An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2020-0239
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
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 a Group Income Protection Scheme. Her Employer is the policyholder of this Scheme. The Provider is the Insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant's Case

The Complainant, a [occupation redacted], fell in her place of employment on **[month redacted] 2015**, following which she engaged in light duties until she went absent from work on [month redacted] 2015. She completed an Employee Claim Form to the Provider on 15 December 2015, as follows:

> *"**Describe in detail your illness/condition***
> *[accident redacted] and full body weight landed on left hand & arm*
>
> ***How does your condition prevent you from working?***
> *Unable to remove finished product with hand.*
> *Unable to [occupation activity redacted]".*

The Complainant's GP Dr S. completed a Practitioner Report to the Provider on **14 January 2016** wherein she detailed the Complainant's illness, as follows:

> *"**What is the exact nature and cause of disability?***
> *Soft tissue injury to left hand and wrist.*
> *Pain at base of thumb and scaphoid area.*
>
> ***Describe the symptoms which prevent the claimant from working***
> *Pain & reduced strength in left hand. Left arm aches if elevated".*

As part of its claim assessment, the Provider arranged for the Complainant to attend for a medical examination with Consultant Orthopaedic Surgeon Prof P. on 10 October 2016. Following this, the Provider was satisfied that the medical evidence supported a valid claim. Accordingly on [month redacted] 2017, the date on which the Complainant returned to work in a part-time capacity to a different area of the factory, the Provider admitted the income protection claim for the period from the end of the policy deferred period, 22 December 2015 to 31 May 2017.

The Complainant went absent from work again on [month redacted] 2017 with an escalation in her injury. In order to assess whether it could reinstate her claim, the Provider arranged for the Complainant to attend for medical examinations with Consultant Orthopaedic Surgeons Prof J. on 17 November 2017 and later Prof P. on 19 February 2018, following which the Provider upheld its decision to cease payment of the income protection claim in May 2017, as it concluded that the Complainant no longer met the policy definition of disability insofar as she was fit to return to work.

In her correspondence to this Office dated 10 August 2018, the Complainant sets out her complaint, as follows:

> *"The reason for the delay in my claim being processed was due to the business of the HR department in* [my Employer] *from the time of the accident to my return to work and second period of absence due to the excessive pain of the injury.*
>
> [Prof P.'s] *initial visit* [on 10 October 2016] *was for a second opinion in which he advised me that a second surgery may not benefit me and that he would think that* [my Employer] *would find phased back to work for me in a different position.*
>
> *I returned to work on [month redacted] 2017 to a different position on a 4 hour a day shift, but I had to go out again on sick leave on [month redacted] 2017 due to extensive pain in my hand, thumb, upper arm and side of neck. The pain was debilitating to the extent that I was in tears every day when I completed my shift. I certainly gave it my all on returning to work.*
>
> *On my second visit to* [Prof P. on 19 February 2018]*, he examined me briefly and sent a letter to the HR department in* [my Employer] *to state that not only was I fit to return to work but also to my original position. This would have been impossible for me to do as it [occupation activity redacted] and I strongly disagreed with his and* [Prof J.'s] *findings on my medical condition.*

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> *Since reports from both Consultants, I have returned to my GP for help and have been to see a* [Consultant] *Pain Specialist,* [Mr T.] *…*
>
> *I believe there are major discrepancies between* [the Provider's] *Reports and the other letters and reports from* [my treating doctors]*. Please note that I have in my opinion addressed every request from* [the Provider] *to the very best of my ability …*
>
> *To sum up, I am an honest [age redacted] lady who has been working since I was 15 years old. I have never been involved in any claim or appeal in my work history until now. I have been made to feel humiliated, hurt, not believed regarding my injury and pain, by* [the Provider]*. I can honestly state that I am unable to work and I find everyday tasks at home difficult to do, such as, cutting and preparing vegetables, making the beds, vacuuming and cleaning, washing and drying my hair. My injury also affects my driving abilities.*
>
> *I am appealing for someone to hear my side of events as I am the person who is enduring this ongoing pain and symptoms while taking pain relief on an ongoing basis"*.

In this regard, the Complainant advises in the Complaint Form she completed, as follows:

> *"I would like my income protection payment continued from the day it ceased on 31st May 2017, as I returned to work on [month redacted] 2017 and continued to work for 10 weeks in severe pain and had to leave work on [month redacted] 2017 as I felt I was inflicting more damage to my injury and pain.* [The Provider] *have stopped my income protection payment and I feel it's very unfair"*.

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

The complaint is that the Provider wrongly or unfairly refused to reinstate payment of the Complainant's income protection claim from May 2017, in circumstances where she continued to remain unfit for work.

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

Provider records indicate that on 20 January 2016 it received an Employee Claim Form that the Complainant had completed on 15 December 2015, stating her first date of work absence as [month redacted] 2015 after she

> *"[accident redacted] at place of employment and full body weight landed on left hand & arm."*

In addition, her Employer completed an Employer Claim Form on 10 December 2015 wherein it advised that the Complainant had suffered a *"left wrist injury 29/04/15 following a reported [accident redacted] at work"*, following which she had engaged in light duties until her first date of absence on [month redacted] 2015. In addition, the Complainant's GP

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Dr S. completed a Practitioner Report on 14 January 2016, which was not submitted to the Provider until 6 September 2016, some eight months later, wherein she detailed the Complainant's illness, as follows:

> *"**What is the exact nature and cause of disability?***
> *Soft tissue injury to left hand and wrist. Pain at base of thumb and scaphoid area.*
>
> ***Describe the symptoms which prevent the claimant from working***
> *Pain & reduced strength in left hand. Left arm aches if elevated."*

In order for an income protection benefit to be payable, a member of the Group Income Protection Scheme must satisfy the policy 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"*.

