An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0164
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Rejection of claim - fit to return to work
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complainant is a member of her employer's Group Income Protection Policy, underwritten by the Provider.

The Complainant submitted a claim to the Provider on **13 July 2016**. The Provider paid benefits from **28 August 2016** to **30 April 2017**, when it ceased payment on the basis that the Complainant was fit to return to her normal occupation and she did not satisfy the definition of disablement under the Policy. It subsequently upheld its initial decision, following an appeal by the Complainant.

The Complaint disagrees with the decision of the Provider.

The Complainant's Case

The Complainant submits that she was on sick leave, as recommended by her own doctor and the medical professionals in the maternity hospital she was attending, from **September 2015** to **January 2016** and was then on maternity leave until **June 2016**. The Complainant submits that she was on maternity leave when she suffered the loss of her husband.

The Complainant submitted a claim under her employer's Group Income Protection Policy, on **13 July 2016**.

The Provider initially paid benefits under the Policy, from **28 August 2016** to **30 April 2017**.

The Complainant submits that she was asked by the Provider to attend at a specialist, which she did on **24 November 2016**. This Consultant reported that she was fit to return to work.

The Provider advised the Complainant's employer on **27 February 2017** that it was ceasing payments under the policy with effect from **30 April 2017**.

The Complainant appealed this and submitted a letter from her GP dated **16 March 2017** as well as a letter from her Consultant Psychiatrist dated **18 May 2017**, which stated that she was not fit to return to work.

The Provider then asked her to attend a further specialist, on **09 June 2017** who also reported that she was fit to return to work.

The Complainant has set out the factual errors contained in the report of this specialist, which had left her extremely upset and which she informed the Provider about - which included the date of her child's birth and the date and location of her husband's death, and his reference to them as "*minor revisions*". The Complainant submits that "*these are two of the most significant days in my life, the latter which has had a devastating effect on me. Yes I have to deal with daily life so that my [child] is brought up to the best of my ability in such stressful circumstances. But they don't see the stress I suffer trying to hide my grief on days when it surfaces from my little [child]…I still cannot face large amounts of people outside my close family and friends circle. I still don't go to the local supermarkets because of this preferring to go to the next town where I am less known in order to avoid the people asking how I am, how's [her child] as this normally results in me breaking down crying….I do hope to return to work in the future but I do not feel mentally ready to do so at this moment in time.*"

The Complainant disputes the Provider's assessment of her claim. She submits that she is not fit to return to work and suffers from stress and depression, but that there has been little acknowledgement of this by either of the independent Consultant Psychiatrists and the Provider has not attached sufficient weight to the medical opinions of her own treating doctors.

The Complainant submits that both her own GP and consultant psychiatrist who she has been attending since her husband's death, on a monthly basis, have advised that she is not fit to return to work.

She submits that she does not feel ready to return to normal duties and wishes for the Provider to act on her doctors' advices and continue to make payments under the Policy for the foreseeable future.

The Complainant's position is that she is not currently capable of returning to her normal occupation and she seeks the ongoing payment of benefit under the policy by the Provider.

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The Provider's Case

The Provider submits that it received a completed a claim form from the Complainant dated **13 July 2016**. On the claim form she detailed her illness as "*suffering from complete stress and lack of concentration*". It also received a GP report dated **12 July 2016** from the Complainant's GP on **19 July 2016**, in which she advised that the nature and cause of the Complainant's disability was "*depression*".

Upon review of the evidence received from the Complainant's GP the claim was accepted and paid from **28 August 2016**. A review of the claim was carried out at the end of **September 2016** and an Independent Medical Examination with a Consultant Psychiatrist took place on **24 November 2016**.

The Provider submits that it received a copy of this Psychiatrist's report on **19 January 2017**. During the course of the report it was stated that:

> *"Her presentation is most consistent with normal grief. Grief is not a psychiatric disorder. While sudden untimely death is a risk factor for depression or "pathological grief" following such loss, [the Complainant] is bolstered by the responsibility of parenthood and the support of extended family."*

> "*I note that [the Complainant] is prescribed an antidepressant duloxetine although the dose is sub therapeutic. [The Complainant] would like to attend counselling and such grief counselling is to be recommended given the nature of the loss*."

> *"I consider [the Complainant] capable of carrying out her normal occupation. It is desirable (but not essential) that her return to work be phased beginning half time and building up to full time over a 3 month period."*

The Provider says that on the basis of the medical evidence received, it was of the opinion that the Complainant was fit to return to her normal occupation as she no longer satisfied the definition of disablement.

