Decision Ref:	2021-0296
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Disagreement regarding Medical evidence submitted Failure to provide product/service information Failure to process instructions Rejection of claim - fit to return to work
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The Complaint concerns a claim under a Group Income Protection Policy with the Provider. The policy was arranged by the Complainant's employer. The Complainant is an insured person under this group policy.

The Complainant had made a claim under the policy for disability benefit. The Provider admitted the claim for the period **May 2016** to **31 December 2016**, but considered that the Complainant was fit for work thereafter.

The Complaint is that the Provider has wrongly and/or unfairly ceased paying the Complainant's income protection claim since **31 December 2016**.

The Complainant's Case

The Complainant submits that on **20 September 2014** he underwent an MRI for a back injury which confirmed that he had significant disc degeneration and disc protrusion. The Complainant submits that in **March 2015** he injured his neck. The Complainant submits that due to his injuries he suffered from pain radiating into his back, scapula and neck regions.

The Complainant submits that on **30 October 2015** he took sick leave from his employment due to his injuries and he states that he was informed by his employer to claim illness benefit from the Department of Employment Affairs and Social Protection. The Complainant submits that he was unaware at the time that his employer held a group income protection policy with the Provider and that this information was not disclosed to him by his employer until **07 April 2016,** which ultimately delayed him making the claim.

The Complainant submits that in **May 2016** he furnished his employer with a completed claim form in relation to his back and neck pain and his employer forwarded the completed claim form to the Provider on **18 July 2016**, which was seven weeks after he had submitted it and nine months after he had first taken sick leave from his employment.

The Complainant states that while he was on certified sick leave his symptoms worsened and he subsequently developed a psychological condition which in addition to his physical symptoms prevented him from returning to work. The Complainant states that since he went on sick leave on **30 October 2015,** both conditions (physical and psychological) have been confirmed by his general practitioner (GP) as well as his employer's occupational health assessor.

The Complainant submits that the Provider admitted the claim up to **31 December 2016**, at which time, it ceased payments on the claim.

In a letter dated **08 November 2016**, the Provider informed the Broker to the Income Protection Scheme that, based on the supporting medical evidence, it was admitting the claim effective from **05 May 2016**, which represented the end of the deferred period under the policy, until **31 December 2016**. The Provider submits within this correspondence that it was basing its claim decision on the medical report of the independent medical examiner who had assessed the Complainant and concluded that the Complainant was fit to return to work on an initial phased basis from **01 December 2016** for a period of four weeks, with a return to full time employment on **31 December 2016**. The Provider stated within the letter dated **08 November 2016** that it was happy to admit the claim until **31 December 2016**, to allow the Complainant sufficient time to arrange a return to work process with his employer.

The Complainant rejects the Provider's position that he has been fit to return to work and disagrees with the findings of the orthopaedic surgeon that was appointed by the Provider to assess him as part of its claim assessment process. The Complainant states that he attended the Provider's orthopaedic surgeon on **17 October 2016** and prior to that date, the Provider was furnished with his medical records from both his general practitioner and his employer's independent health assessors. The Complainant states that the conditions for which he was be assessed, included both his back and neck condition and his mental health condition.

The Complainant contends that the medical findings from the assessment on **17 October 2016** are flawed and that the medical examiner's report contains incorrect information. The Complainant contends that the medical examiner incorrectly noted during the assessment that his back symptoms had largely settled. The Complainant submits that the

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medical examiner had also exaggerated his physical activities on the report. The Complainant contends that the medical examiner also claimed that his work is sedentary which he rejects and states that his duties of employment require him to attend events nationwide. The Complainant states that his medical symptoms are severe rather than mild as he submits was described by the medical examiner.

The Complainant states that on **20 April 2017** his GP appealed the Provider's decision to discontinue the payment of the claim.

The Complainant submits that the Provider arranged for him to attend a medical assessment with a consultant psychiatrist on **11 July 2017**, the conclusion of which ultimately deemed that he was fit to return to work. The Complainant states that the psychiatrist's report contained many inconsistencies and that it did not accurately reflect the information that he has provided on the day of the assessment, including and not limited to the extent of his back and neck pain. The Complainant has questioned the independence of the medical examiners appointed by the Provider in their assessment of his conditions.