As part of its claim assessment, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Orthopaedic Surgeon Prof P. on 10 October 2016, who in his ensuing Report of the same date advised, *inter alia*, as follows:

> *"Examination of* [the Complainant's] *left thumb reveals an obvious curved scar over the dorsal ulnar aspect of her thumb consistent with her recent surgery. This is well healed. There is no particular swelling or hypersensitivity of the thumb …*
>
> *She does get discomfort on forced adduction of her thumb. Nevertheless, the joint itself is stable. She has reduced pinch grip due to stiffness in the IP joint. Nevertheless, she is able to make a pinch grip but the power would be slightly reduced …*
>
> *I would describe her symptoms as mild to moderate rather than severe. I believe her symptoms would be manageable to allow her to return back to the workforce assuming that there is no further surgery planned by her second opinion from the doctor over in* [named] *clinic …*
>
> *Therefore it is my belief that this lady certainly has residual pain and discomfort in her thumb with no hypersensitivity or instability that needs any further surgical intervention. Assuming this is confirmed by her hand surgeon she should have a phased return back to work using an orthotic support if necessary with some accommodation from a physical perspective"*.

The Provider wrote to the Complainant on 8 November 2016 to establish whether further surgery was planned and she telephoned on 24 November 2016 to advise that there was no further surgery proposed and that she was planning to return to work in January 2017. The Provider then emailed the Employer on 6 December 2016 to establish the exact date that the Complainant was returning to work and on what basis. The Employer later advised by

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email on 2 February 2017 that it was hoping to have a return to work date for the Complainant in the 2-3 weeks following.

The Complainant telephoned the Provider on 10 April 2017 to advise that she was now returning to work on [month redacted] 2017, which the Employer subsequently confirmed by email. In this regard, the Provider notes that the Complainant returned to work on [month redacted] 2017 on a phased basis, working in a part-time capacity (4 hours per day initially) in a different area of the factory, where she had to use computers and inward packages were arriving which she had to unwrap and open. This return to work was 3 months later than the initial planned return.

The Provider says that the claim was not fully submitted until 6 September 2016 (when it received the Practitioner Report that the Complainant's GP had completed 8 months earlier, on 14 January 2016). This was some 17 months after the injury, but the Provider accepted that on balance, the Complainant had been unfit for work but had now recovered sufficiently to allow her to return to work. As a result, the Provider admitted the income protection claim from 22 December 2015 (when the 26 week policy deferred period expired) up to 31 May 2017, to support the Complainant in her phased return to work.

In this regard, the Provider wrote to the Employer on **12 April 2017** to advise that a one off claim payment of €10,118.96 for the period 22 December 2015 to 31 May 2017 (527 days) would issue at the end of the month. The Provider considers that the payment of this benefit was a significant concession on its part.

The Provider later received an email from the Employer on 31 August 2017 advising that the Complainant had been absent from work again since [month redacted] 2017 with an escalation in her injury. The Provider requested an up-to-date report from the Complainant's treating specialist in order to see if it could consider the claim to be linked, rather than have her submit a new income protection claim. Instead, the Provider received a letter from the Complainant's GP dated 19 September 2017 confirming that the Complainant was unable to sustain her return to work and had been certified unfit for work and would remain so for the foreseeable future.

The Provider then arranged for the Complainant to attend for an independent medical examination with Consultant Orthopaedic Surgeon Prof J., initially on 26 October 2017 but rescheduled to 17 November 2017 at the Complainant's request. In his ensuing Report dated 17 November 2017, Prof J. advised, *inter alia*, as follows:

> *"*[The Complainant] *has evidence of having had previous surgery and a slight residual fixed flexion deformity. She is also describing more proximal pain for which she has not sought any attention. On examination she has full functioning of her hand on this side. Her power in particular is normal.*
>
> *With regard to this lady's injury to her first metacarpophalangeal joint, it would be expected that a patient with this injury would be able to resume sports and high level activity.*

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She has described new symptoms since [month redacted] when she stopped work but states she has not had these looked at or investigated.

My impression is that [the Complainant] *should be regarded fit to return to work"*.

Following this review, the Provider wrote to the Employer on 12 December 2017 to advise that it was upholding its original decision to cease payment of the claim from 31 May 2017.

The Provider received a telephone call and an email from the Employer on 19 December 2017 advising that the Complainant was unhappy with the Consultant who had carried out the medical examination on 17 November 2017. Given her grievances, the Provider arranged for the Complainant to attend for another independent medical examination on 22 February 2018, this time with Consultant Neurosurgeon Dr G. at a particular location. As the Complainant then advised that this was too far for her to travel, the Provider instead arranged for her to attend once again with Consultant Orthopaedic Surgeon Prof P. on 19 February 2018. In his ensuing Report dated 19 February 2018, Prof P. advised, *inter alia*, as follows:

"[The Complainant] *has had no particular interactive intervention or treatment and has just attended her GP and is taking Panadol and Solpadine at night for her current symptoms …*

[The Complainant] *sat comfortably during the consultation period. She moved her hand freely. She is able to lift bags using her left hand with no apparent discomfort. She did need some help with a zip on the posterior aspect of her jumper to help her get it off, but was still able to get her jumper off with no great difficulty or apparent discomfort …*

Examination of her left hand and thumb area reveals no obvious muscle wasting or swelling …

She has no gross neurological deficit and just some mild hypersensitivity around her thumb ulnar collateral ligament. She has no signs of a chronic regional pain syndrome clinically …

Grip strength was normal …

I see no other treatment modalities that are going to make an improvement in her disability and certainly on assessment today there is a discrepancy between her perceived symptoms and her clinical findings which reveals some minor sensitivity of the scar and discomfort in her thumb without any obvious severe disabling symptoms that would preclude her from returning back to work …

I can see no physical reason why this lady cannot return back to the workforce. As stated previously an orthotic support may help her thumb sensitivity but I can see no other reason why she would not be deemed medically fit to return back to her previous occupation".

