An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0290
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant held a travel insurance policy with the Provider. The policy period in which this complaint falls, is from 13 October 2015 to 12 October 2016.

The Complainant's Case

The Complainant was holidaying abroad when, on **16 June 2016**, she suffered a fracture injury to her left shoulder.

On 30 June 2016, the Complainant contacted the Provider to notify it of her injury and that she was due to undergo emergency surgery on her shoulder at her holiday location on **4 July 2016**.

The Complainant did not undergo this surgery, as the Provider instead arranged for her to fly home on 5 July 2016 so that she could seek treatment in Ireland instead.

The Complainant returned to Ireland on **6 July 2016** and the following day, **7 July 2016**, attended Hospital A., where conservative management of her injury was advised.

The Complainant sought a second opinion and was referred to Consultant Orthopaedic Surgeon Mr Z. at Hospital B. On his advice, the Complainant underwent a left proximal humerus open reduction and internal fixation surgery on **4 August 2016** and later, a left shoulder arthroscopic subacromial decompression surgery on **21 April 2017**.

The Complainant submits that if she had undergone the surgery abroad on 4 July 2016 as first planned, instead of the Provider arranging for her to return to Ireland to seek treatment which resulted in a delay in her undergoing surgery on her left shoulder, that she may have recovered sooner and/or better, from her injury.

In this regard, in an undated letter emailed by the Complainant to this Office on **15 June 2020**, Consultant Orthopaedic Surgeon Mr Z. states as follows:

> *"*[The Complainant] *presented with a left proximal humerus fracture six weeks following injury in* [abroad] *… a surgery was performed on the 4th of August 2016 to try to reconstruct the proximal humerus fracture. The surgery was difficult given the delay from the time of fracture and further surgery to the left shoulder was required in the form of an arthroscopy and subacromial decompression in May 2017. In an ideal circumstance the proximal humerus fracture would have been treated surgically as an emergency case preferably within the first two weeks of presentation. It is very difficult however, to be certain that that would alter the long term outcome in such fractures"*.

In addition, in her email to this Office on **15 June 2020**, the Complainant submits as follows:

> *" … when the orthopaedic surgeon in* [abroad] *saw my x-ray, he ordered CT scan of shoulder and booked me for emergency surgery on his next theatre day. I broke my shoulder 16th June* [2016]*. I thought it was only bruising and would settle. I'm a nurse, I have some knowledge, but mobility didn't improve, and after more than a week I had x-ray which confirmed* [it]*. I went next day to orthopaedic surgeon. I certainly suffered a lot of pain. And I was anxious to have* [it] *treated, as outcome may well have been better in first 2 weeks post* [injury]*, as opposed to surgery* [in Ireland]*, 9 plus weeks later, as bones* [had then] *started to calcify in wrong alignment and poor position.* [The Provider] *coerced the* [doctor] *in* [abroad] *and challenged him. Of course I was fit to fly but a* [fractured] *shoulder requires surgery ASAP,* [it] *is an emergency. People cannot be left to continue trying to live normally, with untreated broken bones.*
>
> *The impression I got from the* [Provider's] *people in* [abroad] *was that their priority was not in* [the] *best interest for the outcome for my shoulder, but to get me off their hands and back to Ireland ASAP and let* [me] *sort* [myself] *out from there, knowing very well treatment would be delayed, as one can't just walk into hospital and have surgery. I mentioned my anxiety over this but got no sympathy. I felt the general attitude appeared to be, that it be less expense for* [the Provider] *if I'm got back to Ireland*".

When the Complainant made her complaint to this Office, she submitted that the impact of her injury was such that she was unable to return to work as a nurse.

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In this regard, in a letter dated 26 September 2018, Orthopaedic Registrar Dr C. at Hospital B. stated:

> *"*[The Complainant] *suffered a left proximal humerus fracture in June 2016 while abroad. She underwent surgery for this in August 2016 and further surgery in April 2017.*
>
> *She unfortunately continues to be affected by this with a reduction in her shoulder movement and occasionally pain. This injury has prevented her from returning to her full activities in work, and she would not be able to return to work in any capacity"*.

