018, ultimately gave rise to what appears to have been something of an impasse. The Complainant's email of 13 July clearly asked for an assessment form to be sent to the doctor who was treating her. The Provider's response was to advise the administrator that the Provider would "*be happy to consider up to date medical evidence from* [her] *specialist*".

Accordingly, I am satisfied that it is appropriate to substantially uphold the complaint, that the Provider wrongfully or unfairly ceased benefit payments to the Complainant with effect from 31 December 2017, in the particular circumstances and given in particular that, in my opinion, the Provider ought reasonably to have conducted a fresh review of the claim appeal process, on receipt of notification in July/August 2018 that the Complainant had been admitted to the psychiatric unit, as an inpatient.

To mark that finding I consider it appropriate to direct the Provider to reinstate benefit payments to the Complainant for the period from 1 January 2018 onwards, pending a further review of the claim in the usual way, to consider whether the Complainant continues to meet the definition of "*disability*" as laid down within the Group Income Protection Voluntary Scheme.

It will be important for the Complainant to understand however, in that regard, that simply because the claim was admitted for benefit payments in 2017, which will now continue pending a further assessment, this does not mean that the benefit payments will continue indefinitely. Rather, the Provider is entitled to periodically review the Complainant's condition, in the context of the medical evidence available, in order to establish whether she continues to meet the definition of disability under the policy, in order to qualify for the continuation of benefit payments.

For the reasons outlined above, this complaint is substantially upheld.

/Cont'd…

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is substantially upheld on the grounds prescribed in ***Section 60(2) (c)*** and ***(g).***

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to rectify the conduct complained of by reinstating benefit payments to the Complainant for the period from 1 January 2018 onwards, pending a further review of the claim in the usual way, to examine whether the Complainant continues to meet the definition of "*disability*" as laid down within the Group Income Protection Voluntary Scheme.

- The Provider is also required to comply with ***Section 60(8)(b)*** of the ***Financial Services and Pensions Ombudsman Act 2017.***

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

3 April 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.