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The Provider notes that Prof P. examined the Complainant's left hand and thumb and could see no obvious muscle wasting or swelling and submits that as this would indicate that her left hand and thumb is in regular use despite her self-reported pain, that it is therefore reasonable to conclude that the Complainant would be in a position to return to the workplace with the assistance of an orthotic support.

Taking into consideration all the evidence on file, the Provider wrote to the Employer on 27 March 2018 to advise that it remained of the view that the Complainant no longer met the policy definition of disability insofar as she was fit to carry out her normal occupation and therefore it was upholding its decision to cease payment of the income protection claim from 31 May 2017. In this regard, the Provider later issued the Complainant with a final response letter on 27 July 2018, which set out the reasons for its position.

The Provider accepts that pain is very subjective and there is no doubt that the Complainant is experiencing some soreness and discomfort when carrying out her daily activities. However, following three separate independent medical examinations (with Consultant Orthopaedic Surgeons Prof P. on 10 October 2016 and 19 February 2018 and with Prof J. on 17 November 2017), the overall findings were that the Complainant had sufficiently recovered to enable her to return to the workforce and therefore she did not meet the Group Income Protection Scheme policy definition of disability. These independent consultants are asked by the Provider to carry out fair and independent objective assessments and to furnish the Provider with their opinions based on their clinical judgment. In this regard, the Provider believes that all three assessments were carried out in a respectful and non-judgmental manner.

In October 2018, the Provider received a medical report from Consultant Pain Specialist Dr T. dated 4 July 2018, prepared for the Complainant's Employer after it had referred her for an opinion. Having considered this Report, the Provider agrees that it is likely that the Complainant will have a level of pain from time to time, but notes that Dr T. advises that she will have to learn to cope with this. The Provider submits that broadly, this means that the Complainant will have to manage the pain and get on with her normal life, which includes working.

In October 2018 the Provider also received a number of medical reports with various dates throughout 2015 and 2016. In this regard, the Provider is not doubting the Complainant's fitness for work at that time, and it points out that it paid the income protection claim from 22 December 2015 to 31 May 2017. Nevertheless, the Provider notes from these additional reports that the nerve conduction studies were negative and did not indicate any nerve damage. The Provider notes that only up-to-date specialist evidence is considered relevant and in this regard, the medical reports made available to it indicate that the Complainant was in fact discharged from all specialist care by August 2017.
In any event, it appears to the Provider that the Consultant Pain Specialist Dr T. and the independent Consultant Orthopaedic Surgeons Prof P. and Prof J. are of the same opinion, that is, that the Complainant has mechanical pain. From the evidence gathered and having reviewing the results of the nerve conduction studies which were negative for nerve damage, it appears that the Complainant will never have her thumb back to the way it was

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pre-injury, however the Provider considers that this should not preclude her from returning to the workplace and managing her pain.

Taking into consideration all the evidence on file, the Provider remains of the view that in May 2017, the Complainant no longer met the policy definition of disability insofar as she had recovered sufficiently to be able to return to work and the Provider is satisfied that it upheld its decision to cease payment of the income protection claim from 31 May 2017 in accordance with the terms and conditions of the Group Income Protection Scheme, which the Complainant is a member of.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly refused to reinstate payment of the Complainant's income protection claim from May 2017, in circumstances where she continued to remain unfit for work.

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 18 June 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.

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The complaint at hand is that the Provider wrongly or unfairly refused to reinstate the Complainant's income protection claim from May 2017, in circumstances where she continued to remain unfit for work.

In this regard, the Complainant is a member of a Group Income Protection Scheme. Her Employer is the policyholder of this Scheme. The Provider is the Insurer, responsible for the underwriting of applications for cover and assessing claims.

The Complainant, a [occupation redacted], fell in her place of employment on **[month redacted] 2015**, following which she engaged in light duties until she became absent from work on [month redacted] 2015. She completed an Employee Claim Form to the Provider on 15 December 2015, as follows:

*"**Describe in detail your illness/condition***

[accident redacted] at place of employment and full body weight landed on left hand & arm

How does your condition prevent you from working?
Unable to remove finished product with hand.
Unable to [occupation activity redacted] …

Has a diagnosis been made?
Yes … ligament damage to hand & thumb

Is your condition ☐ *Deteriorating* ☐ *Improving* ☑ *Stable …*

Have received 3 steroid injection. Treatment ongoing.

Are your symptoms ☐ *Constant* ☑ *Intermittent …*

Come upon at different stages and times of day. Every day.

Have you been hospitalised in connection with this illness/condition?
Yes … Day clinics for injections and consultations …

What treatment are you receiving?
Cortisone injections x 3 to date

If medication has been prescribed, please list the name(s) of the medication and the prescribed dosage
As above. Light pain killers. Paracetamol".

The Complainant's GP Dr S. completed a Practitioner Report to the Provider on 14 January 2016 wherein she detailed the Complainant's illness, as follows:

*"**What is the exact nature and cause of disability?***
Soft tissue injury to left hand and wrist.

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Pain at base of thumb and scaphoid area.

Describe the symptoms which prevent the claimant from working
Pain & reduced strength in left hand. Left arm aches if elevated …

[The Complainant] *has no limitation with her R hand however has significant reduced grip strength in the L hand and gets pain in the L arm on carrying …*

Aware of pain in L arm when reaching up, above her shoulder. Pain in L hand with gross or fine manipulation, especially if strength required. Normal sensation …

Please provide details of current treatment plan including name and dosage for any medication
Rest only.
No medication prescribed at present.

Please provide details of types and effect of previous treatment plans
No significant improvement following injections to hand …

If the condition is not improving please confirm why this is
Unresponsive to treatment at present.
Reasons why would require more specialist opinion that I as a GP could offer.

What us your prognosis for the claimant?
She has shown no improvement since the accident occurred almost 9mths ago so prognosis must be guarded …

She would be very happy to return to work in some capacity but is unable to perform any tasks involving L hand & arm gripping, pulling, lifting …

She would be capable of work which did not require left hand strength or dexterity, or lifting/carrying with the L arm".