In **May 2018**, the Complainant sent a Claim Form to the Provider and in her covering letter dated 9 May 2018 she advised:

> *"I wish to apply for permanent disablement of use of my left arm due to injury sustained as an accident whilst on holiday* [abroad] *June 16th 2016".*

'Permanent Total Disablement' is defined in the Complainant's travel insurance policy as:

> *"Disablement which entirely prevents the Insured Person from attending to business or occupation of any and every kind for at least 12 months and at the end of that time being beyond the hope of improvement"*

The Provider declined the Complainant's claim for permanent total disablement benefit as it concluded from the medical evidence received that her condition had improved post-surgery and that the medical file did not support her contention that she is medically unfit to undertake work of any kind.

The Complainant sets out her complaint in the **Complaint Form** she completed in January 2019, as follows:

> *"I would like to challenge the wording "disablement". I have been prevented from working of any kind … I was an agency staff nurse, so they will not provide light duty work for me, maybe had I been employed by the HSE more empathy might have been shown. As a nurse, I'm required to lift people,* [perform] *CPR, manual duties, which is not possible with a weak arm and limited reaching capacity. I cannot be employed and I'm over 60 yrs. Am 2 yrs 8 months unemployed.*
>
> *As I cannot work as a nurse again, my earnings* [are] *now disability* [benefit]*, a big drop from a staff nurse salary. Financial compensation of some kind would be the right thing to do, and show some sympathy for my situation.* [The Provider's] *policy stated "excellent service and cover", very misleading,* [the Provider] *didn't show much empathy towards my situation".*

The Complainant seeks for the Provider to admit and pay her travel insurance claim for permanent total disablement benefit, in the amount of €40,000.

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The Provider's Case

The Provider says that its records indicate that the Complainant first contacted the Provider on 30 June 2016 to advise of an injury she sustained abroad. The Provider understands that this injury occurred on 16 June 2016. The medical records list the injury date as *"June 2016"* and the attending Orthopaedic Surgeon abroad, Dr P. told the Provider's Agent's registered nurse by telephone on 1 July 2016 that he was unsure as to the actual date of the accident, advising that the fall had happened *"a week or two ago"*. The Provider says that the Complainant stated in the Claim Form she submitted to the Provider in May 2018, that the injury occurred on 16 June 2016.

Following the notification from the Complainant on 30 June 2016, the Provider's Agent arranged for a registered nurse to speak with the treating Orthopaedic Surgeon, Dr P., who by telephone on 1 July 2016 confirmed the presenting medical issue and diagnosis as *"Left 2 part proximal humerus fracture"*. Dr P. advised that the Complainant was at that time being treated as an out-patient and her arm was immobilised in a sling, with surgery planned for 4 July 2016. The nurse enquired about the necessity to have the surgery abroad, or whether the Complainant could safely return home for further treatment/surgery. The Provider says that Dr P. agreed this was an option and he would have no objection to the Complainant returning home for treatment.

The Provider says it advised the Complainant on 1 July 2016 that surgery did not need to be carried out abroad and that any surgery deemed necessary in situ, would need to be authorised in advance, in accordance with the terms and conditions of her travel insurance policy.

In this regard, the Provider notes that the '**What to do in the Event of an Emergency'** section of the travel insurance policy document provides at pg. 4:

> *"To comply with the terms and conditions of this insurance You must obtain the prior consent of* [the Provider's] *Assistance Agency Ireland before incurring any expenses over €500 or curtailing Your trip due to Your bodily injury or illness"*.

In addition, the Provider says that Section 2, '**Medical and Other Expenses incurred abroad'**, of this policy document provides at pg. 7:

> *"In the event of Your Bodily Injury or Illness, We reserve the right to relocate You from one hospital to another and to arrange for Your repatriation to Ireland at any time during the Trip. We will do this if in the opinion of the medical practitioner in attendance or* [the Provider's] *Emergency Assistance Agency Ireland You can be moved safely and/or travel safely to Ireland to continue treatment"*.

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The Provider says it telephoned the Complainant on **4 July 2016** to advise of its proposed arrangements for her return journey to Ireland. This proposal involved an upgrade to business class, with an extra seat on her affected side, on a more direct flight on the evening of 5 July 2016, with a stopover of 1 hour 15 minutes before a transfer thereafter to Dublin, arriving on the morning of 6 July 2016. In addition, wheelchair and luggage assistance would be arranged and a taxi on arrival in Dublin would bring her to her home. The Complainant confirmed her satisfaction with this arrangement.

