An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0081
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Claim handling delays or issues
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, a secondary school teacher, became a member of a Group Income Protection Scheme on **10 May 2007**. The Provider is the Insurer of this Scheme, responsible for assessing the income protection claims.

The Complainant's Case

The Complainant completed an income protection claim notification to the Provider in November 2015 detailing that he was certified as unfit for work since **September 2015** due to *"Anxiety Depression Stress"*.

As part of its claim assessment, the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist Dr P. on **17 February 2016**, who determined that the Complainant was *"fit to carry out his normal occupation"*. The Complainant notes, however, that in and around this time *"*[Consultant Psychiatrist Dr J.]*, Clinical Director, HSE…assesses me and hospitalised me on suicide watch"*.

Notwithstanding that Dr S. had advised the Provider of this hospitalisation, the Complainant notes that that Provider determined that he was fit to return to work and declined the income protection claim in **April 2016**. In this regard, in his email to this Office dated 17 May 2020, the Complainant submits, *inter alia*, as follows:

> *"At the time, the Provider's medical assessor,* [Consultant Psychiatrist Dr P.]*, stated that I was "fit to work"; despite the fact that I was in…Hospital when* [the Provider] *received his report".*

The Complainant's treating Consultant Psychiatrist Dr J. submitted a second report to the Provider in **June 2016** asking it to review its claim decision. As part of this review, the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist Dr F. on 9 August 2016, who determined that the Complainant was *"fit to carry out his normal occupation"*. The Provider then wrote to the Complainant on **31 August 2016** to advise that it had upheld its original decision to decline the income protection claim.

The Complainant does not accept the findings of the two medical examinations arranged for him by the Provider nor the decisions of the Provider in relation to the income protection claim. In this regard, the Complainant notes that subsequent occupational health assessments arranged for him by his Employer on 9 March 2017 and 31 July 2017 found on both occasions that he was *"unfit for work"*. In addition, in his recent email to this Office dated 14 August 2020, the Complainant advises, *"I am not fit to return to work"*.

The Complainant sets out his complaint in the Complaint Form he completed on 17 June 2017, as follows, as follows:

> *""Salary Protection" has a meaning. My salary has not been "protected" & has suffered since 24/12/15 payslip.*
>
> *I want what I understood I was paying for: Protection of my Salary in the event of being unable to work.*
>
> *The medical practitioners who know me best agree that I am too ill to work; my* [Employer's occupational health assessor] *also agrees.*
>
> *Only* [the Provider's] *privately paid medics disagree...one of whom may have risked my life by reporting good health to the insurance company <u>while</u> I was actually hospitalised for two weeks.*
>
> *It was my understanding that extensive certified illness was protected. The issue of "total disablement" and its definition was not raised when I bought into the scheme nor the intervening years …*
>
> *I cannot return to work unless…my employer-appointed Doctors assess that I am no longer unable.*
>
> *Throughout all this time, my salary has NOT been "protected" by the "Salary Protection" I paid for …*
>
> *From the time I began paying for salary protection, it was not my understanding that I would ever be left in this situation.*
>
> *Since March 2016, I have suffered the additional stress of "sick pay" reduced to "*[Temporary Rehabilitation Remuneration]*" of €384* [a] *fortnight with a family of four of us.*

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> *As a consequence, I have suffered continuing arrears in mortgage, credit card, utilities, GP, medication etc. and this, too, has added to stress and exacerbated my illness. It had actually impeded treatment & recovery"*.

The Complainant seeks for the Provider to *"make retrospective the "Salary Protection" that was supposed to be in place"* and admit his income protection claim.

The Complainant's complaint is that the Provider wrongly or unfairly declined to admit and pay his income protection claim in April 2016, and stood over that position on appeal, in August 2016.

The Provider's Case

Provider records indicate that the Complainant, a secondary school teacher, completed an income protection claim notification to the Provider in **November 2015** detailing that he was certified as unfit for work since September 2015 due to *"Anxiety Depression Stress"*. The Provider notes that the Complainant's sick leave record indicates that the first date of absence for this period was 14 September 2015.

In order for income protection benefit to be payable, the Complainant was required to satisfy the Group Income Protection Scheme policy definition of disablement, as follows:

> *"**1. Disablement -** For the purpose of this Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind)"*.

As part of its assessment of his income protection claim, the Provider arranged for the Complainant to undergo a tele-interview with a specialist nurse on **24 January 2016,** where he was asked to provide details regarding, *inter alia*, his occupational duties and his medical complaint and history. In addition, the Provider also arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr P. on **17 February 2016**. The Provider received a Report from Dr P. dated 17 February 2016 on 2 March 2016, in which he concluded, as follows:

> *"*[The Complainant] *is being treated for depression since 2010. However, I do not feel he is suffering from clinical depression or any other major psychiatric illness …*
>
> *Current treatment is sufficient to lead to a resumption of work …*
>
> [The Complainant] *is fit to carry out his normal occupation"*.