Whilst the Complainant and her Employer submitted the requisite claim forms to the Provider in January 2016, I note that the Provider did not receive the outstanding Practitioner Report completed by the Complainant's GP on 14 January 2016, until 6 September 2016, which then facilitated its assessment of the income protection claim.

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

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

As a result, in order for income protection benefit to be payable, a claimant must satisfy the policy definition of disability.

In this regard, the '**Interpretation**' section of this Policy Conditions booklet provides, *inter alia*, at pg. 4, as follows:

*"**Disability***

The member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury; upon occurrence of which the benefit under the policy becomes payable, after the deferred period.

The member must not be engaged in any other occupation".

In addition, Section IV, '**Claims**', of this Policy Conditions booklet also provides, *inter alia*, at pg. 13, as follows:

"We will arrange any such independent examination with any physician chosen by us as may be reasonably required to assess our liability under the claim and cover the cost of the independent examination"

I note that as part of its claim assessment, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Orthopaedic Surgeon Prof P. on **10 October 2016**, who I note in his ensuing Report of the same date advised, as follows:

"[The Complainant] *has not worked since [month redacted] 2015. Her problems started before that when she had an accident at work. This occurred on [month redacted] 2015. She states she was at work [occupation redacted] and* [description of accident]. *She was shocked at the time. She was able to get up but had soreness immediately within her left thumb area…She had a coffee break and then noticed increasing symptoms affecting her right thumb with pain radiating up her arm towards her neck area. She reported the accident to the work team leader who advised her to see the company doctor. At that stage she complained predominantly of left sided thumb soreness and after review she went home.*

Subsequently she developed increasing pain in her dorsal ulnar aspect of her thumb area. She was referred by the company Doctor, [Specialist in Occupational Medicine, Dr B.] *to see* [Consultant Orthopaedic Surgeon Mr X.]*…. She had a clinical review but no obvious x-rays at that time and he diagnosed a soft tissue injury to her thumb and advocated physiotherapy. During this time she was still able to attend work with ongoing pain in her thumb but she was working night duties which was more*

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administrative rather than physical type of work. Physiotherapy she felt irritated her thumb symptoms and her symptoms increased in her thumb. As a result of this she went to her employer and advised them on [month redacted], that she was unable to continue working due to her symptoms.

Subsequently the occupational Doctor [Dr B.] *referred this lady to see* [Consultant Trauma and Orthopaedic Surgeon Mr P.]…*in…. She had x-rays and MRI scan and had three targeted injections under* [Mr P.'s] *care under x-ray control in October and November time. Unfortunately she had ongoing persistent symptoms and* [Mr P.] *recommended exploration for, as the patient documents, a triggering of her thumb and exploration of the ulnar collateral ligament on the ulnar side of her thumb area. This was performed in … in February 2016 and she was in a post-operative cast for six weeks. She then attended extensive physiotherapy for the next three months or so. This also required her to wear a splint.*

Unfortunately she still had ongoing activity symptoms of discomfort and had a CT scan done in July 2016 and [Mr P.] *noted she had radial sesamoid and was considering excising the sesamoid bone with further surgery being contemplated. She saw* [Mr P.] *after her scan and she is nervous to proceed with further surgery and she has asked her GP to organise a second opinion and she is due to see a surgeon over in … in the next three to four weeks.*

Over the summer months her symptoms remained largely the same and I saw her today for the purpose of this report.

Clinical Assessment 10/10/2016

Current Complaints:

This lady has not worked since [month redacted] 2015. She is eight months after her surgical exploration of her left thumb. She still complains of ongoing pain and activity discomfort in her thumb. She takes occasional paracetamol and nurofen. However her thumb is okay in the morning time but as the day goes by she gets increasing soreness and stiff ness in her thumb particularly doing normal household duties such as cleaning the floor or cutting vegetables or opening doors etc. She gets soreness particularly on the dorsal ulnar aspect of her thumb area with pain particularly if she grabs any object. She can drive a car but finds it sore to change a gear, She has no particular hypersensitivity of nerve pain but does have stiffness in her thumb involving the interphalangeal joint and metacarpal phalangeal joint which gives her reduction of her pinch grip. She also complains of occasional neck pain radiating down to her arm with soreness at night. She feels that her thumb is sore doing any heavy physical activity such as cleaning etc. …

Occupation history:

[The Complainant] *has worked for* [her Employer] *for 18 years as a [occupation redacted]. She states she loves her job. This physical job requires her to work with*

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[occupation activity redacted]. She is right handed but say a lot of work involves using her left hand at times. Certainly she feels her pain symptoms would impair her ability to do her job at the moment. She states a desire to return back to work but is nervous to undergo any further surgery and has requested a second opinion as described above.

Clinical Examination: 10/10/2016

Clinical examination revealed [the Complainant] *sat comfortably during the consultation period.*

Examination of her left thumb reveals an obvious curved scar over the dorsal ulnar aspect of her thumb consistent with her recent surgery. This is well healed. There is no particular swelling or hypersensitivity of the thumb. The scar itself is not sensitive. She has stiffness in her thumb, 0 to 45 degrees of IP joint function compared to the normal of 0 to 80 degrees on the normal right side. Similarly her metacarpal phalangeal joint is stiff, 0 to 40 degrees compared to 0 to 70 degrees on the normal right side. She has mild sensitivity and tenderness over the soft tissues on the ulnar side of her thumb. However her ulnar collateral ligament is clinically stable in 0 degrees and 30 degrees of flexion. She does get discomfort on forced adduction of her thumb. Nevertheless the joint itself is stable. She has reduced pinch grip due to stiffness in her IP joint. Nevertheless, she is able to make a pinch grip but the power would be slightly reduced. She has a full pain free range of motion of her wrist joint with no signs of any carpal instability or scaphoid tenderness. Neurological examination of her upper limb was normal.