The Provider notes that a second doctor at the treating facility abroad assessed the Complainant on 4 July 2016 and completed a Fit to Fly Certificate confirming she was fit to travel on 4 July 2016, without a medical escort. The Provider says that the Complainant departed her holiday location on 5 July 2016 and arrived in Ireland on 6 July 2016.

The Provider notes from the medical file that the Complainant attended Hospital A. the following day, 7 July 2016, where she was advised regarding conservative management of the injury.

The Provider notes that the Complainant sought a second opinion as to conservative versus operative management of her injury and was referred for review to Consultant Orthopaedic Surgeon, Mr Z. at Hospital B. She was first reviewed at Mr Z.'s clinic on 13 July 2016 and an impacted fracture of the left humerus and anatomical neck was noted, as was the fact that she had been treated conservatively in a sling. An x-ray showed a healing fracture. The Complainant was started on pendular exercises and was to be seen in two weeks for a repeat x-ray. The Complainant met with Mr Z. on 27 July 2016, who admitted her to Hospital B. on 3 August 2016 and she underwent a left proximal humerus open reduction and internal fixation on 4 August 2016.

The Provider notes that the Complainant attended Mr Z.'s clinic on 11 January 2017 and on review it was noted she had undergone a proximal humerus fracture open reduction and internal fixation in August 2016 for which she still complained of some impingement, and she was listed for left subacromial decompression. The Complainant was later admitted to Hospital B. on 21 April 2017 and underwent a left shoulder arthroscopic subacromial decompression surgery. The Provider says that this was an elective admission and that the recommendation on discharge, was for a collar and cuff for comfort and exercises as per physiotherapy recommendations.

In response to the Complainant's comments that if she had undergone the surgery abroad on 4 July 2016 she may have recovered sooner and/or better from her injury, the Provider says that these comments are purely speculative and there is no medical evidence confirming that the surgery should have taken place earlier, or that the time elapsed between the injury and surgery has had any impact on her recovery.

The Provider notes that the Complainant was not hospitalised abroad and was initially managed conservatively. At the time of her injury, she had an x-ray and was diagnosed with a hairline fracture and told she would need surgery, but this surgery was not carried out on an immediate emergency basis.

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The Provider says that on her return to Ireland, the Complainant immediately sought medical review, and neither of the treating physicians at Hospital A. on 7 July 2016 nor at Hospital B. on 13 July 2016 initiated emergency surgery. The Provider says it is evident from the medical reports received that while surgery was eventually required, it was not urgent, and that none of the treating physicians either abroad, or in Ireland, believed it was necessary to carry out surgery in the immediate aftermath of the injury sustained on 16 June 2016. Rather the surgery was carried out seven weeks later on 4 August 2016.

The Provider says that in arranging for the Complainant to return to Ireland, it was guided at all stages by the medical advice, and that the treating Orthopaedic Surgeon abroad, Dr P. was supportive of the alternative of having treatment following return to Ireland. A second doctor at the treating facility abroad also assessed the Complainant on 4 July 2016, following which he issued her with a Fitness to Fly Certificate. In addition, on return to Ireland, neither the Complainant's treating physicians in Hospital A. or Hospital B. identified a need for urgent surgery.

In his undated letter that the Complainant emailed to the Financial Services and Pensions Ombudsman on **15 June 2020**, the Provider notes that Consultant Orthopaedic Surgeon, Mr Z. offers the opinion that in an ideal circumstance, the Complainant's proximal humerus fracture would have been treated surgically as an emergency case, preferably within the first two weeks of presentation, though he qualified this opinion by adding, *"It is very difficult however, to be certain that that would alter the long term outcome in such fractures".* The Provider therefore says that this 'hindsight' review by Mr Z. is inconclusive, in that while it appears to confirm a preference for early treatment (a preference the Provider notes was not supported by Mr Z.'s own forward scheduling of treatment at the time), it also confirms that there is no way of knowing if early treatment impacts the long-term outcome of such fractures.

In any event, the Provider says the fact that the surgery scheduled abroad for 4 July 2016 was not within the first two weeks of the Complainant sustaining her injury on 16 June 2016, meant that the 'ideal' timeframe now outlined by Mr Z. had already elapsed before the Complainant first contacted the Provider on 30 June 2016.