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The Provider says that on **14 March 2016** it also received a Medical Questionnaire completed by the Complainant's treating Consultant Psychiatrist Dr J. on 10 March 2016, which stated that the Complainant was *"currently in hospital"*, though an amendment initialled by Dr J. advised, *"UPDATE – DID NOT ENGAGE, had left"*. Dr J. also advised that he considered the Complainant was fit to return to work on a phased basis at that time. The Provider says that it forwarded this Medical Questionnaire to Consultant Psychiatrist Dr P. to review and who subsequently advised in writing, as follows:

> *"*[Dr J.'s] *report does not alter my view that* [the Complainant] *is fit to…carry out his normal occupation from a psychiatric point of view"*.

The Provider says that based on the weight of the medical evidence received, it concluded that the Complainant did not meet the policy definition of disablement and was fit to return to work and it wrote to the Complainant on 20 April 2016 to advise that it had declined his claim.

The Provider received a Report from the Complainant's treating Consultant Psychiatrist Dr J. dated **28 June 2016** on 12 July 2016, asking it to review its claim decision. As part of its appeal review, the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 9 August 2016, who in his ensuing Report of the same date concluded advised, *inter alia*, as follows:

> *"In my opinion* [the Complainant] *is currently fit to carry out his normal occupation. There is no objective evidence of disabling psychiatric illness that is preventing him from performing the material and substantial duties of his normal occupation. Any residual symptoms are not disabling in nature …*
>
> *It is reasonable to return to work when there are residual symptoms of psychiatric illness because work and achievement of occupational functioning have therapeutic benefits. Occupational functioning is recognised to be an integral and essential part of recovery from psychiatric illness"*.

The Provider says that having considered in full the medical evidence before it, it wrote to the Complainant on 31 August 2016 to advise that it was affirming its claim declinature. It says that following this, on 7 September 2016 it received a further Report from the Complainant's treating Consultant Psychiatrist Dr J. dated 24 August 2016. The Provider says that it considered this Report but it did not contain any new information that it was not already aware of from the evidence of Consultant Psychiatrist Dr F.'s Report of 9 August 2016 and there was no objective evidence therein to say why the Complainant might be unfit for work.

As part of the original assessment and subsequent appeal of the income protection claim, the Complainant attended for two independent medical examinations with two different Consultant Psychiatrists, namely, Dr P. on 17 February 2016 and Dr F. on 9 August 2016. The Provider says that income protection is an insured benefit, and as a result, there are certain criteria that must be satisfied in order for a claim to be admitted.

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It was the Provider's opinion, based on the medical evidence before it at the time of making its original decision to decline the claim on 20 April 2016, and subsequently when it affirmed that decision on 31 August 2016, that the Complainant was fit to return to work and did not meet the policy definition of disablement.

The Provider notes the Complainant's comments regarding his employer's occupational health department finding him unfit for work. However, the Provider points out that it is not bound by the views of third parties and it is entitled to form its own opinion on the fitness for work or otherwise of an insured person, before making a decision on any income protection claim. In addition, the Provider says that the two occupational health assessments referred to by the Complainant took place in March and July 2017; each after the Provider had already made its decisions on the income protection claim in April 2016, in the first instance, and in August 2016, on appeal, and the Provider can only consider the evidence which is available to it at the time of making its decision. In any event, having reviewed these since, the Provider confirms that there is nothing contained in these occupational health reports to suggest that the medical evidence relied upon by the Provider to make its claim decisions in 2016, was not accurate.

The Provider notes that its claims philosophy is one of paying claims when this is supported by objective medical evidence and declining claims when the claim is not supported by the objective medical evidence obtained. The vast majority of new claims received are admitted and go into payment and once claims are in payment, the Provider expect the payments to continue unless the medical evidence clearly indicates that the insured person is medically fit to resume work. The Provider would, therefore, generally gather medical evidence at the pending stage to ensure that the policy definition of disablement is met and also when claims are in payment, to ensure that the definition of disablement continues to be met.

The Provider confirms that all medical evidence it obtains is given very careful consideration and it is aware of how important it is for it to obtain reports from a claimant's treating doctors and where appropriate, reports from independent assessors when assessing income protection claims. In this regard, no particular emphasis is placed on the origin of a medical report, whether the report is from a treating doctor or an independent examiner, as it is very important that the decisions on claims are made on the basis of the objective evidence obtained.

The Provider says that reports from treating specialists and GPs, contain very important information that is key to the assessment of claims, information such as medical history, current treatment, results of investigations, fitness or otherwise for work and referrals for further review. Equally, reports from independent medical examiners also contain very important information such as a fresh view from a doctor who has not been involved in the care of the claimant, a contemporaneous interview and examination of the claimant and an independent opinion on fitness or otherwise for work. In this regard, the Provider always provides the independent examiner, prior to their examination, with copies of all available medical reports for their careful consideration.