She has a full pain free range of motion of her cervical spine, left shoulder and left elbow area with no signs of any neuropathic pain down her left arm.

Opinion / Prognosis:

[The Complainant] *is now one year and six months since a low velocity fall at work where she injured her left thumb. She hasn't worked since [month redacted] 2015 due to ongoing chronic pain symptoms in her thumb. Her diagnosis would be of residual pain post-surgery. It seems she had triggering of her thumb which was corrected by* [Mr P.] *but is left with a stiff painful thumb rather than an unstable thumb with predominately soreness and discomfort on the ulnar collateral ligament thumb metacarpal phalangeal joint. She had episodes of some pain going up her arm but there are no signs that she has any neuropathic or discogenic pain radiating from her neck into her arm on assessment today.*

Her symptoms affect her on a day to day basis doing physical activity with little symptoms in the morning but increasing symptoms the more she uses her thumb with soreness and discomfort which would be considered mild to moderate rather than severe. This certainly gives her some soreness when she cleans floors, cuts vegetables or drives.

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Her current symptoms at the moment would be mild and she takes intermittent paracetamol and nurofen.

At this stage she has had prolonged physiotherapy with little improvement in her symptoms and is left with residual stiffness in her thumb metacarpal phalangeal joint and IP joint.

I would describe her symptoms as mild to moderate rather than severe. I believe her symptoms would be manageable to allow her to return back to the workforce assuming that there is no further surgery planned by her second opinion from the doctor over in … . Obviously she has a stable thumb but it does cause her pain and some physical task would be uncomfortable but it should not have any long term negative effect on her thumb function. I believe an orthotic support at work would also help her from a physical perspective to allow her to do her job.

Therefore it is my opinion that assuming that her hand surgeon in … has no alternative surgical plans for this lady that she has a stable but painful thumb that should be able to be accommodated with an orthotic support to allow her to return back to the workforce. It would be beneficial for her to have initially part time duties or less manual physical duties for the first two weeks and then on to normal working duties after that.

Therefore it is my belief that [the Complainant] *certainly has residual pain and discomfort in her thumb with no hypersensitivity or instability that needs any further surgical intervention. Assuming this is confirmed by her hand surgeon she should have a phased return back to work using an orthotic support if necessary with some accommodation from a physical perspective"*.

I note that the Provider then wrote to the Complainant on 8 November 2016 (this letter is misdated 16 June 2016) to establish whether further surgery was planned.

I note that following a referral from her Employer's Specialist in Occupational Medicine, Dr B., the Complainant had attended with Consultant Orthopaedic Surgeon Ms A. on 16 November 2016, who in her ensuing Report of the same date advised, *inter alia*, as follows:

"Thank you for referring [the Complainant] *for a second opinion with regards to her work related injury. This injury occurred in [month redacted] 2015. … At the time of the injury she* [had] *x-ray and found to have no fracture. Her films and injuries were discussed with the Orthopaedic team at* [named] *Hospital and at that stage they recommended a Futuro wrist splint for her to have a new x-ray in ten days' time to ensure there were no issues or ongoing symptoms. She was referred to* [Mr X.]*, Orthopaedic Consultant. He saw her in his clinic on the 7th of May 2015 and based on her symptoms he suggested an MRI Scan of this wrist to outrule any intra-articular issues. Apparently she was noted to have tenosynovitis issues involving the extensor carpe ulnaris and it was suggested she may have a tear of the triangular fibrocartilage on these initial scans. During this time she returned to work as a [occupation redacted]. It involves variations from very fine work to lifting boxes. She*

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returned to work approximately seven weeks following the injury. However she had to stop work on the [month redacted] 2015 as she was unable to continue on doing the same job. She had ongoing symptoms.

She was referred on to [Consultant Trauma and Orthopaedic Surgeon Mr P.] *… for an opinion and was seen on the 30th of June 2015. He organised for her to have an MR Arthrogram and nerve conduction studies carried out. These revealed no major abnormalities. There was a suggestion of an old injury to her ulnar collateral ligament on the left thumb and early degenerative changes of the thumb carpo-metacarpal joint and metacarpal phalangeal joint.*

By March 2016 the decision was taken that she was going to have an exploration and repair of her thumb ulnar collateral ligament. This was carried out on the 20th of April 2016. She was then referred to Hand Therapy for splinting over the course of six weeks. Due to the fact that she had ongoing symptoms despite surgery, she was sent for a CT Scan. I reviewed these scans but I do not have a report of this. My opinion is that she has early degenerative changes in her thumb CMC joint and she looks as if she has degenerative changes in the region of her sesamoid bone.

My understanding from my discussion with [the Complainant] *is that she and* [Mr P.] *have discussed the possibility a thumb metacarpal phalangeal joint fusion.*

On my examination today I found that she has pain over her left thumb globally. Specifically she has pain on palpation and axial loading of her thumb carpo-metacarpal joint, her left thumb metacarpophalangeal joint. She also has pain over her left 1st extensor compartment and is positive on her Finklestein test which is diagnostic of de Quervain's tenosynovitis. She also has pain in the region of her left thumb A-1 pulley. She does not have pain or instability on stressing her ulnar collateral ligament of this thumb.

She has told me that she has ongoing issues with gripping particularly with pincer grip. She had difficulty holding turnips and washing potatoes. She finds that her pain might be bearable early in the day but get worse with time. She states she does get night pain. She localises her pain currently to the dorsum of the left thumb in the region of the MCP joint. She states she also gets a spread of her pain across the dorsum of her hand and she has intermittent paraesthesia with this also.

Based on the review of her notes, her radiological imaging, and clinical examination, she is presenting with poorly localised pain of her left thumb and radial side of her wrist. I think much of this may be related to issues with pain management. She states that she only intermittently takes analgesia and takes Nurofen at a maximum of three times a week.