In response to the Complainant's assertion that the Provider's priority was *"to get me off their hands and back to Ireland ASAP"*, the Provider says that its efforts to return the Complainant home were made in absolute good faith, with the intention throughout, being that her travel home should be made as safe and comfortable as possible.

In response to the Complainant's assertion that her *"shoulder requires surgery ASAP,* [it] *is an emergency"*, the Provider once again points to the fact that upon arrival in Ireland, the medical opinion sought did not determine an urgent need for surgery. Indeed, when surgery was carried out, it was not on an emergency basis but rather 3 weeks after consultation. In response to the Complainant's assertion that *"one can't just walk into hospital and have surgery"*, the Provider says that where a situation is deemed an emergency, surgery can and often is carried out immediately. The Provider says that clearly it is quite evident in this case that the treating physicians both abroad and in Ireland, did not identify any immediate emergency need for surgery.

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In response to the Complainant's allegation of coercion by the Provider of the Complainant's treating Orthopaedic Surgeon abroad, Dr P., the Provider says it would never seek to coerce any party to alter its position and it strenuously refutes any such suggestion. The Provider says it had no reason to doubt the basis of the medical opinion provided by Dr P., who no doubt was willing to carry out the surgical procedure on 4 July 2016 but also supported the Complainant's return home for treatment, which the Provider says clearly indicates that he did not deem the surgery to be urgent or medically necessary, at the time of travel.

In addition, the Provider says it is ever mindful of the fact that its policyholders posit their trust in its ability to assist them competently when needed. The Provider says that there are no circumstances where it would insist on or influence any course of action which might be contrary to the best medical interests of any policyholder. The Provider submits that it routinely supports overseas treatment and procedures for thousands of policyholders each year, where treatment is deemed medically necessary.

The Provider says that in all cases it is guided by the medical evidence and in this case, it is satisfied that it was presented with no case for necessary treatment at travel, and no evidence that it would have been the best course of action, following the Complainant's return.

The Complainant submitted a Claim Form to the Provider on **11 May 2018**, seeking to claim Permanent Total Disablement benefit under her policy.

Following its assessment, the Provider wrote to the Complainant on **23 May 2018** to advise that it was declining her claim, as follows:

> *"We wish to draw your attention to page 5 of your policy wording and the definition of Permanent Total Disablement:*
>
> ***Permanent Total Disablement: Disablement which entirely prevents the Insured Person from attending to business or occupation of any and every kind for at least 12 months and at the end of that time being beyond the hope of improvement.***
>
> *You will note from the above this benefit is applicable to a person who is unable to attend to business or occupation of any kind and that after 12 months there is no hope of an improvement. We note from your claim submission that you have regained some of your range of motion in your shoulder but it is considerably restricted from what it was previously to your accident. We further note it is your intention to retrain to do an easier type of work in the future"*.

The Provider subsequently advised the Complainant in its letter of **3 August 2018** that in order for it to further review the claim, it would require the following:

> *"Full computerised medical records from the date your injury was sustained on 16.06.2016 up to date inclusive of hospital consultation records/reports.*

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Confirmation from your consultant as to the disablement that you have sustained, please have them confirm the following:

- *Confirmation of permanent total disablement – please have them provide details of the permanent disablement and how they deem you to now have a permanent total disablement*
- *Clarification that you are medically unfit to recommence in any work in any capacity*
- *Confirmation of what is preventing her from attending in any work in any capacity*
- *Confirmation that they cannot see you returning to any work in any capacity"*.

The Provider says it was furnished with a handwritten letter from an Orthopaedic Registrar at Hospital B. dated 26 September 2018, and subsequently received the full file of hospital records on 3 December 2018.

The Provider says that although the letter from the Orthopaedic Registrar dated 26 September 2018 references the Complainant's inability to work, it provides no supporting medical evidence whatsoever to support the sudden and surprising change in prognosis indicated in the letter, which the Provider says, is at odds with the contents of all medical reports over the two-year period from the injury in June 2016 to July 2018.