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The Provider says that it cannot be bound by the opinions of a claimant's own doctors and similarly it is not necessarily guided by the opinions of the independent examiners in any particular case. Each claim is considered on its own merits and it will make a decision based on the weight of the objective evidence available. The Provider says that it has many claims in payment where it has not been necessary for the claimants concerned to attend for an independent medical examination, as it is satisfied based on the reports from the claimants' own doctors, that they are unfit for work. The Provider says that similarly, there are many claims where the independent examiners agree with the opinions of the claimants' own doctors that they are unfit for their normal occupation. The Provider also says that it has claims in payment where the opinion of the independent examiners is outweighed by the objective evidence provided by the claimants' own doctors.

The Provider says that it is not uncommon to see such a diversion of medical opinions between medical specialists and this diversion would be seen in other areas where fitness for work is being considered, such as occupational health assessments, claims for Illness Benefit and Invalidity Pension and employer or personal injury claims.

The Provider points out that the matter under dispute is its decision to decline the Complainant's income protection claim in **April 2016** and to stand over this decision in **August 2016**, following an appeal. The Provider says that in reaching this decision, it gave careful consideration to all of the medical evidence received, namely, the reports of the independent examiners together with the reports from the Complainant's treating doctors. The Provider notes that the Complainant states that he would be unable to return to work as he has not been certified as being fit to return to work. In this regard, it is the Provider's role to make a decision on a contract of insurance and the issue of providing certification of fitness to return to work is a separate matter between the Complainant, his employer's occupational health assessors and his treating doctors.

The Provider says that following additional representations made on behalf of the Complainant in August 2018, which were made on hardship grounds, it decided that it would put the income protection claim into payment with effect from 2 September 2018 (monthly in arrears with the first payment made on 1 October 2008) on an ex-gratia basis, while it conducted a further full review. In making these ex-gratia payments, the Provider was satisfied that the claim decisions it made in 2016 were correct, however, it was also cognisant of the Complainant's circumstances at the time.

Having completed the review, it remains the Provider's view that the Complainant did not meet the policy definition of disablement at the time of its claim decisions in 2016 but it confirmed that it would continue the ex-gratia payments until September 2020 to allow time for the necessary return to work arrangements to be made. In addition, the Provider will make available any supports the Complainant may require to ensure a successful return to work, such as access to a Vocational Rehabilitation Consultant and access to counselling services. Furthermore, the Provider advised in June 2020 that should the Complainant require a short period of time beyond 1 September 2020 to achieve a successful return to work on a full-time basis, it would be happy to support him during this phased return with additional payments for a limited period.

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In conclusion, the Provider says that it must be guided by the weight of the objective evidence available to it at the time of making its claim decisions. The Provider declined to admit and pay the Complainant's income protection claim in April 2016, a decision it stood over on appeal in August 2016, and it remains satisfied that these were the right decisions at the time, considering the medical evidence that was available to it. Accordingly, the Provider is satisfied that it correctly declined to admit and pay the income protection claim in accordance with the terms and conditions of the Group Income Protection Scheme that the Complainant is a member of.

The Complaint for Adjudication

The complaint at hand the Provider wrongly or unfairly declined to admit and pay the Complainant's income protection claim in April 2016, and stood over that decision, on appeal in August 2016.

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 **9 November 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.

On **24 November 2020**, the Complainant sought clarification as to the date by which his further submission would need to be made to this Office, as this had been the subject of discussions between him and his advisor. Although this Office clarified by return, that any such submission was required by 30 November 2020, and the Complainant proceeded to make a submission in writing, on 30 November 2020, he subsequently sought the "*continued indulgence*" of this Office on the basis that he was awaiting advice from his representative and he was also awaiting updated legal advice.

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Ultimately, as the Provider advised that it had no further comments to make and as no further submissions were received from the Complainant, this Office wrote to the Complainant on **9 February 2021** to advise that it would not be possible to hold the adjudication of the complaint open indefinitely, and in those circumstances, the FSPO would diary the matter for a final period of 1 month and if we did not hear from the Complainant within that period, this Office would take it that the adjudication of the complaint should proceed on the basis of the information already held on the file. Following the consideration of all such submissions from the parties, the final determination of this office is set out below.

The Complainant, a secondary school teacher, is a member of a Group Income Protection Scheme and the Provider is the Insurer of this Scheme, responsible for assessing claims. The Complainant completed an income protection claim notification to the Provider in November 2015 detailing that he had been certified as unfit for work since September 2015 due to *"Anxiety Depression Stress"*. Following its assessment, the Provider declined to admit and pay this income protection claim in April 2016, a decision which it upheld upon review in August 2016.

I note that the Complainant has not yet returned to work since September 2015. It is not, however, a matter for this Office to determine whether the Complainant, at this juncture, is unfit for work, as the conduct of the Provider giving rise to this complaint, dates from 2016.

Neither is it the role of this Office to determine the Complainant's medical status in 2015/2016. Rather, this Office must examine the totality of the medical evidence which was available to the Provider at the relevant time, to determine whether the decision made by the Provider in April 2016 to decline the Complainant's claim for benefits under the Group Income Protection Scheme (and to stand over that position following the Complainant's appeal in August 2016) was reasonable, based upon the medical evidence that was available to the Provider at those times.