The Provider submits that the definition of disablement for the purpose of the Group Income Protection Policy of which the Complainant is a member, is:

> *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.*

It says it therefore ceased the claim with effect from **30 April 2017**. It communicated its decision to the Complainant's employer on **27 February 2017** and also outlined the appeals process. The Complainant submits that in order to appeal, the Complainant would have to provide up to date objective medical evidence to support this appeal.

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It submits that it received correspondence from the Complainant's GP on **27 March 2017**. The Provider wrote to the Complainant on **27 April 2017** stating that the letter from her GP was not sufficient to support her appeal. It says that it required her to provide it with up to date objective evidence from her treating specialist. The Provider submits that it also offered the Complainant counselling services.

The Provider received a letter dated **18 May 2017**, from the Complainant's treating specialist, a Consultant Psychiatrist on **31 May 2017**. This letter stated that the Complainant attended him regularly for work stress and grief and that he had advised her to stay out of work on medical grounds. The Provider submits that "*While there was very little detail given in her letter in order to give the appeal our full consideration a second Independent Medical Examination was organised with another Consultant Psychiatrist for 09 June 2017."*

The Provider submits that following this medical examination, it received a copy of the Consultant's Report on **16 June 2017** which stated that:

> "*the current symptoms do not pose a major impediment to her day to day lifestyle and typically will likely improve as she engages further with the process of recovery."*
>
> *"At present her symptoms are not posing any major restriction on her day to day lifestyle in terms of childcare, managing a household, driving, interacting with computerized technology etc."*
>
> *"She feels she is not yet sufficiently recovered to return to work and that she is not ready to move to the next phase of recovery. However, her status is likely to further improve as she continues to engage with her usual day to day lifestyle and moves towards a full recovery a return to work will be an important element in this continued journey."*

The Provider submits that it carried out a thorough review of the claim but it remained its opinion that the Complainant remained fit to return to her normal occupation, as she did not satisfy the definition of disablement. It wrote to her employer on **06 July 2017** to advise that it was standing over its decision on the claim.

The Provider notes that the Complainant raised concerns over details of the report and that it raised this with the Consultant who had prepared the report. He responded that:

> "*the report details what I understood from my discussion with [the Complainant]. If they are incorrect then I am happy to apologise for having misunderstood the information as it was communicated to me. If she wishes I can amend these details to include these minor events. These changes do not alter my conclusions in terms of her fitness to return to work*."

The Provider submits that in relation to the Complainant's specific comments about her husband's history of previous depression, the Consultant commented:

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"I am happy to defer to her better knowledge of how formalised the history was. Perhaps that might be more accurately described as 'had experienced depressed mood', which was very much my understanding from our discussion.

I can understand how this distinction might be important to [the Complainant] but it would not alter the conclusion in terms of her current fitness to engage with her employment."

The Provider submits that while it accepts that there were certain discrepancies between the contents of the Report in question and how the Complainant reported it to the consultant, it is nonetheless satisfied that his opinion in terms of her fitness to engage in her normal occupation, is correct.

The Provider noted that subsequently, further evidence in the form of letters from the Complainant's treating consultant dated **31 May 2017** and **10 July 2017** were submitted to it by the Complainant, via this Office on **18 January 2018**. Upon review of these letters, the Provider submits that it offered to arrange a third examination with a Consultant Psychiatrist. The Complainant requested that it arrange the assessment closer to her home but the Provider has advised in this regard that:

"*unfortunately we have a limited number of doctors that carry out these assessments and [the Complainant] had attended the only doctor we had in her area so the only alternative was in Dublin. [The Complainant] decided against attending the new Independent Medical Examination*."

In the circumstances, a further assessment did not take place.

In summary, the Provider states that:

"*in order for an Income Protection Claim to be payable, a claimant must satisfy the definition of disablement. The purpose of the Income Protection policy is to support employees who demonstrate work disability supported by objective medical evidence.*

The objective independent medical reports from both [named Consultants] clearly indicate [the Complainant] no longer has a disabling psychiatric illness and she is fit for work.

It is generally accepted that, a disabling psychiatric complaint not just impedes an individual from working but also adversely impacts an individual's ability to perform normal every-day tasks and activities. However the level of activity she has demonstrated in terms of managing her home and her childcare responsibilities is not commensurate with a disabling psychiatric illness that would prevent her from working."