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> *On review of her scans she has very early degenerative changes in her thumb CMC joint and her thumb MCP joint. Clinically she has pain consistent with de Quervain's tenosynovitis and a mild left trigger thumb. My feeling is a fusion of her thumb CMC joint is not going to address these multiple symptoms.*
>
> *She states that due to the fine nature of her work, she uses her pincher grip quite a lot. I feel that surgery may not address these issues and she may not be able to return to the job that she did before at the previous level that she performed. Based on review of all the information I have to hand I would encourage conservative management for the moment as I feel that going down the route of a joint fusion is not without risks and does guarantee relief of her thumb symptoms".*

I note from the evidence before me that the Complainant telephoned the Provider on 24 November 2016 to advise that there was no further surgery planned and that she was intending a return to work in January 2017. As a result, the Provider emailed the Employer on 6 December 2016 to establish the date that the Complainant was returning to work and on what basis and hours. I note that the Employer later emailed the Provider on 2 February 2017 to advise that it was hoping to have a return to work date for the Complainant in the 2-3 weeks following. In this regard, I note that the Complainant then telephoned the Provider on 10 April 2017 to advise that she was now returning to work on [month redacted] 2017, which the Employer subsequently confirmed by email was on a phased basis, working in a part-time capacity (4 hours per day initially) in a different area of the factory.

Having considered the evidence before it, I note that the Provider accepted that on balance, the Complainant had been unfit for work but had now recovered sufficiently to allow her to return to work and it admitted the income protection claim for payment from the end of the 26 week policy deferred period on 22 December 2015, to 31 May 2017. In this regard, the Provider wrote to the Employer on 12 April 2017 to advise that it was making a one off claim payment of €10,118.96 for the period 22 December 2015 to 31 May 2017 (527 days).

The Provider later received an email from the Employer on 31 August 2017 advising that the Complainant had been absent from work again since [month redacted] 2017 with an escalation in her injury. The Provider requested an up-to-date report from the Complainant's treating specialist in order to see if it could consider the claim to be linked, rather than have her submit a new income protection claim. Instead, the Provider received a letter from the Complainant's GP Dr S. dated 19 September 2017, wherein she stated, as follows:

> *"*[The Complainant] *returned to work on [month redacted] 2017 on reduced hours on a trial basis. However, she was unable to continue with her duties due to her left hand injury, which resulted from a fall in work in [month redacted] 2015. She was certified unfit for work again on [month redacted] 2017 and remains so to date and for the foreseeable future"*.

The Provider then arranged for the Complainant to attend for an independent medical examination with Consultant Orthopaedic Surgeon Prof J. on 17 November 2017, who in his ensuing Report dated 17 November 2017 advised, *inter alia*, as follows:

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"[The Complainant] *describes that she was at work and* [description of accident]*. She [on to her left hand and thumb. She got up and she subsequently saw the Company Doctor,* [Dr B.]*. She was referred on to an Orthopaedic Surgeon,* [Mr X.] *and physiotherapy was recommended.*

She continued to work, however in light duties which involved filling binders into folders. She states that she did have some discomfort doing this job. She was subsequently seen by [Consultant Trauma and Orthopaedic Surgeon Mr P.] *in the …. She describes she had injections and subsequently an exploration of the ulnar collateral ligament of her first metacarpophalangeal joint on her left thumb.*

She states that she felt worse after this. She states she attended physiotherapy. She states that she was contacted by [Mr P.]*, who recommended further exploration and in view of the poor outcome from the initial surgery she was very reluctant to have this done.*

She subsequently attended [Consultant Orthopaedic Surgeon Ms A.] *in the … who advised against surgery.*

She states she went back to work on the [month redacted] 2017 with a different job with lighter duties, doing a 4-hour shift. She states she struggled to open packages and use her thumb.

She now is complaining of pain in her left hand which radiates up her arm and into her neck. She states that it wakes her up. She gave up work completely on the [month redacted] 2017. She had not attended anybody with regard to further assessment of the pain which now is in a different distribution.

She states she struggles at home with household jobs such as washing the kitchen floor, raking leaves or peeling turnips …

EXAMINATION:

On examination of her left thumb, she has a healed scar on the ulnar side dorsally, of her metacarpophalangeal joint in her left first ray. She has a small fixed flexion deformity in this joint. The joint is stable and non-tender, there is no neurological deficit and her sensation is normal. On examination of her neck, she has a full range of motion and no neurological deficit in her upper limbs. Her left shoulder has a full pain free range of motion.

OPINION:

[The Complainant] *is describing pain around the metacarpophalangeal joint. She has evidence of having had previous surgery and a slight residual fixed flexion deformity.*

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She is also describing more proximal pain for which she has not sought any attention. On examination she has full functioning of her hand on this side. Her power in particular is normal.

With regard to this lady's injury to her first metacarpophalangeal joint it would be expected that a patient with this injury would be able to resume sports and high level activity.

She has described new symptoms since [month redacted] when she stopped work but states she has not had these looked at our investigated.

My impression is that this lady should be regarded fit to return to work".

Following this review, I note that the Provider wrote to the Employer on 12 December 2017 to advise that it was upholding its original decision to cease payment of the income protection claim from 31 May 2017.

I note that the Employer next emailed the Provider at 13:42 on 19 December 2017, as follows:

"Thanks for taking my call this morning, as discussed I met with [the Complainant] *yesterday to let her know the findings of the independent medical examination which she had a few weeks back with* [Prof J.]. [The Complainant] *is very unhappy with his findings stating that 'she is currently fit to carry out her normal occupation".*

When I spoke with [the Complainant] *yesterday she explained that she had a very quick review with* [Prof J.] *which lasted 4-5 minutes, she stated that he did not want to see any MRI scans or medical reports which she had brought along to the examination. She explained that he did a very quick physical examination of her hand and that was all he did.* [The Complainant] *said that he apologised for being late and she noticed that there were a lot of other people waiting in the waiting room for their appointments.*

She is not happy with his decision and would like to appeal it. Can you confirm if another independent medical examination can be arranged …"

As a result, the Provider then arranged for the Complainant to attend for another independent medical examination, which I am of the opinion was a reasonable approach for it to adopt. I note that the Complainant attended once again with Consultant Orthopaedic Surgeon Prof P. on 19 February 2018, who in his ensuing Report of the same date advised, *inter alia*, as follows:

"[The Complainant] *is now one year and five months since the time of my last review. At the time of my last review she had ongoing symptoms affecting her left thumb and left am area. She went to see* [Ms A.] *who advocated against any further surgery to her left thumb. Unfortunately her* [relative] *died of an illness in 2016 and she was*

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considerably shaken by this and due to a combination of her physical symptoms and psychological grief she didn't return back to work until 2017.