The Complainant contends that neither of the medical examiners, which were appointed by the Provider, had jointly assessed his physical and psychological conditions, and that they did not consider how the combination of these medical conditions affected his ability to perform the duties of his normal occupation.

The Complainant submits that he has obtained medical certificates from both his general practitioner and from his employer's health assessor confirming that he continues to be medically unfit to return to work.

The Complainant submits that as a result of his medical conditions he was not in a position to make a complaint or appeal the Provider's decision to discontinue the claim at the time, and that the Provider has informed him that it is not now accepting new evidence at this time.

The Complainant wants the Provider to reinstate the claim and continue to make payments to him for his physical and mental health conditions under the policy.

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

The Provider states that the Income Protection policy is designed to provide financial support to employees when they are medically disabled from working. The Provider says as the Insurer, this decision rests with it. The Provider submits that on review, it is satisfied it met its obligations under the terms of the policy, as it says it paid the claim from **05 May 2016** to **31 December 2016** following two independent medical examinations.

The Provider states that it is a general misconception that the diagnosis of a medical condition automatically equates to prolonged work disability. The Provider however says,

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more often than not this is not the case. The Provider states that it is widely recognised in the medical community that occupational functioning has many therapeutic benefits and is a positive contributor to a person's overall health and wellbeing.

The Provider submits that there was a delay in receiving the claim forms for the Complainant's claim as they were not received until 9 months after his first date of absence. The Provider, however says, it notes the Complainant's comment regarding the delay in receiving information on the process and in receiving the Income Protection claim forms. The Provider states that all claims should be submitted around week 13/14 of absence from work in order to allow the Provider to fully assess the validity of the claim before the 26 week deferred period ends. The Provider, however says, it agreed to assess the claim and following his attendance at a medical assessment, the Complainant was deemed fit to return to work and the Provider paid his claim for a period of time.

The Provider states that it received a letter from the Complainant's GP to appeal and subsequently arranged a second medical appointment for the Complainant to attend. The Provider's position is that following this assessment it was happy to stand over its original decision on the claim.

The Provider states that the Complainant submitted his complaint to this office approximately two years following the decision on his appeal. The Provider says this makes it very difficult to retrospectively review the claim. The Provider states that when issuing the Final Response Letter to the Complainant it advised that it could not consider any new evidence submitted at this point as its decision had been made on this claim with the medical evidence it had on file at the time, and the claim file was closed.

The Provider notes that in his submission the Complainant makes reference to how the doctors who carried out the Medical Examinations were not independent as the Provider arranged them and paid for their service. The Provider's response is that in accordance with the policy conditions:

> "We [the Provider] reserve *the right to use any appropriate and legal means to investigate the claim. We will arrange any such independent examinations with any physician chosen by us as may be reasonably required to assess our liability under the claim and cover the cost of the independent examination.*"

The Provider states as both Mr N and Dr M are practicing doctors for many years and have vast experience with working in both the HSE and private practice, and carrying out medicals for the insurance industry, it has no concerns with their independence and states that, to question their professional integrity is unwarranted.

The Provider notes that the Complainant mentions that he felt parts of the Doctor's reports were inaccurate. The Provider says following both assessments it did not receive any correspondence from either the Complainant or his GP with regard any inconsistencies. The Provider states that the Complainant's GP submitted an appeal letter to the Provider dated **20 April 2017** and he made no reference to any inconsistencies in Mr N's report from the **17 October 2016**.

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The Provider states that following Dr M's examination on **11 July 2017**, this report was also sent to the Complainant's GP and it received no correspondence from either the Complainant or his GP advising the Provider of any inconsistencies in Dr M's report.

The Provider submits that the comment from the Complainant in his complaint to this office is the first the Provider was made aware of any possible errors/mistakes, therefore it says it was not given the chance to clarify any concerns. The Provider states that both Consultants would have made their opinion on the Complainant's fitness for work based on their assessment of his condition on the day of the examination, and on the medical evidence which they would have received prior to the appointment. The Provider, therefore says, even if there were a few factual errors these would not change the overall outcome of the assessment.