For example, the Provider notes that the Consultant Report dated 22 November 2017 indicates that at review on 15 November 2017 the Complainant was doing very well, had a very good range of motion of the left shoulder and that the pain was tolerable and she was not taking any pain relief. In addition, the Consultant Report dated 18 July 2018 indicates that at review on 11 July 2018 the Complainant was doing well, had a reasonable range of movement and her pain had improved.

The Provider says that the letter from the Orthopaedic Registrar dated 26 September 2018 is also at odds with the Complainant's own submissions. In this regard, the Provider notes from her complaint papers that in her letter dated 28 November 2016 addressed to the 'Deciding Officer', the Complainant mentions a requirement to retrain to do an easier type of work in the future, which she suggests will not be easy at her age, and she references another medical condition which makes it difficult to drive the distance to work.

The Provider notes a handwritten comment was added to this letter that said, *"I cannot do the same work anymore".* In addition, in her handwritten letter to the Provider dated 9 May 2018 (in which she enclosed the Claim Form) the Complainant wrote *"Cannot do hospital nursing ever again"*. The Provider notes through further documentation submitted by the Complainant, that she herself has accepted that she could return to work in another field or for lighter duties, but is reluctant to do so because of her age and the complications of another underlying medical condition.

In its Final Response letter dated **24 January 2019**, the Provider advised the Complainant that its Medical Panel reviewed her medical records and the Medical Panel confirmed that, given the documented evidence of the improvement of the Complainant's injury post-surgery, the injury did not meet the policy definition of permanent total disablement.

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The Provider acknowledges that the Complainant's ability to work as a nurse was temporarily limited, and it acknowledges that she may not ever return to nursing in the same capacity as before. However, for the Complainant to qualify for the permanent total disablement benefit, the Provider says it must be medically evident that as a result of her injury she will never return to work in any capacity. Whilst the Provider accepts that the Complainant suffered a significant injury, the overall view of the medical evidence provided does not support her contention that she is medically unfit to undertake work of any kind.

The Provider understands and accepts that as a result of her injury, the Complainant may not be able to return to nursing in the same capacity as before and that she may experience long-term effects from her injury, and it sympathises sincerely with this. However, the benefit available under the travel insurance policy is not payable for permanent injury. Rather it is payable for permanent total disablement, which has a clear definition set out in the policy document. The Provider is satisfied that it is evident from an overall view of all the medical evidence received and the Complainant's own submissions that her circumstances do not meet the policy definition of permanent total disablement.

The Permanent Total Disablement benefit is payable when the policyholder is not able to take up work of any kind, solely due to the injury sustained. The Provider does not believe that the Complainant has demonstrated by way of medical evidence that she is medically unfit to do work of any kind. The Provider had requested computerised medical reports to support the Complainant's assertions, which were not forthcoming, but the Provider remains open to reviewing them and further clinical evidence supporting a deterioration and new prognosis should these become available.

The Provider says that a medical prognosis which declares a person permanently unable to undertake work of any kind is significant. It is the Provider's experience that in such circumstances there is usually an abundance of medical evidence to support such a prognosis, including assessment and consistent clinical reports documenting either no improvement or no hope of improvement or a clear deterioration in the condition, in which case x-rays and other documentation is generally available. If her Consultant has reached that prognosis, the Provider invites the Complainant to arrange for the supporting medical evidence to be submitted for its review.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly declined the Complainant's travel insurance claim for permanent total disablement benefit.

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Decision

During the investigation of this complaint by this Office, the Provider was requested to supply its written response to the complaint and to supply all relevant documents and information. The Provider responded in writing to the complaint and supplied a number of items in evidence. The Complainant was given the opportunity to see the Provider's response and the evidence supplied by the Provider. A full exchange of documentation and evidence took place between the parties.

In arriving at my Legally Binding Decision I have carefully considered the evidence and submissions put forward by the parties to the complaint. Having reviewed and considered the submissions made by the parties to this complaint, I am satisfied that the submissions and evidence furnished did not disclose a conflict of fact such as would require the holding of an Oral Hearing to resolve any such conflict. I am also satisfied that the submissions and evidence furnished were sufficient to enable a Legally Binding Decision to be made in this complaint without the necessity for holding an Oral Hearing.

A Preliminary Decision was issued to the parties on **29 July 2021**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Complainant held a travel insurance policy with the Provider. Whilst holidaying abroad, she suffered a fracture injury to her left shoulder on **16 June 2016**.