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The Provider says that it "*fully empathises with [the Complainant's] situation and that it understands that returning to work may not be a priority for her at this time but that the weight of the independent evidence suggests she is capable of working"* and that it *"could reach no other conclusion on the claim*."

The Complaint for Adjudication

The complaint is that the Provider's decision to cease payment of the Complainant's claim under the income protection policy, from **April 2017** and its further decision not to uphold her appeal of its decision, as communicated by letter to her employer in **July 2017**, were wrongful and/or unreasonable. The Complainant states that she is not capable of returning to work and he seeks full payment of benefit by the Provider.

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 **12 March 2020**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter.

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

It is important to emphasise that, from the point of view of assessing this complaint, it is not the role of the Ombudsman to comment on or form an opinion as to the nature or severity of the Complainant's condition but rather to establish whether in this instance, on the basis of an objective assessment of the medical evidence submitted to it, the Provider has adequately assessed the claim and was reasonably entitled to arrive at the decision that it did, upon assessment of the medical evidence received.

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I note that the Policy sets out, under Section IV *"Claims*", "*When are benefits payable?"* that:

> *"The benefits shall be payable to the policyholder at the end of the deferred period once we are satisfied that the member meets the definition of disability"*

I note that the definition of disablement within the Policy is:

> *"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*."

The Complainant has set out the background to her claim within her submissions. The claim form which was signed and dated by the Complainant on **13 July 2016** identifies the date of her first absence from work as **17 September 2015**. The Complainant notes that this absence occurred in circumstances where she "*was advised complete rest from 17/09/15 to end of my pregnancy on 14/01/16 due to pregnancy being classified as high risk. My husband [died] on [date]. I was admitted to hospital with [condition] on 24/04/16. I am on antidepressants and blood thinners to treat latter 2.*"

On **16 August 2016** a letter issued from the Provider to the Complainant's employer in respect of the income protection claim, which advised that:

> *Based on the supporting medical evidence received our decision is to admit this claim with effect from the end of the deferred period the 29/08/2016. We will review this claim again in 2 months' when updated medical evidence will be requested and the member may be required to attend an IME…*
> *…*
> *An initial payment for the period 29/08/2016 – 30/09/2016 (33 days) of €4,422.57 will be issued to [the employer] at the end of September with regular payments to follow at the end of each month.*

On **30 September 2016** the Provider sent an email to the Complainant, referring to the Policy and which stated that:

> *The claim is payable as long as the definition of disability as required under the policy is satisfied.*
> *The members 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 engage in any other occupation."*
>
> *To determine whether or not you satisfy the definition of disablement under the policy, we require you to attend an Independent Medical Examination…*

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The Provider wrote to the IME, a Consultant Psychiatrist, on **04 October 2016** requesting an assessment of the Complainant's health, for the purpose of establishing whether or not the Complainant continued to meet the definition of disablement under the policy.

The Provider emailed the Complainant on **02 November 2016** advising of the appointment scheduled for **24 November 2016**. The Complainant attended at the consultation and the Report which subsequently issued, provided as follows:

Mental State Examination

An alert middle aged woman. She was attired in black clothing and her hair was back. She wore wedding rings on the left hand. She was quiet spoken. She was tearful throughout. She had good rapport and eye contact. Her mood was depressed but not severely depressed but not psychotic or suicidal. She maintained mood reactivity, and normal attention and concentration throughout.

Additional Psychological and Cognitive Assessments

1. *'CNS Vital Signs' Neurocognitive assessment battery (Gualteiri & Johnson, 2006.). This is a computerised battery of tests taken on a computer and commonly used in this type of independent assessment. The instructions are straightforward and are at a primary school level of understanding. The test measures memory, psychomotor speed, reaction time, complex attention and cognitive flexibility. These five principle domains are aggregated to form the Neurocognition Index (NCI). From the NCI and from the individual tests conclusions may be drawn with respect to the cognitive functioning of the patient. Certain patterns relating to certain known conditions such as traumatic brain injury, minimal cognitive impairment detention deficit, hyperactivity disorder and certain psychiatric conditions may be evident.*
   The result s of the CNSVS were reviewed. [The Complainant] achieved a standardised score of 62, percentile 1, on the Neurocognition Inex (NCI) – very low. Her domain scores were Composite Memory 89, percentile 1; Complex Attention, 57, percentile 1; Cognitive Flexibility, 81, percentile 10; Reaction Time 52, percentile 1. These scores were consistent with her self-reported daily function and her objective performance at interview. In my opinion she is not cognitively impaired.