She returned back to work in [month redacted] 2017 in a part time work capacity in a different area of the factory. She was in the engineer store where she had to use computers and inward products which were wrapped and she had to unwrap and open packages. She was working 20 hours per week. This work practice aggravated her thumb and arm symptoms in particular.

She continued at work until [month redacted] 2017 and has not been at work since then. She had had no particular interactive intervention or treatment and has just attended her GP and is taking Panadol and Solpadine at night for her current symptoms …

Clinical Assessment 19/2/2018

Current Complaints:

[The Complainant] *has not worked since [month redacted] 2017. She has ongoing activity symptoms affecting her left arm and thumb area. She describes discomfort on the left side of her neck anteriorly radiating into her left shoulder and down as far as her hand and thumb area. She describes this as a nerve pain which is there all the time, it is sore when she walks, stands or lifts or uses her hand to any great degree. It is not associated with any significant weakness in her arm but occasional pins & needles down her hand. She finds thumb movement such as opening cans, doors or lifting activities aggravate her thumb symptoms. She has no further specialist reviews or investigations and is attending her GP on a regular basis with Panadol during the day and Solpadine at night. She finds it sore to drive or do domestic household duties.*

Clinical Examination 19/2/2018

Clinical examination revealed this lady sat conformably during the consultation period. She moved her hand freely. She is able to lift bags using her left hand with no apparent discomfort. She did need some help with a zip on the posterior aspect of her jumper to help her get it off, but was still able to get her jumper off with no great difficulty or apparent discomfort.

Inspection of her neck reveals no cervical stiffness or localised spasm. She had a full range of motion of her neck joint with no obvious arm pain down her arm on lateral flexion and rotation to the left particularly. Cervical extension causes no neck or arm pain. Examination of her left shoulder and left elbow was normal with a full range of motion and no signs of any motor weakness.

Examination of her left hand and thumb area reveals no obvious muscle wasting or swelling. She has a scar on the ulnar side of her thumb which is well healed. She has 5 degrees fixed flexion deformity of her thumb, she can flex to 90 degrees with some mild discomfort. She is mildly tender over her ulnar collateral ligament but the

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ligament is stable in extension and flexion and there are certainly no signs of any gross instability of her thumb. She has no gross neurological deficit and just some mild hypersensitivity around her thumb ulnar collateral ligament. She has no signs of a chronic regional pain syndrome clinically. She has no hypersensitivity or skin colour changes. She is able to pinch grip and close her thumb with some discomfort but no significant power loss. Grip strength was normal.

Opinion / Prognosis

[The Complainant] *has ongoing symptoms affecting her left thumb and arm. These have been ongoing since an accident at work on [month redacted] 2015. Her ongoing thumb and arm symptoms have been extensively investigated by* [Consultant Trauma and Orthopaedic Surgeon Mr P.] *with nerve conduction studies and MRI scans etc. He diagnosed an abnormality with the ulnar collateral ligament with her thumb and proceed to a surgical exploration which did not improve her symptoms and she has had a second opinion from another surgeon advising no further surgery for her condition.*

Her current clinical situation reveals arm and thumb pain on the left side with no obvious neurological signs or symptoms consistent with any nerve root impingement from her neck or referred pain down her arm. Certainly she is mildly tender over her ulnar collateral ligament and surgical scar but the thumb itself is stable with no excessive hypersensitivity or signs of a chronic regional pain syndrome. She has got good functional range of motion of her thumb with normal pinch grip with discomfort but no severe pain on assessment today.

There certainly is a discrepancy of [the Complainant's] *description of her pain and her clinical findings which reveal some stiffness and sensitivity of the scar of her thumb but no obvious neurological deficit in her upper limbs.*

[The Complainant] *has ongoing left thumb pain and arm pain which is unexplained on her mechanical assessment today. She certainly has some residual discomfort in the ulnar collateral ligament and sensitivity of her scar but this itself would be relatively mild and doesn't explain her arm pain symptoms which she refers as originating from her thumb area up her arm to her neck. She has had extensive investigations in the past including nerve conduction studies which outruled any other cause for her symptoms and* [Mr P.'s] *exploratory surgery in her thumb hasn't improved her current situation. There are no signs of any obvious chronic regional pain syndrome on assessment today clinically.*

On examination today [the Complainant's] *symptoms were mild with no obvious discomfort apparent on opening her bag, taking off her jumper etc in relation to her thumb. She states her pain restricts her from daily living in terms of walking but she can drive with discomfort. The only treatment she has currently is Panadol medication and intermittent Solpadine at night time. There are no obvious further*

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rehabilitative recommendations which can be offered at this stage. Her symptoms have plateaued. She is left with a painful, thumb which is not hypersensitive or unstable.

[The Complainant] *does come across as a genuine lady who has an excellent working track record. She is left with residual pain in her left thumb which radiates up to her neck which is non-specific in terms of any nerve dermatome. Her symptoms have persisted despite surgery and time.*

There is no further surgery or investigations or management of her symptoms at this stage apart from medication anticipated ongoing in the future. That being the case I see no other treatment modalities that are going to make an improvement in her disability and certainly on assessment today there is a discrepancy between her perceived symptoms and her clinical findings which reveals some minor sensitivity of the scar and discomfort in her thumb without any obvious severe disabling symptoms that would preclude her from returning back to work.