The Group Income Protection Scheme that the Complainant is a member of, like all insurance policies, does not provide cover for every eventuality. Rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation. In this regard, in order for income protection benefit to be payable, the Complainant must satisfy the Group Income Protection Scheme policy definition of disablement, as follows:

> *"**1. Disablement -** For the purpose of this Policy*
>
> *(i) total disablement shall be deemed to exist where (a) the Insured Person is unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted and (b) the Insured Person is not engaging on a full-time or part-time basis in any other occupation (whether or not for profit or reward or remuneration, including benefit in kind)"*.

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The purpose of income protection is to support employees who demonstrate work disability supported by the objective medical evidence. Income protection insurance decisions made must be based on the objective medical evidence and the job demands of the occupation, to ascertain whether the claimant meets the policy definitions for a valid claim.

In order to assess his claim, I note that the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr P. on **17 February 2016**, who in his ensuing Report of the same date advised as follows:

> *"**Reasons*** **[the Complainant]** ***went on sick leave***
>
> [The Complainant] *said he has been treated for Depression since 2010. He said his depression occurred on a background of financial problems and a friend being … killed ….*
>
> *In 2010, he took about 1 year off work. Following his return he took recurrent periods of sick leave of up to three weeks at a time. These occurred at "Times when I felt terribly depressed". In summer 2015,he felt "really bad". He said he was "Staying in bed almost all day…no motivation…hiding from the world". He said his appetite was poor and he experienced suicidal thoughts. He said thoughts of his children prevented his acting on his suicidal thoughts.*
> [The Complainant] *returned to work after the summer holidays. He said he was initially happy but then pressure mounted. His bank started proceedings to repossess his house and his wife spoke of her intention to separate. This "completely pushed me over the edge, I just lost all sense of a future". He took sick leave about one week later and has not returned since.*
>
> ***Treatment***
>
> [The Complainant] *attended his General Practitioner in 2010. He was also referred to a Psychiatrist around this time and commenced on anti-depressant medication. After different trials, he was maintained on Sertraline 75 mgs daily. He tried to come off it in 2014 but felt "totally scared….suicidal". He saw his GP who put him back on his original dose.*
>
> *In September 2015, his GP referred him to the Medical Assessment Unit of…Hospital. He underwent various investigations and was referred to his local HSE Psychiatry service…The anti-depressant Mirtazapine was added although he does not know what dose was prescribed. He admits intermittent compliance with medication as he says he cannot afford it. He currently attends the Mental Health Services…and is under the care of* [Dr Y] *(Consultant Psychiatrist).*
>
> ***Current Symptoms***
>
> [The Complainant] *says he feels "awful…like nobody cares about me at all, only my kids". He said his appetite is poor, his mood is "depressed", his sleep is "sporadic" and he is interested in "nothing".*

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He reports poor short term memory and low energy which he attributes to medication. He said "if you walked out of this door for 60 seconds I could fall asleep". He said life was not worth living but he had no intention of committing suicide because of his children. [The Complainant] *said his motivation is low and he said he has become socially withdrawn …*

Reasons* [the Complainant] *said he cannot return to work

[The Complainant] *said his colleagues leaned heavily on his knowledge of computers which resulted in his own work being interrupted regularly. He felt the Board of Management in the School were critical of him over his time keeping and attention to his own duties. He said his school had about* xx *computers and due to his knowledge, he often helped out with IT difficulties. Sometimes this would involve turning on a computer for a teacher.*

[The Complainant] *said he requested three classes a week off and extra time between classes to help with computer queries from colleagues. His school did not support this. He described difficulty establishing boundaries with his colleagues and not responding to the requests he received.*

Having said that, [the Complainant] *said he enjoyed his job as a teacher and said it was all he ever wanted to do. He said "I would love to be a teacher again" but he has no back to work plan and is considering that his career might be over …*

Mental State Examination

[The Complainant] *presented as an overweight man with plethoric facies. There was a smell of alcohol for his breath. He was vague in his description of his symptoms and only on direct questioning did he endorse mood symptoms.*

He tended to drift off the point and displayed an exaggerated emotional response to many questions during the assessment. He reported a subjective low mood and was frequently tearful during the interview. Objectively, he was reactive at times and impressed as overstating his psychological distress. He maintained good concentration during the assessment and his recall was intact. He was not psychotic. He denied current suicidal intent and said he would not commit suicide for the sake of his children, he spoke of his desire to get better and I do not feel he was suicidal during the interview.

SIMS

This screening questionnaire of malingered psychopathology and cognitive symptoms consists of 75 questions over 5 categories and can be a useful adjunct for identification of suspected feigning of symptoms.

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In this case [the Complainant] *scored above the threshold on 3 of the 5 scales. On the Neurologic Impairment Scale he scored 6 (clinical cut >2).* [The Complainant] *endorsed symptoms that are highly atypical or inconsistent with the presentation of a patient with a genuine neurological impairment and suggests exaggeration of neurological symptoms.*

On the Affective Scale he scored 8 (clinical cut off >5). This score indicates endorsement of affective symptoms that are rarely seen in constellations in genuine mood disorders.

