Decision Ref: 2021-0334

Sector: Insurance

Product / Service: Income Protection and Permanent Health

Conduct(s) complained of: Rejection of claim - did not meet policy definition of disability
Rejection of claim - fit to return to work

Outcome: Partially upheld

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

This complaint relates to an occupational Income Protection Scheme.

The Complainant's Case

The Complainant states that he had been in receipt of benefit under an occupational illness Income Protection Scheme held with the Provider or its predecessor in title since August 2011.

The Complainant stated that he was attending a psychiatrist from 2016 and at a date unknown to him the Provider contacted his psychiatrist to ascertain the Complainant's then current health status. The Complainant submits that in August 2018, the Provider received a letter from his psychiatrist who offered the opinion that the Complainant was fit to return to work. The Complainant submits that his GP has not had sight of this letter.

The Complainant states that following this, the Provider arranged a medical appointment that he had to attend with a doctor on the Provider's panel of independent doctors. The Complainant submits as a result of this and his psychiatrist's letter, the Provider informed him in March 2019 that his income protection payments were being cancelled. The Complainant states that he unsuccessfully appealed this decision.

The Complainant submits that he was a vulnerable person and that the Provider took these actions and reached this decision without providing him with a copy of the letter from his psychiatrist. He further submits that as a result of not having access to this letter, he was denied fair procedures and was not afforded a fair and reasonable or balanced consideration in the appeal.

The Complainant states that as a result of the conduct of the Provider, his complaint is grounded on two issues. The first issue relates to a sensitive medical report about him that was sent to the Provider without the Complainant having the right to comment on it or seek amendments to it. The Complainant contends that following a heated debate between the author of the report and himself, the report was written with “mischief as its intent".

The second issue of the complaint relates to the assessment and subsequent reliance upon the report of the independent medical doctor which the Complainant asserts did not take into consideration any other report or medical advice available had the request been made.

The Complainant contends that the decision to withdraw his income protection payments was financially motivated as opposed to based on a full consideration of his underlying mental health issues. The Complainant states that the Provider's independent medical findings are in contrast to the fact that the Complainant remains eligible for the State Invalidity Pension.

The complaint is that the Provider has wrongfully decided to cease payments to the Complainant under the Income Protection Scheme and that the appeal process was unfair.

The Complainant wants the Provider to restore his occupational income protection payments

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

The Provider states that the payments to the Complainant ceased because he no longer met the eligibility criteria in accordance with the group scheme policy terms and conditions. The Provider states that the medical evidence did not support the continued acceptance of the claim because it states that the medical evidence confirms that the Complainant was medically fit to return to work.

The Provider states that claims are considered on the basis of medical evidence received and meeting the "Period of Disability" policy definition for a valid claim. The Provider states that all income protection claims in payment are subject to review and are not guaranteed to be paid indefinitely.

The Provider states that all claims that are reviewed consider up-to-date professional medical evidence to ensure continued validation against the " Period of Disability " policy definition.

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The Provider asserts that the Complainant's claim was reviewed in May 2018 and he completed a Claim Continuation Form. The Provider states that on this form, the Complainant provided details of his Consultant Psychiatrist with whom he had recently attended and had scheduled a further appointment in the upcoming November. The Provider states that the form contained a signed declaration by the Complainant providing his consent to the Provider to seek medical information from any doctor or other medical professional who had at any time attended him and permitting such doctors or medical professionals to furnish such information as the Provider may require.

The Provider requested a report from the Consultant Psychiatrist whom the Complainant had identified on the Claim Continuation Form and states that the report was received in August 2018. The Provider states that in completing its review of the Complainant's claim, it relied on the report received from the Complainant's Consultant Psychiatrist along with an independent medical report completed by another Consultant Psychiatrist on 11 October 2018.

In relation to the Complainant's appeal, the Provider asserts that the Complainant requested a copy of the report furnished by his Consultant Psychiatrist and the Provider indicated to the Complainant that he should contact his Consultant directly in relation to this because the Provider did not have the Consultant's express authority to release the report to the Complainant's GP. The Provider asserts that a report from a claimant's own GP or consultant is usually the first action taken upon a claim review and that the Complainant was always free to contact his consultant or GP to obtain any report, consult with them and obtain further reports if any amendment to the professional medical opinion and records already provided was necessary.

The Provider explains that in considering the Complainant's appeal, it procured a further medical report from another Consultant Psychiatrist and also received a report and enclosures from the Complainant's GP. The Provider states that its medical assessment review and the subsequent appeal took into consideration all of the available medical evidence.

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.