The Provider states it believes it has met its obligations under the terms of the policy by paying the claim for a period of time. The Provider says the Complainant was assessed by two Medical Consultants who both deemed him fit to return to work. The Complainant attended Mr N who described his symptoms as mild and was of the opinion that the Complainant was fit to return to work in November 2016 on a phased basis and then on a full time basis in January 2017. The Provider states it paid the claim in full up to **31 December 2016** to allow the Complainant return to work on the phased basis recommended. The Provider says when the appeal was submitted the Complainant's GP, felt *"at this point it is his ongoing anxiety depression disorder that is making him unfit".*

The Provider says although it was apparent at the initial time of the claim that it was more the physical issues which was causing the Complainant to be absent from work, the Provider did carry out a review of his mental health issue so that it was able to get an opinion on this. The Provider's position is that in order to assess the severity of these mental health symptoms it arranged a medical examination with Dr M, Consultant Psychiatrist. The Provider says Dr M was of the opinion that the Complainant was fit to return to work from a psychiatric perspective. Having assessed the claim from a physical and psychiatric perspective the Complainant had been deemed fit to return to work and the Provider's decision on the claim remained unchanged.

The Provider submits that the Complainant also made reference to reviews with his company doctor and GP. The Provider's response is that while it respects their opinion, it is up to the Provider to make a determination on the validity of claims and it can only do so on the medical information it has.

The Provider says that from the medical information it had on file, there was no objective medical information to prove that the Complainant was unable to return to work. The Provider states that it is now nearly 3 years after the decision on the appeal was issued on the claim and it notes no further correspondence was made to the Provider until it received the letter on the **10 March 2020** from this office. The Provider also notes that as far as it is aware the Complainant did not make any attempt to return to work even though in the assessment with Dr M it was noted that his own doctor had been encouraging him to return to work.

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Evidence

09 February 2016 – Employer's Occupational Health Physician

> *"[The Complainant] reports that he suffers from 2 separate medical conditions which have resulted in his withdrawal from work in November 2015. …*
>
> *[The Complainant] reports that he has developed a second separate medical condition over the last 3 months. He reports that the genesis of this condition is related to personal stressors and is unrelated to work. He has sought appropriate treatment via his GP in this regard. [The Complainant] reports that there has been some gradual improvement in his symptoms. Examination today is consistent with the history given with evidence of active medical difficulties. …*
>
> *In my opinion [the Complainant] is currently unfit to return to work. This is likely to remain the case for at least 6 weeks. He has ongoing medical difficulties which are not sufficiently stable at the present time for working life. I have advised him to discuss treatment options available to him with his GP. I suggest Occupational Health review in 6 weeks to review his progress and fitness to work. At this time I will also explore if any workplace accommodations are required to facilitate a successful return to work".*

29 March 2016 – Employer's Occupational Health Physician

> *"As you are aware his current workplace absence has been in relation to two separate medical conditions. He continues to avail of appropriate treatment on both fronts with gradual improvement. His GP has suggested specialist input in relation to one of his conditions. At present however his residual medical difficulties continue to impact negatively upon his wellbeing and functional capacity. This was evident on assessment.*
>
> *In my opinion [the Complainant] is currently unfit for work. His medical difficulties are not sufficiently stable at the present time to render a regular, reliable and efficient service in the workplace. 1 have encouraged [the Complainant] to continue to engage with his current treatment plan. I cannot currently provide a definitive date for a return to work but I am happy to review his progress perhaps in 6-8 weeks and provide an updated opinion then on his fitness for work".*

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11 May 2016 – Employer's Occupational Health Physician