On the Amnestic Scale he scored 7 (clinical cut off >2). This suggests endorsement of symptoms of memory impairment that are inconsistent with the presentation in patients who have genuine memory impairment, given the illogical, inconsistent and /or atypical nature of the symptoms he endorsed.

Montreal Cognitive Assessment

This measure of cognitive functioning assesses areas such as executive function, memory, attention, delayed recall and orientation. It is measured out of 30 and scores of greater than 26 out of 30 are considered normal. In order to achieve an accurate score, the subject must be motivated and employ sufficient effort d inuring the testing.

In this case [the Complainant] *scored 27 out of 30 on the MOCA. He lost 3 points on delayed recall but otherwise displayed good cognitive function. Taken collectively with his SIMS Assessment and Mental State Examination, I feel* [the Complainant] *could have employed better effort on the MOCA and feel he overstated his cognitive problems.*

REY Test

The REY 15 Item Test is a simple test which detects malingering, 50% of the time. The person is asked to remember 3 categories comprising 15 items. Scores of less than 9, in the absence of specific brain injury, suggests falsification.

[The Complainant] *scored 15 out of 15 on the REY test.*

Conclusions

[The Complainant] *is being treated for depression since 2010. However, I do not feel he is suffering from clinical depression or any other major psychiatric illness …*

On direct questioning [the Complainant] *endorsed a number of depressive symptoms. He did not spontaneously report these and I felt that he was overstating his current symptoms as evident by his elevated score on the SIMS assessment and Mental State Examination. There was a degree of inconsistency about some of his symptoms e.g. he reported a poor appetite and dietary intake yet he was overweight.*

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It was difficult to establish any clear routine to [the Complainant's] *days and he said he spends most of his time around the house in his night clothes. He reported such poor day to day functioning that independent evidence would be useful …*

Current treatment is sufficient to lead to a resumption of work but I do not feel he is motivated towards a return …

[The Complainant] *is fit to carry out his normal occupation. He has extensive experience in teaching and I feel he still has the ability to work as a teacher, if he wishes. He spoke of unreasonable demands being placed upon him at work such as excessive requests by colleagues to fix basic IT problems (e.g. plugging a computer in). If this is the case, he should establish clearer professional boundaries with his colleagues. Excessive requests for assistance by work colleagues do not equate with illness and I could not find evidence of disabling psychiatric symptoms that prevent his returning to work …*

I feel [the Complainant] *has become entrenched in the sick role and he is overstating his current symptoms. This raises questions about his motivation to return to work. He speaks positively about teaching and how much he enjoyed it and return to work should therefore be therapeutic. I do not feel he is suffering from a major psychiatric illness but his adoption of the sick role is likely to affect his prognosis"*.

I note that shortly after on **14 March 2016**, the Provider received a Medical Questionnaire completed by the Complainant's treating Consultant Psychiatrist Dr J. on 10 March 2016, which stated, as follows:

*"**Date** **[the Complainant]** **last attended?***
09/03/2016 … Currently in hospital – UPDATE, DID NOT ENGAGE, has left …

What is the diagnosis of** **[the Complainant's]** **condition?
Depressive Disorder
Alcohol Dependence Syndrome

Please provide details of** **[the Complainant's]** **current symptoms?
Low mood, anxious +agitated …

What is the severity of the current symptoms?
Significant

How well controlled are the symptoms at the moment:
Poorly Controlled

Hoe do** **[the Complainant's]** **symptoms impact on his activities of daily living? Please provide details
Extensive impacts. Not functioning well at basic requirements / occupational requirements. Difficult home circumstance also relevant.

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Please provide details of* [the Complainant's] *treatment?
Detox. Antidepressants + mood stabiliser. Counselling … Addiction Counselling

How is* [the Complainant] *responding to treatment?
Only early responses seen

What is the prognosis of the condition?
a) In the short term? *Fair*
b) In the long term? *Uncertain*

Is* [the Complainant] *currently fit to carry out all the duties of his normal occupation as a Teacher?
No

If no, what particular aspects of his job does* [the Complainant] *have difficulty undertaking?
All

If you feel that* [the Complainant] *is not currently fit to carry out all work as a Teacher in your opinion is he currently capable of carrying out these duties on a phased basis leading to a return to his normal occupation?
Yes

If yes, what schedule would you recommend?
3-6 months [indecipherable] *minimum* [indecipherable] *…*

Have you discussed a return to his normal occupation with* [the Complainant]*. If so, what was outcome.
Not ready to contemplate".

I note that the Provider forwarded this Medical Questionnaire to Consultant Psychiatrist Dr P. to review and that he subsequently advised the Provider in writing, as follows:

> *"I reviewed the Income Protection Claims Medical Questionnaire completed by* [Dr J.] *(Consultant Psychiatrist) dated 10.03.16. The questionnaire indicated that* [the Complainant] *was admitted to hospital with Depression and Alcohol Dependence but did not engage in treatment and subsequently left. It is evident that alcohol is a bigger factor in his presentation than* [the Complainant] *stated during his assessment on 17.02.2016.* [Dr J.'s] *report does not alter my view that* [the Complainant] *is fit to return carry out his normal occupation from a psychiatric point of view"*.