The Complainant contacted the Provider on **30 June 2016** to notify it of her injury and to advise that she was due to undergo emergency surgery on her shoulder in her holiday location, on **4 July 2016**. The Complainant did not undergo this surgery, as the Provider instead arranged for her to fly back to Ireland on **5 July 2016** so that she could seek treatment in Ireland instead.

The Complainant arrived home on 6 July 2016 and attended Hospital A. on 7 July 2016, where conservative management of her injury was advised. The Complainant sought a second opinion and was referred to Consultant Orthopaedic Surgeon Mr Z. at Hospital B., on whose advice, the Complainant underwent a left proximal humerus open reduction and internal fixation surgery on **4 August 2016** and later, a left shoulder arthroscopic subacromial decompression surgery on **21 April 2017**. I note that the Complainant submits that if she had undergone the surgery abroad on 4 July 2016 as first planned, instead of the Provider arranging for her to return to Ireland to seek treatment (which resulted in a delay in her undergoing surgery on her left shoulder) she may have recovered sooner and/or better from her injury. In addition, the Complainant also says that the impact of her injury is such that she is unable to return to work as a nurse and in May 2018, she submitted a claim to the Provider for Permanent Total Disablement benefit.

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I note that following its assessment, the Provider declined the claim as it concluded from the medical evidence received that the Complainant's condition had improved post-surgery and the medical file did not support her contention that she is medically unfit to undertake work of any kind.

The role of this Office is to examine the totality of the medical evidence which was before the Provider at the relevant time, to determine whether the decisions made by the Provider

- In July 2016, to arrange for the Complainant to return to Ireland to seek treatment,
- in May 2018, to decline the Complainant's travel insurance claim for Permanent Total Disablement benefit,
- in January 2019, to stand over this outcome,

were reasonable decisions based upon the medical evidence that was available to the Provider at those times when it made those decisions now complained of by the Complainant. This is in accordance with the views of the High Court in *Baskaran v. FSPO* [2016/149MCA], where the Court confirmed that:

> *"The function of the* [Financial Services and Pensions Ombudsman] *in considering the…complaint was, in general terms, to assess whether or not* [the Provider] *acted reasonably, properly and lawfully in declining the claim of the Appellant"*.

I note that following the notification from the Complainant on 30 June 2016, the Provider's Agent's registered nurse spoke with the Orthopaedic Surgeon abroad, Dr P. by telephone on **1 July 2016**. I note from the documentary evidence before me that the nurse's ensuing medical report provides as follows:

> *"I explained to* [Dr P.] *that* [the Complainant] *has travel insurance in place for emergency treatment only, and asked whether she could return to* [Ireland] *for further management/surgery.* [Dr P.] *agreed that this was an option and that he would have no objection to* [the Complainant] *returning to* [Ireland].
>
> *Based on the information obtained during the telephone call* [the Complainant] *should be able to return on her original flight which I believe is 3/7/16/ She will require an extra seat on the affected side (left) to ensure that her arm is protected from accidental bumps or knocks, and that she has extra space for comfort. She will benefit from wheelchair assistance to facilitate her journey through the airports.*
>
> [The Complainant] *should be advised to follow-up with her GP/fracture clinic as soon as she returns home".*

In those circumstances, I am of the opinion that it was reasonable for the Provider to conclude that if the Orthopaedic Surgeon abroad, Dr P. had deemed the surgery that had been scheduled for 4 July 2016 to have been a necessary emergency surgery, that he would not then have advised that he had no objection to the Complainant returning to Ireland, instead of undergoing the surgery abroad.

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I also note from the documentary evidence that a second doctor at the treating facility assessed the Complainant on **4 July 2016** and this other doctor completed a Fit to Fly Certificate confirming she was fit to travel on that date without a medical escort.

I am of the opinion that it was reasonable therefore, for the Provider to conclude that the surgery that had been scheduled for 4 July 2016 was not immediately necessary and that it was medically safe for the Complainant to fly home to Ireland to seek treatment for her injury there.