> *"He reports a recent deterioration in medical symptoms in relation to one of his medical concerns. He has availed of further care in this regard with specialist input pending in the coming weeks. Symptoms in relation to his other medical condition persist with no significant improvement since last assessment. Clinical evaluation was suggestive of ongoing and active difficulties on both fronts.*
>
> *In my opinion, [the Complainant] is currently unfit for work. His medical difficulties are not sufficiently stable at present to render a regular, reliable and efficient service in work. While he is availing of appropriate care in relation to one issue, I believe that he may benefit from additional medical input for the other and have advised him in this regard. I suggest occupational review in 6-8 weeks to provide an updated opinion on his fitness for work, by which time he will have availed of specialist review and hopefully further support as advised".*

08 July 2016 – Employer's Occupational Health Physician

> *"Since last occupational assessment he reports 'slight' overall improvement in his medical difficulties. In relation to one of his medical conditions, he tells me that he did not avail of specialist treatment as he had previously planned. Instead he opted to avail of treatment from an alternative health practitioner to which he reports some initial response. He reports some improvement in the symptoms of his other medical condition with non-medical support.*
>
> *[The Complainant] reports that his residual symptoms continue to impact negatively upon his wellbeing and functional capacity and that he is not engaging in the normal activities of daily living.*
>
> *Clinical evaluation was indicative of little interval improvement.*
>
> *In my opinion [the Complainant] is currently unfit for work. His medical conditions are not yet sufficiently stable to render a regular, reliable, and efficient service in the workplace. During the consultation I advised him on additional avenues of medical care that I felt appropriate in his recovery. Subsequent to my assessment. I liaised directly with his GP who has confirmed that [the Complainant] has re-attended him in this regard and that adjustment to his treatment has been made. In addition he has availed of specialist opinion with further input planned.*
>
> *His GP concurs with my opinion that he remains unfit for work at present. Given the nature of [the Complainant's] difficulties, the duration of absence and the rate of recovery to date and bearing in mind recent and pending adjustments to treatment, I anticipate that he is likely to remain unfit for*

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work for at least the next 2 months. I suggest occupational health review thereafter to provide an updated opinion on fitness for work matters".

01 September 2016 – Private Medical Attendance Report from the Complainant's GP to the Provider in respect of the Complainant's claim

In this Report, the Complainant's GP noted the reason for absence from work as being:

"right sided neck/shoulder/upper back pain/spasm. Grief reaction [Loss of family member] . Stress/anxiety."

17 October 2016 – Mr N - The Provider's appointed Consultant Orthopaedic Surgeon

"Clinical Examination: 17/10/2016

*"… He is not overtly depressed or anxious but obviously was sad and emotional when discussing his **[Loss of family member]**. This certainly has impacted him psychologically but he is adamant that this is not the main reason why he has not returned back to work as he is improving from this point of view and is on medication. …..*

[T]o summarise this man had ongoing neck and scapular symptoms typically myofascial in nature which are slowly improving with time. I believe his disability is improved enough that he now should finish off his physiotherapy course and return back to work at the end of November 2016 in a part time capacity initially and a full time capacity in January 2017. Accommodation to his working environment with a stand up desk would be appropriate if available to help him from a soft tissue symptom point of view while working at a computer".

20 April 2017 – The Complainant's GP

"At this point it is primarily his on-going anxiety/depression disorder that is making him unfit for work and if his progress remains slow 1 will refer him to .. Mental Services for specialist review and opinion".

06 June 2017 - Mr N - The Provider's appointed Consultant Orthopaedic Surgeon

"Certainly from my perspective this man has certainly ongoing genuine residual soft tissue symptoms in his neck and shoulder area. I felt these physical symptoms in isolation were certainly not enough to prevent him from returning back to his work place in a graduated fashion as per my report. Certainly his GP feels his psychological anxiety depression symptoms are a barrier to work and I obviously can't comment on this but certainly his GP letter would not change my mind from his physical point of view where I feel

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his physical symptoms in terms of neck pain would prevent this man from returning back to his job as a student enrolment officer".

8 June 2017 – the Complainant's GP

"At this point in my opinion it is primarily his ongoing anxiety / depression disorder that is making him unfit for work, and if his progress remains slow I will refer him to … Mental Services for specialist review and opinion".