Following its assessment of the medical evidence received, I note that the Provider concluded that the Complainant did not meet the policy definition of disablement and that he was fit to return to work.

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As a result, the Provider wrote to the Complainant on **20 April 2016** to advise that it had declined the income protection claim, as follows:

> *"It is our opinion, based on the medical evidence received that you are not currently totally disabled from following your normal occupation as required by the policy and you are fit to return to work. I must advise therefore that we are unable to admit this claim".*

I note that the Provider then received a Report from the Complainant's treating Consultant Psychiatrist Dr J. dated **28 June 2016** asking the Provider to review its claim decision, as follows:

> *"Further to my previous report I wish to update position in regards to* [the Complainant]*. He attended me again on 22nd June 2016. Since I last wrote to you he has engaged in an alcohol recovery programme and I have reasonable ground to believe that he is now sober and motivated to remain so. I indicated that absolute sobriety is required for him to recover. He continues to present with ongoing symptoms of anxiety and depression and these are clearly complicated by his ongoing domestic and financial difficulties. As he is no*[t] *receiving any financial support in regard to his income protection his debts and…other difficulties are mounting. These are now an impediment to recovery. He continues to take antidepressant and mood stabilising medication with benefit. He will remain in ongoing outpatient care in the interim. I would ask you to review the payment decision in the light of the above in that he a) remains symptomatic despite sobriety b) that his recovery is incomplete and c) that he has ongoing mixed anxiety depressive features and likely illness complicated by now increasingly pressing personal issues.*
>
> *I would put it that in order to maximise his opportunity to recover that his income support could be instated it would significantly improve his circumstances and all other things being equal he has agreed a deadline to return to work between September and October 2016 and I will undertake to maximise therapeutic from here to that end. Somebody who previously had to my knowledge no significant period of work absence I think that additional support if it could be agreed would be both humane and therapeutic".*

As part of its appeal review, I note that the Provider arranged for the Complainant to attend for an independent medical examination with Consultant Psychiatrist Dr F. on 9 August 2016, who in his ensuing Report of the same date advised as follows:

> *"**History of illness***
>
> [The Complainant] *has a history of depression since 2010. This was precipitated by the death of a friend …. There was also financial pressures at that time. He was off work for approximately one year after that first episode of depression.*
>
> [The Complainant] *became depressed in September 2015 because of personal problems and financial problems, he told me that his wife sought a separation.*

/Cont'd…

His bank was threatening to repossess his house. He said, "The loss of my marriage and family was the biggest problem". He and his wife have not yet separated but legal processes are going ahead. He is awaiting a free legal aid appointment. His solicitor has managed to stop his home being repossessed but he said, "It's still simmering there in the background".

[The Complainant] *said that when his wife sought separation, "I just found I couldn't cope".*

He told me that his wife said that she would not separate if he got help. This meant him going to hospital and this was the reason her went in to…Hospital for two weeks in March 2016. He said, "I believe they saved my life in there". When asked if he had left earlier than had been medically advised, he strongly denied this. I note that his treating consultant, [Dr J.]*, commented in the medical questionnaire dated 10.03.2016 that* [the Complainant] *did not engage and had left hospital. When asked how he had benefitted from this hospitalisation* [the Complainant are] *replied, "They helped me to I suppose start putting into practice the skills that I thought I had but I suppose I only knew them from an academic perspective…They tried to make me see some positives" …*

[The Complainant] *told me that since that admission to…Hospital he has been coping. He said, "I've been coping…I wasn't coping before I went in".*

He said hospitalisation helped prevent the plan that he had to kill himself. He had thought that his children would be better off without him. He now realises it would have destroyed them…

He told me that his wife is still going ahead with the separation. He feels that it is now inevitable and there is nothing he can do to prevent it.

When directly asked, [the Complainant] *denied having an alcohol problem. He said he has had no alcohol since before the hospitalisation …*

Current symptoms

[The Complainant] *told me that he continues to feel low in mood but nowhere near as bad as he was before he went into hospital. He said that he is anxious about the next court date to do with his separation in September. He did not describe diurnal mood variation. He is not experiencing suicidal ideation and his family are clear protective factors.*

He said his sleep is variable. He said he might sleep like a baby on some nights but on other nights he sleeps too much. He sleeps during the day and then he cannot sleep at night.

Appetite is variable. He said his weight is up and down …

/Cont'd…

He said his energy levels are low and he suffers from "chronic fatigue…Struggle to stay up'. He told me that he has been advised by his treating psychiatrist in the past that he needs to improve his sleep hygiene and correct his sleep pattern.

He told me that he has no motivation to do anything and no interest in doing anything. He blames "cumulative financial stress and emotional stress" for his current situation.