Section 2, '**Medical and Other Expenses incurred abroad**', of the applicable travel insurance policy document provides at pg. 7:

> *"In the event of Your Bodily Injury or Illness, We reserve the right to relocate You from one hospital to another and to arrange for Your repatriation to Ireland at any time during the Trip. We will do this if in the opinion of the medical practitioner in attendance or* [the Provider's] *Emergency Assistance Agency Ireland You can be moved safely and/or travel safely to Ireland to continue treatment"*.

I am therefore of the opinion that in arranging for the Complainant to fly home on 5 July 2016 (rather than undergoing surgery on 4 July 2016), that the Provider was acting on the advice of the Complainant's treating physicians abroad and it was also acting in accordance with the terms and conditions of her travel insurance policy.

I note that in **May 2018**, the Complainant submitted a Claim Form to the Provider seeking to claim Permanent Total Disablement benefit, which the policy schedule lists as **€40,000**.

The Complainant's travel insurance policy, like all insurance policies, does not provide cover for every eventuality. Rather the cover wiill be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

I note that Section 5, '**Personal Accident'**, at pg. 8 of the applicable travel insurance policy document provides that:

> *"If you suffer accidental bodily injury during the Trip, which within 12 months is the sole and direct cause of death or disablement, We will pay You or Your legal personal representatives the amount shown on Your schedule of Cover due to:*
>
> 1. *Death*
>
> *OR*
>
> 2. *Loss of one or More limbs, or total irrecoverable Loss of Sight in one or both eyes*
>
> *OR*
>
> 3. *Permanent Total Disablement".*

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The '**Definitions**' section of this policy document defines 'Permanent Total Disablement' at pg. 5, as follows:

> *"**Permanent Total Disablement:** Disablement which entirely prevents the Insured Person from attending to business or occupation of any and every kind for at least 12 months and at the end of that time being beyond the hope of improvement"*.

This policy definition makes it clear that in order for her to be eligible for Permanent Total Disablement benefit, it must be medically evident that the Complainant is not able to take up work of <u>any</u> and <u>every</u> kind, solely due to the injury sustained to her left shoulder and there must be no hope of improvement.

Having reviewed in full the documentation before me, I am of the opinion that it was reasonable for the Provider to conclude that the medical evidence before it did not support the Complainant's contention that she is medically unfit to undertake work of <u>any</u> and <u>every</u> kind.

In a letter dated 26 September 2018, Orthopaedic Registrar Dr C. at Hospital B. states:

> *"*[The Complainant] *suffered a left proximal humerus fracture in June 2016 while abroad. She underwent surgery for this in August 2016 and further surgery in April 2017.*
>
> *She unfortunately continues to be affected by this with a reduction in her shoulder movement and occasionally pain. This injury has prevented her from returning to her full activities in work, and she would not be able to return to work in any capacity"*.

I note there was no medical evidence referenced in or submitted with this letter, to support the statement that the Complainant would not be able to return to work in any capacity.

In this regard, I accept the Provider's position that a medical prognosis which declares a person to be permanently unable to undertake work of any and every kind, is significant. I also accept that in such circumstances there is typically an abundance of medical evidence to support such a prognosis, including assessment and clinical reports and test results documenting either no improvement or no hope of improvement, or a marked deterioration in the condition.

I note that the Provider has advised that if the Complainant's Consultant has reached the prognosis that she is permanently unable to take up work of any and every kind solely due to the injury sustained to her left shoulder, that the Complainant can arrange for the supporting medical evidence to be submitted to the Provider for its review. I consider this to be a reasonable approach for the Provider to adopt in this matter. That said, I note from her telephone call to this Office on **1 April 2020**, that the Complainant advised that she was at that time back working part-time, during the coronavirus pandemic. She has since advised thia Office that she does not recall phoning this Office at that time; she advised that she did "*volunteer reading to kids in hospital . Before the pandemic*".

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Irrespective of the Complainant's employment status in April 2020, I am satisfied for the reasons outlined above, that the Provider was entitled to conclude that the Complainant did not meet the policy criteria for payment of permanent total disablement benefit, when it made that decision in May 2018.

I am also satisfied that in January 2019, when the Provider reviewed the Complainant's grievances and stood over its position, that on the basis of the information which had been made available at that time, it was reasonable for the Provider to continue to maintain that position.

Accordingly, I take the view on the evidence made available to this Office that there is no reasonable basis upon which this complaint can 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.

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

27 August 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—

(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.