08 July 2017 - Dr L – The Complainant's Consultant in Anaesthesia and Pain Medicine

"He has engaged in every form of rehab possible in an attempt to return to normal levels of activity and unfortunately hasn't had complete resolution of his symptoms.

On examination, he has significant facet joint tenderness over C.2/3 and C.4/5 with some mixed facet and paraspinal muscle tenderness down as far as T.4/5. He has a good range of movement but against resistance he has pain in the right scapular region and around the axilla around the level of C.4. Examination is consistent with significant muscle spasm as well as possibly some upper cervical facet joint degeneration.

..

I have discussed these issues with [the Complainant] and I have suggested that we initially start with some facet joint and trigger point injections".

11 July 2017 - Dr M – The Provider's appointed Consultant Psychiatrist

"Claims Assessor's Questions:

1. ***Does [the Complainant] currently have a psychiatric diagnosis?***
   He has a diagnosis of anxiety.
2. ***What is the current mental state?***
   His mental state is described above. There is no major abnormality.
3. ***Please outline the nature and severity of the current symptoms.***
   The nature and severity of his symptoms are mainly physical symptoms. He has no major psychiatric symptoms, apart from some anxiety.
4. ***How does [the Complainant] typically spend his day?***
   His current daily routine shows that his activities are unrestricted.
5. **What restrictions/limitations are there on his normal daily activities?**
   See number 4.
6. **What treatment is he actively engaged in?**
   He is on appropriate antidepressant medication and counselling.

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7. **What is [the Complainant's] prognosis?**
   The prognosis is good. He is making slow and steady progress.
8. **What goals has [the Complainant] set himself regarding a return to work?**
   He is keen to return to work but has no specific date in mind.
9. ***What does [the Complainant] cite as the main reasons preventing him from returning to work?***
   See above.
10. **In your opinion, is [the Complainant] currently fit to carry out his normal occupation?**

It is my opinion that he is currently fit to carry out his normal occupation, he has no debilitating psychiatric symptoms".

The Complaint for Adjudication

The Complaint is that the Provider has wrongly and/or unfairly ceased paying the Complainant's income protection claim since **31 December 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 **12 August 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.

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On **12 August 2021** the Provider acknowledged receipt of the Preliminary Decision. In the absence of additional submissions from the parties, within the period permitted, my final determination is set out below.

The policy defines disability as:

> *"The member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury; upon occurrence of which the benefit under the policy becomes payable, after the deferred period. The member must not be engaged in any other occupation."*

The Complainant completed an Income Protection claim form received by the Provider on **19 July 2016**. The Provider also received a form from the Complainant's GP on **01 September 2016**. The Complainant's employer listed his first date of absence as **30 October 2015**.

Both the Complainant and his employer noted that the reason for the Complainant's absence was due to neck and back pain.

The Provider received the completed form from the Complainant's GP, on the **01 September 2016**. In this form, the Complainant's GP noted the reason for absence as being: *"right sided neck/shoulder/upper back pain/spasm. Grief reaction* ***[Loss of family member]*** *Stress/anxiety."*

The GP felt that the Complainant had a good prognosis and that he would have gradual resolution with time, and he expected the duration of absence to be that of just 3-6 months.

The GP included some additional reports with his form, including one from Dr L (Consultant in Anaesthesia and Pain Medicine) and 3 MRI reports.

The Provider states that the 2 MRI reports from 2015 were unremarkable apart from some moderate narrowing on the right in the cervical spine MRI from **05 March 2015**.

The Provider notes the MRI report from **20 September 2014** shows a central posterior annular tear at L5/S1 and a shallow disc protrusion but no nerve root compression.

The Provider notes that Dr L, in his report dated **08 July 2016** states:

> *"suggested we initially start with some facet joint and trigger point injections... Follow on with graded exercise and advice regarding Pilates."*

The Provider states that in order to assess the claim and to consider whether the Complainant satisfied the definition of disability, it arranged for a medical examination with Mr N, a Consultant Orthopaedic Surgeon, on **17 October 2016**.