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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 6 July 2021, outlining my preliminary determination 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 issue of my Preliminary Decision, the Provider made a submission under cover of its letter to this Office dated 26 July 2021, a copy of which was transmitted to the Complainant for his consideration.

The Complainant has not made any further submission.

Having considered the Provider's additional submission and all submissions and evidence furnished by both parties to this Office, I set out below my final determination.

A copy of the applicable Group Scheme Policy has been provided. It is signed and dated 23 May 1996. In the Second Schedule, Policy Conditions, the term "Period of Disability" is defined as follows:

> Period of Disability means a period throughout which a Member is totally unable by reason of sickness or accident to follow employment.

Clause 3 of the Second Schedule states as follows:

> <u>Entitlement to Disability Benefit</u>
>
> Entitlement to Disability Benefit will commence on the expiry of the Deferred Period and will continue until the earliest to occur of
>
> *(a)* the termination of the Period of Disability
> *(b)* the death of the Member
> *(c)* the Expiry Date in respect of the Member
> *(d)* the date on which the Member ceases to be in the Employer's service
>
> There will be no entitlement to Disability Benefits in respect of any period during which the Member engages in a remunerative occupation.

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Clause 9 of the Second Schedule of the policy deals with the payment of the benefit and the claims procedure. Amongst other things, this clause provides the following wording:

> The liability of [the Provider] will at all times be subject to production by the Member and/or Employer of such reasonable information and evidence satisfactory to [the Provider] as [the Provider] at its absolute discretion may require. This will include, as often as [the Provider] may require,
>
> *(a)* the Member travelling to and being examined by a Medical Officer appointed by [the Provider], so as to provide evidence that the Period of Disability continues
>
> …

Accordingly, the terms establish the entitlement of the Provider to assess ongoing disability benefits from time to time in order to establish requisite medical evidence to permit the period of disability (within the meaning of the terms and conditions of the policy) to continue.

The Complainant's eligibility was established in 2011 and the "period of disability" continued from 2011 until the decision to cease the payments, the subject matter of this dispute.

The Provider wrote to the Complainant by letter dated 24 May 2018 to inform him that his claim was currently being reviewed and the Provider requested that the Complainant complete and return the enclosed Claim Continuation Form and upon receipt of the completed Form the Provider would review the claim further.

A copy of the completed Claim Continuation Form which is signed by the Complainant and dated 28 May 2018 has been provided. Amongst other things, the form identifies the conditions that the Complainant states that he was suffering from along with detailed symptomology, medical treatment being administered to the Complainant and medical appointments attended by the Complainant. The Complainant also identified the name and address of the consultant psychiatrist who had recently assessed him.

The claim continuation for also contains the following declaration:

> [The Provider] may seek medical information from any doctor or other medical professional who has at any time attended me concerning anything which affects my physical or mental health, and I permitted such doctor/medical professional to furnish such information as [the Provider] may require.

Following this, the Provider sought the opinion of the consultant psychiatrist identified in the Complainant's Claim Continuation Form. This consultant wrote to the Provider by letter dated 3 August 2018. Amongst other things, the letter sets out a brief history of the Complainant's condition, diagnosis and treatment. It notes that this consultant took over the Complainant's care in June 2016 and that the Complainant was reviewed in July 2017 by a non-consultant hospital Doctor who reported the Complainant's mood was normal.

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This result was repeated in a further review in December 2017. The letter goes on to note that his most recent review was in May 2018 when the Complainant was reviewed by a psychiatric registrar who reported the Complainant's mood as normal. It adds that the Complainant's next review is planned for November 2018 when it is likely "if he remains well that he will be discharged from service". The letter concludes "however, following my review of the files and the fact that his mood has remained normal over 12 months, I do not see any reason as to why he cannot resume work".

The Provider also sought a psychiatric report from a consultant psychiatrist on its panel of independent experts. This report is dated 11 October 2018 and again it goes through the Complainant's past history.

The report ultimately concludes as follows:

> "The observations of his community mental health team is (sic) that there should be no impediment for him to return to work and I would agree with this. In fact, activation would likely be beneficial albeit it would have to be done in a graded supported way because of the length of time that he has been out of work.
>
> He may or may not choose to return to work but at this point he is certainly fit to return to work".

The documents furnished to this office in evidence include further communication from the Provider's Chief Medical Officer dated 14 March 2019 which observes that the Provider is in possession of two reports which confirmed the Complainant is fit to work and not disabled by psychiatric illness. The correspondence goes on to state that the claim should be ceased and terminated at this point.