2. *Rey 15- item test, score 15 out of 15 – normal score. No indication of exaggerated or feigned cognitive impairment here.*

Summary & Conclusions

- *[The Complainant] is a [age] year old recently widowed mother of one who presents with depressed mood, anxiety and social avoidance precipitated by her husband's suddenly untimely death … [date], two months after the life event of her only [child's] birth. She has good social support and no prior history of mental ill health.*

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- *Her presentation is most consistent with normal grief. Grief is not a psychiatric disorder. While sudden untimely death is a risk factor for depression or 'pathological grief' following such a loss, [the Complainant] is bolstered by the responsibility of parenthood and the support of extended family.*
- *I note [the Complainant] is prescribed an antidepressant duloxetine although the dose is subtherapeutic. [The Complainant] would like to attend counselling and such grief counselling is to be recommended given the nature of her loss.*
- *I consider [the Complainant] capable of carrying out her normal occupation. It is desirable (but not essential) that her return to work be phased beginning half-time and building up to full time over a 3 month period.*

By letter dated **27 February 2017** the Provider wrote to the Complainant's employer with the following determination:

> *With due consideration to the recommendations of the Independent Medical Evaluation carried out on the 24 November 2016, [the Complainant] has been deemed fit to return to work to full-time duties after a phased return. In arriving at our decision we must be guided by the weight of the objective evidence obtained which, in our opinion, clearly indicates that [the Complainant] no longer meets the definition of disablement under the policy.*

It advised that a final payment of €8,175.05 would be issued on the **25 March 2017** in respect of the period **01 March 2017** to **30 April 2017**, in order to allow time for the necessary return to work arrangements to be made.

It stated that if the Complainant was unhappy with the decision on her case an appeal could be submitted within three months, supported by objective specialist evidence which indicated that she is "*currently totally disabled from following her normal occupation*".

The Complainant did appeal and she submitted a letter from her GP, in support of her appeal.

This letter stated that:

> *[The Complainant] is a patient in our surgery.*
>
> *Due to a traumatic tragedy in her family [the Complainant] has been unwell and unfit to return to work. In the meantime and due to her continuing stress I have referred [the Complainant] on to see a specialist and she is awaiting on an appointment to be seen, When this report comes through then perhaps the situation can be re-assessed but, at the moment I do think [the Complainant] is not fit to return to work.*

However, the Provider responded per letter of **25 April 2017** that the letter in question from her GP was not sufficient to support her appeal and that it required up to date evidence from her treating specialist that she was "*currently totally disabled from carrying out [her] normal occupation.*"

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The Complainant proceeded to submit a letter from her consultant psychiatrist dated **18 May 17.** This stated that:

> *To whom it concerns.*
> *This is to state that [the Complainant] attends me regularly for work stress and grief RxN.*
> *She is on medication and having psych Tx.*
> *I have advised her to stay out of work on medical grounds for the foreseeable future. I will review her in 1 month.*

The Complainant attended a second IME Consultant Psychiatrist at the Provider's request on **09 June 2017**.

The Consultant's Report sets out the following:

> *Illness History*
>
> *[The Complainant] describes a happy working life at [employer]. Her life was progressing normally until the birth of her [child, name] in [date] but [specified period] after this her husband [died] at their family home. This was an unexpected event and in the aftermath her life was in turmoil. She received good support from her GP [name] and has also attended [consultant psychiatrist's name] since March 2017 on a monthly basis. She is receiving duloxetine 60mg bd and has found this helpful. However, she reports that she does not yet feel ready to move on and feels that she needs more time. She does not report any particular symptoms of depression or other major mental disorder and describes that her [child] is her saving grace. She continues to grieve and attends the grave on a regular basis…[the Complainant] has not received any specific psychological intervention (e.g. grief counselling). She remains in regular contact with her employer but has no plans to return to work in the near future. She is keen to return to work at some point.*

The report goes on to state:

> *Recent daily pattern*
>
> *[The Complainant] describes a typical day as waking at 7am. She feeds her [child, age] and takes breakfast which is typically toast with boiled eggs and coffee. She tends to spend the morning doing household chores and spends time with her [child]. After lunch they go out to visit family. [The Complainant] has no difficulty driving. In the evenings she engages with the internet to look up things and check the news. She watches Soaps on TV and typically retires to bed after 9pm. She is able to manage household responsibilities and describes no great difficulty concentrating with everyday tasks. She looks after the household shopping and drives to the local supermarket for same. She rarely goes out socialising as she still feels inclined to avoid crowds since the loss of her husband. She recently started meeting friends for lunch again and is trying to increase her social capital again.*

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Mental State Examination

A formal assessment of mental state at interview revealed a casually dressed and pleasant woman who was calm during the assessment. She drove to the appointment. [The Complainant] was able to describe things in good detail and with minimal difficulty in terms of concentration and recall during the interview. It was easy to establish a good rapport with her. She was understandably upset describing the tragic loss of her husband. Her mood was subjectively and objectively normothymic with a resonant affective tone. She was able to share humour about a variety of topics and reported a positive perspective regarding the future. There were no ideas of self harm. There was no evidence of any major disturbance to thinking or perception. She did not describe features of OCD, panic disorder or PTSD. There were no features of psychosis or other major mental illnesses noted. Cognition was grossly intact.

Formal testing:

(i) Montgomery-Asberg Depression Rating Scale (MADRS) score was 6/60 which is consistent with no active depressive illness.

(ii) MoCA test score was 30/30 which indicates normal cognition and is in keeping with the rest of the assessment. The level of performance would not pose a barrier to conducting her employment role.

(iii) Rey 15-item test score was 12/15 which is consistent with accurate reporting of abilities.

As regards the specific questions which had been posed by the Provider in its letter of instruction to the Consultant of **07 June 2017**, he responded as follows:

Does [the Complainant] currently have a formal psychiatric diagnosis?

The diagnosis is of a bereavement reaction.

What is the current mental state and is there evidence of cognitive decline, social decline, thought disorder, frank delusions, hallucinations, or catatonia.

The symptoms of grief are progressing and although somewhat prolonged, she does not have evidence of secondary depression. Her difficulties do not include major cognitive difficulties, functional impairment or psychosis. The current symptoms do not pose a major impediment to her day to day lifestyle and typically will improve as she engages further with the process of recovery.

Please outline the exact nature and severity of the current symptoms

As per (2) above.

How does the Complainant typically spend her day?

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[The Complainant's] typical day is described above. She engages with a variety of activities, social interaction and functional tasks (which include being principal parent for her child) without any major difficulty but remains somewhat reticent about major social engagements.

What restrictions/limitations are her symptoms placing on her normal activities of daily living, eg house duties, shopping driving travel etc.

At present her symptoms are not posing any major restriction on her day to day lifestyle in terms of childcare responsibilities, managing a household, driving, interacting with computerized technology etc.

What treatment is [the Complainant] currently engaged in to address her symptoms? In addition has her recovery proceeded as you would expect? If not, in your opinion are there any particular factors inhibiting recovery?

The current treatment is duloxetine 60mg bd and attendance with a consultant psychiatrist [named]. There are no major barriers to her recovery as the workplace environment was not a significant factor in her difficulties which are highly situational in nature. Organising appropriate childcare will be an important issue for her to address before returning to work.

What is the current mental state?

The current mental state is described above. This does not include symptoms of major mental illness but rather reflects an adjustment reaction to her major loss.

What goals has [the Complainant] set herself regarding a return to the workforce and what success has been achieved against these goals since her illness commenced?

[The Complainant] is keen to return to her employment which she usually enjoys but at present has no specific plans for a return date. She feels that she is not yet sufficiently recovered to return to work and that she is not ready to move to the next phase of recovery. However, her status is likely to further improve as she continues to engage with her usual day to day lifestyle and moves towards a full recovery. A return to work will be an important element in this continued journey.

What does the Complainant cite as the main reasons preventing her from returning to the workplace?

As per (8) above.

In your opinion is [the Complainant] currently fit to carry out her normal occupation?

Yes. [The Complainant] is currently fit to re-engage with full time employment.

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Following receipt of this report the Provider wrote to the Complainant's employer by letter dated **06 July 2017** stating that, based on the report and a review of medical records on file, it remained of the opinion that the Complainant did not meet the definition of disability under the policy and that it was not upholding the Complainant's appeal or changing its decision to cease benefit payments

Upon receipt of the Report, the Complainant wrote to the Provider to express her concern at certain contents of the Report and expressing that she was "*both shocked and upset at some of the statements and errors on his report*."