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The Provider says it received a copy of Mr N's report on **02 November 2016**. During the course of the report, Mr N states:

> *"I would describe his symptoms as mild. There are associated with an anxiety depressive element that are obviously associated with the* ***[Loss of family member]*** *which impacted significantly psychologically on him for a period of time. He is adamant though that this has improved and that his current inability to return back to work is more related to his physical symptoms rather than any psychological issues at this stage."*
>
> *"Overall he feels his symptoms are slowly improving and he has now set up a work-station at home and works at a computer but finds it sore to sit and stands often. His back symptoms have largely settled over the last six months."*
>
> *"He had attended the pain specialist and there was some consideration for facet joint injections into his cervical spine and he has a tentative date to consider these in November but he is uncertain whether he should go down this road as his overall symptoms are slowly improving with conservative treatment of physiotherapy."*
>
> *"I would describe his disability as mild and I do feel he is at the stage where he now should consider a return back to the workforce. I feel he should continue off his course of physiotherapy and I believe he should be fit to return back to work by the end of November 2016. Certainly in light of his clinical assessment today I don't believe facet joint or trigger point injections are required and that his physiotherapy management has been successful in overall improving his symptoms slowly that he should be fit to return back to work at the end of November 2016."*
>
> Finally Mr N states:
>
> *"Therefore to summarise this man had ongoing neck and scapular symptoms typically myofascial in nature which are slowly improving with time. I believe his disability is improved enough that he now should finish off his physiotherapy course and return back to work at the end of November 2016 in a part time capacity initially and a full time capacity in January 2017."*

The Provider says that it was of the opinion that the Complainant was fit to return to his normal occupation as he no longer satisfied the definition of disablement and accordingly the Provider says it was unable to accept a claim.

The Provider made a once-off payment on the claim for the period from **05 May 2016** to **31 December 2016**. The Provider states that this payment was to facilitate the phased return to work that had been recommended by Mr. N, and to enable both the Complainant and his employer to make the necessary return to work arrangements.

The Provider communicated its decision on **08 November 2016** to the broker to forward to the employer.

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The Provider received a letter from the Complainant's GP on **26 April 2017** to appeal the Provider's claim decision. In his letter the Complainant's GP noted:

> *"it is primarily his ongoing anxiety/depression disorder that is making him unfit for work.".*
>
> He also stated
>
> *"He is fearful that returning to work too soon will exacerbate his pain and set him back".*

The Provider states it also notes at this point there had been no attempt made by the Complainant to return to work.

The Provider submits that, on the original employee claim form which the Complainant completed, he did not mention anxiety/depression as being a reason for his absence, and he also advised Mr N during the medical examination on **17 October 2016** that this had improved and that his current inability to return back to work was more related to his physical symptoms rather than any psychological issues at that stage.

The Provider states nevertheless, it reviewed the claim as part of the appeal, and as part of that review, it arranged a second medical examination, this time with Dr M, Consultant Psychiatrist on **11 July 2017**. The Provider submits that this was arranged in order to assess the Complainant's claim, this time, from a mental health perspective.

The Provider notes that during the course of his report, Dr M noted that:

> *"His **[Loss of family member]** died suddenly on … . He had a phone call from work to inform him*
> *of the death and he has not returned to work since. He said when **[Loss of family member]** died everything crashed. A few weeks after **[Loss of family member]** he was commenced on antidepressant medication by his GP. When **[Loss of family member]** he got a lot of pain, particularly in his neck and his chest and he had difficulty sleeping. He had trouble standing and sitting for any length of time. He said he is doing the physiotherapy exercise, which they told him would make him better but he was not getting better, therefore becoming stressed."*
>
> *"He has trouble sitting and standing for any length of time. He has difficulty turning his head to the right. He said the fact that he cannot do these things due to pain makes him feel stressed and his heart races and he has breathing difficulties. He has head, shoulder and neck pain. He feels it is both the stress and the back injury that are keeping him out of work."*
>
> *"Every month he thinks he will get back to work. His doctor is encouraging him to get back but he does not feel that he is ready yet."*