Treatment

[The Complainant] *told me that he attends the HSE psychiatry service of* [Dr J..]*. He attends the outpatient clinic…His last appointment was on 29/06/2016 and his next appointment is on 17/08/2016.*

He told me that he is currently prescribed the antidepressant sertraline 150 mg mane and the antipsychotic agent Quetiapine 50m mg QDS. I assume the latter is for antidepressant augmentation, though he thinks it may be for anxiolysis.

[The Complainant] *told me that he has been seeing a psychologist/counsellor…in the...Child and Family Project on Wednesday afternoons. He has had five sessions to date. This was organised through an addiction counsellor he attended …*

He had seen an addiction counsellor…for a good part of the last year. He said he was attending this counsellor "to please my wife". He said, "This was because my wife told [Dr J.] *that I was not depressed…That I was an alcoholic…She lied to him". In the past month he has changed counsellor…He has seen her twice in the past month. He said he will continue to see her every couple of weeks …*

Work / occupational issues

[The Complainant] *said that he feels unable to work at the moment because of, "A fear of losing it…A fear of not regulating my emotions". He said he worries that he will break down at work and destroy the reputation that he has built up over the last* xx *years as a teacher. He said he is not able to work, "Because I'm not temporarily in control of my feelings" …*

[The Complainant] *has not set any goals towards a return to work. He said that he will return "As soon as I feel confident again…As soon as I feel that I can control my emotions". He told me that he has discussed with this treating consultant,* [Dr J.]*, an aimed return to work in September or Halloween at the latest.*

He said he is "petrified" at the prospect. He again talked about destroying his reputation if he goes bac too quickly. He said, "I've got a good xx *years of teaching left in me" but he immediately added, "I could be burned out" …*

/Cont'd…

History of psychiatric illness

[The Complainant] *had his first episode of depression in 2010. He was off work for about one year at that time. He attended the stress clinic in* [named] *Hospital privately on three occasions at that time. He was treated with antidepressants, initially escitalopram and later sertraline, responding to the latter. He was also treated with the tranquilliser alprazolam. He said that after this episode of depression he remained well until 2015 …*

Montgomery-Åsberg depression rating scale (MADRS)

The Montgomery-Åsberg depression rating scale is a clinician-rated instrument that assesses the range of symptoms that are most frequently observed in patients with major depression. It is completed based on a comprehensive psychiatric interview. It is not a diagnostic instrument but is considered a measure of illness severity.

The MADRS score for [the Complainant]*, based on the psychiatric interview on 09/08/2016, was 14, which is in the range symptoms of mild severity.*

Hamilton Anxiety Rating Scale (HAM-A)

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

The HAM-A score for [the Complainant]*, based on the psychiatric interview on 09/08/2016, was 9, which is in the range symptoms of mild severity.*

Montreal Cognitive Assessment (MOCA) on 09/08/2016

The Montreal Cognitive Assessment (MOCA) is a series of questions and tests that is used to screen for cognitive impairment. A maximum score of 30 is possible. Scores of 26 and higher are usually indicative of normal cognitive function. The MOCA cannot be used alone to make a diagnosis of cognitive or memory impairment. The MOCA result should be interpreted in the light of all available clinical evidence.

The MOCA was administered to [the Complainant] *as part of the psychiatric assessment on 09/08/2016. He scored 26 on the MOCA. He lost four points for recall.*

The result, taken in conjunction with his clinical presentation, is not indicative of any impairment of cognitive function.

SIMS questionnaire

This is a 75-item multiaxial self-administered screening measure, which may help in determining if there is symptom overstatement. It was completed by [the Complainant] *as part of the psychiatric assessment on 09/08/2016.*

/Cont'd…

His total score of 15 was elevated above the recommended cut-off score (14) for the identification of possible symptom overstatement. His scores on three of the five scales within the SIMS were elevated. He endorsed a high frequency of symptoms that are atypical in patients with genuine psychiatric disorders, raising the possibility of symptom overstatement.

On the Affective Disorders scale he endorsed seven of 15 possible symptoms. This rate of endorsement of symptoms that do not generally occur in a constellation, even in an atypical mood or anxiety disorder, is suggestive of symptom overstatement.

On the Amnestic Disorders scale he endorsed four of 15 possible symptoms; endorsement of more than two of these symptoms is suggestive of symptom overstatement. Thus he endorsed symptoms of memory impairment that are inconsistent with patterns of impairment seen in brain dysfunction or injury.

On the Neurologic Impairment scale he endorsed four (cut-off >2) illogical or atypical neurological symptoms that are found rarely in individuals with neurological disorder.

Rey Test

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

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

Mental state examination on 09/08/2016

[The Complainant] *was appropriately dressed. He was overweight. There was palmar erythema. There was tremor of the hands.*

He was often vague in his description of symptoms. He was sometimes discursive in his answers. He had a tendency to speak in generalities rather than specifically about symptoms.

He was at times over-emotional during the assessment. He was solicitous in apologising that he might be inaccurate in dates or timelines.

His mood was depressed subjectively. However, objectively he was unhappy rather than pervasively depressed. Affect was not constricted and there was normal affective reactivity.

He was not credible in his alcohol history. Based on the background documentation. Including documentation from his treating consultant psychiatrist, there is evidence that alcohol is a significant problem.