She identified that the Consultant had, among other things, misspelled her surname and gotten her title wrong. She noted that although the report noted that she had been on sick leave since **June 2016**, which was correct, it also said that she had been on maternity leave prior to that, which was incorrect, as she had been on sick leave from **September 2015** to **January 2016**, when she gave birth and then on maternity leave until **June 2016**.

The Complainant explained that she found certain incorrectly reported details to be extremely upsetting including the month that her child was born and the date and location of her husband's passing. She refuted certain details of her description of her husband's medical history. She noted that while the report referred to her having a history of a particular medical issue, it incorrectly stated that it hadn't been a problem in recent years but that this was incorrect as she had been hospitalised for treatment of same in 2016. Under the heading "*recent daily patterns*", the report stated that she goes to her local supermarket for her shopping, which is incorrect and she had specifically stated to the Consultant that she has not attended the local supermarkets, in order to avoid meeting people.

The Complainant submitted that overall the errors *"completely undermines his report and it should be disregarded."*

I have taken into account the Complainant's submissions in this regard and whilst I appreciate that the errors in the report must have been upsetting for the Complainant, and that both the Complainant and the Provider were entitled to expect the Consultant to carry out his work in a diligent and professional manner, I do not consider that the factual errors highlighted by the Complainant materially affect the particular matter of her fitness to engage with her employment, or that it undermined that the Consultant's opinion in that regard.

The Provider submits that further medical information in the form of letters from the Complainant's treating consultant dated **31 May 2017** and **10 July 2017**, were received from the Complainant, via this Office as part of the investigation of the Complainant's complaint, in January 2018.

I note that the date of its receipt of this medical information postdates the decision of the Provider to cease benefit payments to the Complainant and also postdates the Provider's decision on appeal.

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The letter dated **31 May 2017** advises that:

> *"Her medical and psychiatric history are good overall as is her family history, I noted that she had some [medical condition] last year but these seem to be ok again.*
>
> *She has been on Cymbalta 60 mg in the morning and has received some grief counselling. Overall the diagnosis is that of a major grief reaction and reactive depression. She does not have any drinking situation or indeed any drug problem. She is not suicidal etc.*
>
> *When I saw her in the middle of this month her sadness and loss has grown this year as would be expected and she is in the middle of grieving process as again would be expected.*
>
> *I have completed a letter for [the Provider] stating that she is not in the middle of a grief reaction at present and is not fit for work for the foreseeable future. She is to remain on Cymbalta 60mg in the morning for the moment."*

The Consultant's letter dated **10 July 2017** states as follows:

> *To whom it may concern, this is to state that the above pt attends me regularly for tx of mod-severe reactive depn and major anxiety and I have medically advised [the Complainant] to remain off work for the foreseeable future.*

Upon review of the report, the Provider offered to arrange for the Complainant to attend a third examination with a Consultant Psychiatrist. The Complainant requested that it arrange the assessment closer to her home but that it advised it could not accommodate this on the basis that it had

> "*a limited number of doctors that carry out these assessments and [the Complainant] had attended the only doctor we had in her area so the only alternative was in [location]. [The Complainant] decided against attending the new Independent Medical Examination."*

I have given careful consideration to the submissions made in this complaint. I have reviewed the medical evidence submitted by both parties to the complaint and examined the terms of the insurance policy governing the Complainant's claim for disability benefit.

Having examined the evidence, I am satisfied that the Provider did adequately explain to the Complainant that in order to support a claim under the policy, it would require evidence that the Complainant was "*currently totally disabled from carrying out [her] normal occupation"*, in accordance with the definition of disablement, under the policy.

I accept that overall, based on the medical evidence which was made available to it and considered by the Provider at the time of its decision to cease payment of the Complainant's claim, which was communicated by the Provider in **February 2017** and at the time of its determination of the Complainant's appeal, in **June 2017**, that it was

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entitled to come to a decision that the Complainant's condition was not such that it met the definition of disablement under the policy such that it prevented her from undertaking the material and substantial duties of her normal occupation, as required by the policy.

I have the greatest sympathy for the Complainant's situation and circumstances but I accept that the Provider did not act wrongfully or unreasonably in arriving at the conclusion which it did on the medical evidence before it at the time and I do not find that there are grounds upon which it would be appropriate to uphold the 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.

MARYROSE MCGOVERN
DIRECTOR OF INVESTIGATION, ADJUDICATION AND LEGAL SERVICES

6 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.