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> *"His speech was normal in rate, tone and volume. He answered briefly and to the point. There were no excessive hesitations or qualifications. His attention, concentration and memory were good. Computerised assessment of his memory found that his delayed recall was normal, his paired associate test was slightly slow."*
>
> *"He has a diagnosis of anxiety."... "There is no major abnormality."... "The nature and severity of his symptoms are mainly physical symptoms. He has no major psychiatric symptoms, apart from some anxiety." ... "His current daily routine shows that his activities are unrestricted." ...*
>
> *"He is on appropriate antidepressant medication and counselling." ... "The prognosis is good. He is making slow and steady progress."*

Finally Dr M states:

> *"It is my opinion that he is currently fit to carry out his normal occupation, he has no debilitating psychiatric symptoms."*

It is the Provider's position that it carried out a thorough review of the claim, but says it remained its opinion that the Complainant did not satisfy the definition of disability and was fit to return to work.

The Provider submits that it communicated the decision on the appeal to the broker to forward to the employer on **02 August 2017**. The Provider advised that should the Complainant remain unsatisfied with the outcome, he retained the statutory right to refer the matter to this office.

The Provider says it subsequently received correspondence from this office on **10 March 2020** and reviewed the claim again in full. The Provider then issued a Final Response Letter to the Complainant on **03 April 2020**.

On **04 August 2020** the Complainant furnished a response to the Provider's submission highlighting the following:

- *The four Occupational Health reports dated 09-02-2016, 20-03-2016, 11-05-2016 and 08-07-2016 which [the Provider] reviewed indicated [he] was suffering from two separate medical conditions and [he] was medically unfit for work. The six other Occupational Health reports also state [he is] unfit to return to work due to two separate medical conditions.*
- *[Dr L] suggested an option of injections into [his] neck and back. [His] GP was hesitant on this approach as it carries risks and potential side effects and so referred [hm] for Physiotherapy. [He is] also attending … Mental Health Centre.*

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- *[His] GP is managing [his] conditions and it is up to [his] GP and Occupational Health to assess [his] fitness to return to work. Both [his] GP and Occupational Health have stated [he is] unfit for work.*

The Complainant stated that he remained in employment with his employer.

As regards whether the Complainant made any attempt to return to work since the appeal decision was issued in August 2017, the Complainant stated he had not and commented:

> *"My GP and Occupational Health advised I set up a work station at home which I have attempted but I have difficulty sitting or standing for long periods of time and suffer from pain in my back, neck and right shoulder which makes it impossible to work on the computer for any length of time. I suffer from anxiety and depression which make it impossible to focus and I get migraines. I get tired a lot and I have to lie down frequently to rest.*
>
> *My GP and Occupational Health have stated that my medical conditions have not stabilised and I am not medically fit to attempt a return to work".*

In relation to how the Complainant has been supporting himself financially, the Complainant stated he was on disability payment from the Department of Employment Affairs and Social Protection and also received support through the Housing Assistance Payment scheme. The Complainant stated that he was not working or receiving any other income.

<u>Analysis</u>

The Complainant has questioned the independence of the Provider's appointed doctors. My role is to consider the conduct of the Provider. I cannot comment on the conduct, expertise or opinion of a medical professional. If the Complainant has an issue with a medical professional that is matter more appropriate to the Medical Council.

From the evidence submitted it can be seen that the Complainant's medical conditions have been extensively investigated by the Complainant's own treating doctors and the Provider appointed doctors.

I accept that the Complainant and his employer only highlighted his physical medical condition in their respective claim forms, submitted to the Provider. However, it is noted that the Complainant's GP had highlighted both of the Complainant's medical conditions (physical and Psychiatric) in the Private Medical Attendant's Report that he furnished to the Provider in support of the Complainant's claim. The supporting documentation furnished to the Provider (which included four reports from the employer's Occupation Health physician) also clearly highlighted both medical conditions as preventing the Complainant from engaging in employment.

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I also note the Provider's own appointed medical specialist Mr. N, a Consultant Orthopaedic Surgeon, clearly referred to both of the Complainant's medical conditions in his report of **02 November 2016**.