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I noticed that at the previous [independent medical examination] *with* [Consultant Psychiatrist Dr P.] *he smelled of alcohol. On this occasion there were signs that may be attributable to regular alcohol consumption.*

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

Conclusions / Opinion

In my opinion the diagnosis is an adjustment disorder, the stressor necessary for this disorder being the break-up of [the Complainant's] *marriage. An additional stressor is the financial problems.*

A second diagnosis is alcohol dependence syndrome, which [the Complainant] *minimises and does not acknowledge …*

[The Complainant] *developed psychological symptoms in response to his wife seeking a separation. From his history, it appears that his wife thinks the alcohol abuse/dependence is a significant problem, rather than a mood disorder. He accuses her of lying about this. An additional stressor which may have been implicated in developing mood symptoms is the financial problems, which at the time of onset of symptoms in September 2015 included the possibility that his house may have been repossessed …*

Current symptoms are mild in severity …

There is no evidence that psychiatric symptoms are causing any significant restrictions on [the Complainant's] *ability to carry out normal activities.*
I note his recent achievement of constructing a wind generator and his report that he continues to be a voracious reader, which implies that there are no concentration or attention difficulties …

There is no objective evidence of pathological mood disturbance …

[The Complainant] *has not set any goals towards a return to work His treating consultant has discussed aiming for a return to work in September of this year, but* [the Complainant] *has not committed to this …*

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

There is no evidence that [the Complainant] *is disabled from carrying out normal daily activities outside the workplace. As such he cannot be regarded as being totally disabled.*

/Cont'd…

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

[The Complainant] *should abstain from alcohol and should undertake further addiction counselling. He should also attend a support group for alcoholics …*
Prognosis is guarded because of [the Complainant's] *failure to accept the significant alcohol problem which he has, which is likely to* [have] *significant negative effects on his mood".*

I note that following its assessment of the medical evidence received, the Provider wrote to the Complainant on **31 August 2016** to advise that it was confirming the declinature of his claim.

Shortly thereafter, on **7 September 2016**, the Provider received a further Report from the Complainant's treating Consultant Psychiatrist Dr J. dated **24 August 2016**, which advised, as follows:

"[The Complainant] *was an inpatient in…Hospital in March 2016 …*

I have been seeing [the Complainant] *in outpatient department approximately every 1-2 months since his admission.*

He is engaged with two counsellors and remains on Sertraline 150mg od and Quetiapine 25mg qds. [The Complainant] *is very motivated and has made good progress but remains very anxious, and finds coping with his many psychosocial stressors very difficult.*

At this time it would not be suitable for him to return to work as a secondary school teacher. I would anticipate that he would be unable to return to work for at least this academic year. I would be supportive of his salary protection payment in order to work towards getting his life back on track".

I note that the Provider has advised that having considered its contents, it concluded that this Report did not contain any new information that it was not already aware of from the evidence of Consultant Psychiatrist Dr F.'s Report of 9 August 2016, and that there was no objective evidence presented therein to say why the Complainant might be unfit for work.

Having considered the medical evidence that was available to the Provider at the time, and which I have cited from at length above, including the reports furnished by the Complainant's own treating Consultant Psychiatrist, I am of the opinion that it was reasonable for the Provider to conclude in April 2016, when it declined to admit and pay the claim, and again in August 2016, when it confirmed its position in response to the Complainant's appeal, to continue to decline the claim, that the Complainant did not satisfy the policy definition of disablement at that time.

/Cont'd…

In this regard, the diagnosis and treatment of a medical condition, or being medically certified as unfit for work, is not, in and of itself, sufficient to validate a claim, nor does it automatically equate to work disability. Rather the weight of the objective medical evidence must clearly indicate that a claimant meets the criteria within the policy agreement i.e., in this instance, the policyholder must be

> "*unable to carry out the duties pertaining to his normal occupation by reason of disablement arising from bodily injury sustained or sickness or illness contracted.*"

I note that since the Provider made its decision to decline the claim in **April 2016** and again in **August 2016**, the Complainant has since supplied the Provider and this Office, with more recent medical reports dating from 2017 onwards. I am satisfied however that because these reports came into being after the claim decisions of the Provider had already been made in April 2016 and August 2016, that they could not then, and cannot now, have any bearing on the validity of the decisions made by the Provider at those earlier times.

Whilst I note that 2 years after those claim decisions in 2016, the Provider arranged to make certain benefit payments to the Complainant, on an ex-gratia basis, from September 2018 to September 2020, this is a matter which is entirely separate from the income protection claim decisions, which it had made previously during 2016, and which have given rise to this complaint. As stated above, I am of the opinion that those decisions in 2016 were reasonable for the Provider to make, based on the medical evidence available to it at the time.

Accordingly, in the absence of any evidence of wrongdoing by the Provider during the process of that decision making in 2016, there is no reasonable basis upon which it would be appropriate to uphold this complaint,

Conclusion

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

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

MARYROSE MCGOVERN
DEPUTY FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

7 April 2021

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—

/Cont'd…

(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.