Therefore that being the case on her clinical assessment today I can see no physical reason why [the Complainant] *cannot return back to the workforce. As stated previously an orthotic support may help her thumb sensitivity but I can see no other reason why she would not be deemed medically fit to return back to her previous occupation"*.

I note that the Provider then wrote to the Employer on 27 March 2018 to advise that it remained of the view that the Complainant no longer met the policy definition of disability insofar that she was fit to carry out her normal occupation and thus, that it was upholding its decision to cease payment of the income protection claim from 31 May 2017.

I note that in October 2018 the Provider was furnished with a Report from Consultant Pain Specialist Dr T. dated 4 July 2018, wherein he advised, as follows:

"[The Complainant] *attended my clinic on the 25th June 2018. She is a pleasant [age redacted] of age lady, who has left thumb and hand pain. She fell at work on [month redacted] 2015, apparently there was [accident redacted]. She fell on to her left hand. She is right-hand dominant. She attended her GP and continues on light duties for a number of weeks. She attended physiotherapy, but apparently that made her pain worse. She tried various medications including Solpadine, paracetamol, and Nurofen, but did not get any lasting relief with these. She attended* [Mr P.]*, Consultant Upper Limb Surgeon, who provided her with three Depo steroid injections and then performed surgery on 8th of April 2016.*

According to [the Complainant]*, she did not get any relief with the surgery.* [Mr P.] *has advised her that she could have further surgery, that being a fusion. She then attended other Orthopaedic Surgeons,* [Prof P.] *and* [Ms A.]*, who advised against having surgery.*

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In terms of [the Complainant's] *symptoms, she has pain in her left thumb and hand which she feels radiates up towards her neck. She reports that 7/10 on average, 8/10 at times, described it as severe. She has this during the day and night. She feels that her pain is worsened by, everyday events "preparing vegetables, hoovering, gardening, driving, shopping and improves with rest sometimes with medication and that she feels debilitated, tired, frustrated, and in bad humour, and unable to work". She reports that her pain is worse as the day goes on, which sounds quite mechanical. She has multi-dermatomal pain …*

On examination, she is tender at the base of her left thumb. She has no neurological abnormality. She has no other joint tenderness.

My opinion is that [the Complainant] *has chronic mechanical pain with some more widespread symptoms, which could be described as neuropathic in her left thumb and hand. She has been advised by one surgeon that she could have further surgery and by two others that she is unlikely to get benefit of her widespread symptoms with further surgery.*

In terms of other treatments which could be possible, anti-neuropathic pain medication may give some relief, but can cause cognitive side effects, that being amitriptyline or pregabalin. [The Complainant] *does not display any psychological major morbidity, she does have a degree of inflexibility and states, I want to be 100 percent before "I go back to work". I have advised her that with chronic pain condition, she is not going to be 100% cured and that she has to learn to live and cope with pain, she has had psychotherapy.*

My opinion is that she could benefit from referral to hand therapist for rehabilitation, if a job can be found at work where she does not have to use the left hand, it may be possible for her to return on light duties".

Having considered this Report, I note that in its email to this Office at 16:02 on 1 November 2018, the Provider advises, *inter alia*, as follows:

"We have considered the points raised by [Dr T.] *and note the following:*

[Dr T.] *states that "On examination, she is tender at the base of her left thumb. She has no neurological abnormality. She has no other joint tenderness"*
He also states that "She does have a degree of inflexibility".
"I advised her that with chronic pain conditions, she is not going to be 100% cured and that she has to learn to live and cope with pain, she has had psychotherapy".

Pain is itself a very subjective complaint and [Dr T.] *is a Pain Specialist who deals with the management and treatment of the reported pain levels by the patient.*

We would broadly agree that it is likely [the Complainant] *will have a level of pain from time to time, but* [Dr T.] *acknowledges she will have to learn to cope with this. Broadly this means, getting on with normal life which includes working.*

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> *Having carefully considered the evidence provided, we are happy to stand over our original decision as there is no objective evidence to suggest* [the Complainant] *is medically disabled from working. We believe her symptoms of pain can be managed in conjunction with normal working activity"*.

The conduct being complained of is the decision of the Provider in December 2017 and again in March 2018 to not reinstate the Complainant's income protection claim that it had ceased on 31 May 2017, following her absence from work again, from [month redacted] 2017.

The purpose of income protection is to support employees who demonstrate work disability supported by the objective medical evidence. Income protection insurance decisions are based on objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets the policy definitions for a valid claim. In this regard, the diagnosis of a medical condition is not, in and of itself, sufficient to determine claim validity, nor does it automatically equate to work disability; rather the weight of the objective medical evidence must clearly indicate that the claimant is unable to carry out his or her occupation.

I note that the Provider has never disputed that the Complainant has a medical condition. Indeed if it had disputed this, it would not have made the decision to admit her income protection claim into payment for a period of some 18 months. I note however that the Provider concluded from the objective medical evidence before it in December 2017 and again in March 2018, that at those times, the severity of the Complainant's condition was not such that it rendered her totally unable to carry out her normal occupation.

The Provider, as the Insurer, is entitled to gather medical evidence and arrange assessments in order to assist it in making an informed claims decision, based on the Group Income Protection Scheme terms and conditions and all of the medical evidence before it.

Having carried out its claim review, I am satisfied that it was reasonable for the Provider to conclude from the objective medical evidence before it in December 2017 and March 2018 (which I have cited from above at length) that from May 2017, the Complainant no longer satisfied the policy definition of Disability, insofar as she was fit to carry out the duties of her work. As a result, I am satisfied that the Provider's refusal to reinstate the income protection claim when the Complainant became absent from work again on [month redacted] 2017 was made in accordance with the terms and conditions of the Group Income Protection Scheme which she was a member of. It is my Decision therefore, on the evidence before me that this complaint cannot be upheld.

Conclusion

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

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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
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

10 July 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.