I accept that the Provider should reasonably have had the Complainant's ability for employment initially assessed both in respect of his physical medical condition, and psychiatric medical condition, before it gave its claim decision in November 2016.

It is was only when the Complainant appealed the Provider's decision of November 2016 that the Provider had the Complainant assessed in respect of his psychiatric medical condition.

I note that when the Provider communicated its initial claim decision to the broker of the Income Protection Scheme, in November 2016, it did not set out any appeal process that could be followed. The evidence shows that it was not until **28 March 2017** that the Complainant was informed of an appeal process. It appears that the Complainant was not fully aware at this point that the Provider had only agreed to pay benefit up to January 2017.

While I accept that there were other parties involved in the claim communication process, that is, the Complainant's employer and the Broker to the Income Protection Scheme. I would have expected the Provider to ensure that the Complainant was fully informed of the outcome of the Provider's claim decision and any appeal mechanism.

I have reviewed the medical reports submitted by both parties, and I have examined the terms of the insurance policy governing the Complainant's claim for disability benefit.

A number of the medical reports submitted pointed to the Complainant's inability to return to work while others refer to his ability to return to work in a full time capacity. One of the appointed specialists suggested a phased return to work. There was also an opinion of the benefits to the Complainant of a return to work.

Under an Income Protection Policy, the definition of disablement must be satisfied in order to be eligible for payment. It is standard practice for Income Protection Insurers to seek verification of disablement at claim stage and at appeal stage.

I acknowledge that the evidence indicates that the Complainant has medical conditions that could impact on his ability to work. However, based on the weight of the medical evidence presented to the Provider it was reasonably for it to come to the conclusion that the Complainant's health had improved to the extent that he was able to undertake the duties of his normal occupation, and he therefore no longer met the definition of disablement as required by the policy. That said, I accept that it was only when the Provider had assessed both of the Complainant's physical and psychiatric medical conditions that it could have reasonably come to that conclusion. It was not until the Complainant had appealed the Provider's initial claim decision that he was medically assessed in respect of his psychiatric medical condition. The medical report from the

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Provider's appointed Consultant Psychiatrist is dated **11 July 2017**. In this report the appointed specialist concludes:

> *"It is my opinion that he is **currently** fit to carry out his normal occupation, he has no debilitating psychiatric symptoms."* (My emphasis)

I accept that it is only from the date of this medical report that the Provider could reasonably conclude from a psychiatric perspective that the Complainant was *currently fit to carry out his normal occupation.* The appointed specialist did not give an opinion as to the Complainant's ability to work over the period May 2016 up to July 2017, but that it was his opinion that the Complainant was ***currently*** fit for work. Therefore, as I believe the Provider, unreasonably, did not assess all of the Complainant's medical conditions when it should have had, I accept that a compensatory payment is merited.

I accept that the Complainant's or his employer's failure to not appeal the Provider's claim decision of July 2017, until **March 2020** has prejudiced the Provider's ability to re-assess the claim from that period. Unlike the November 2016 claim decision, I accept that the Complainant and his employer were fully aware of their ability to appeal the July 2017 claim decision but did not until **March 2020**.

Having regard to all of the above, I partially uphold this complaint, and I direct the Provider to pay the Complainant the compensation of €3,000 (three thousand euro) in respect of the failings outlined above.

Conclusion

- My Decision pursuant to ***Section 60(1)*** of the ***Financial Services and Pensions Ombudsman Act 2017***, is that this complaint is partially upheld, on the grounds prescribed in ***Section 60(2)(b) -*** *the conduct complained of was unreasonable*.

- Pursuant to ***Section 60(4) and Section 60 (6)*** of the ***Financial Services and Pensions Ombudsman Act 2017,*** I direct the Respondent Provider to make a compensatory payment to the Complainant in the sum of €3,000, to an account of the Complainant's choosing, within a period of 35 days of the nomination of account details by the Complainant to the Provider. I also direct that interest is to be paid by the Provider on the said compensatory payment, at the rate referred to in ***Section 22*** of the ***Courts Act 1981***, if the amount is not paid to the said account, within that period.

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

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

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GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

03 September 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.