Following the decision to terminate the Complainant's benefits, the Complainant exercised his right to appeal and as part of that appeal he furnished the Provider with an opinion from his GP dated 25 March 2019 which expressly states "I do not think he is fit to work with a view to his mental health". The GP observes that the consultant psychiatrist that the Complainant was due to attend in November 2018 and had previously assessed the Complainant in May 2018 had only met the Complainant on that one occasion in May 2018.

In addition, a copy of a letter from a senior clinical psychologist in the primary care psychologist service dated 25 March 2019 was furnished and that letter outlines in detail, the necessity for the Complainant to be referred to the adult mental health service for a review. The letter outlines ongoing mental health issues that the Complainant was suffering from but did not express an opinion on his ability to return to work.

The Provider then sought an additional opinion from a consultant in general adult psychiatry. This consultant furnished a report dated 1 May 2019. The report expressly states that "the purpose of this report is to assist with determination of disablement from working".

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The report also expressly identifies the sources of information for the report including the following:

- Psychiatric interview with the Complainant.

- Psychiatric report by a Consultant Psychiatrist dated 25 October 2012 and 11 October 2018.

- A letter to the Provider from a Consultant Psychiatrist dated 21 February 2012.

- A letter to the Provider from a Consultant Psychiatrist dated 2 March 2012, 10 February 2014 and 24 September 2014.

- A letter to the Provider from the Complainant's Consultant Psychiatrist dated 3 August 2018 (as referred to above).

- A letter to the Provider from the Complainant's GP dated 25 March 2019 and,

- The letter from the Senior Clinical Psychologist dated 25 March 2019.

The report is lengthy and detailed. It is clear that it does take into consideration other reports or medical advice available. It concludes, amongst other things, that the Complainant has a history of depression and that any psychiatric symptoms present are mild in severity and are not causing significant restrictions to the Complainant's ability to carry out normal activities. The report states that there was "no objective evidence of the pathological depression or anxiety".

In relation to his fitness for work, the report states, amongst other things, that the Complainant was:

> "… not suffering from a disabling psychiatric illness at this time. He has recovered, having had appropriate treatment. There is no objective evidence of disabling psychiatric symptoms that would prevent 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 Chief Medical Officer of the Provider recommended that the appeal be declined in light of the conclusions of the psychiatric medical reports. Accordingly, the Provider upheld its decision to terminate the Complainant's claim.

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Having considered very carefully all of the evidence in this case and all of the submissions, I accept that the Provider was entitled, under the terms and conditions of the Policy, to follow the determination of medical reports received which, in the vast majority, expressed the view that the Complainant was able to return to work and consequently was not “totally unable by reason of sickness or accident to follow employment”. Therefore, it was reasonable and in compliance with the terms of the policy for the Provider, both at the first instance stage and the appeal stage, to terminate the Period of Disability and decline the claim.

The Complainant has asserted that one of the consultant’s reports was written with "mischief as its intent" following a heated debate between the consultant and the Complainant. Such an allegation is not a matter that can be investigated by this office.

The Complainant further submits that because he was a vulnerable person, the Provider should have provided him with a copy of the letter of 3 August 2018 from his consultant psychiatrist. On 20 March 2019, the Complainant sought a copy of this report.

On 26 March 2019, the Provider wrote to the Complainant stating "I am afraid we do not have automatic authority from your consultant to release her report to your GP therefore I would suggest that you request it directly from [the Consultant] instead, as this will be quicker".

The Consumer Protection Code 2012 provides as follows:

GENERAL REQUIREMENTS

3.1 *Where a* ***regulated entity*** *has identified that a* ***personal consumer*** *is a* ***vulnerable consumer,*** the ***regulated entity*** must ensure that the ***vulnerable consumer*** *is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the* ***regulated entity.***

A ‘vulnerable person’ is defined in the 2012 Code as follows:

"vulnerable consumer" *means a natural person who:*

a) *has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or*

b) *has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties).*

From the evidence available to me, I am not aware of the Complainant informing the Provider that he was a vulnerable consumer. Nor do I note any reason why the Provider

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would have come to the conclusion that he was a vulnerable consumer within the definition above.

In my Preliminary Decision I had stated that the Provider in its response to this office states that it indicated to the Complainant that he should contact his own consultant directly as the Provider did not have the consultant's express authority to release the report to his GP. I accept from the foregoing correspondence that this is broadly what occurred. However, as the correspondence of 26 March 2019 indicates, it was also open for the Provider to seek authority from the consultant to release a report. It was merely suggested to the Complainant that it would be quicker if he did it himself. However, in circumstances where the Provider was relying on this report to cease payment of benefit under the policy, it would have been reasonable for the Provider to furnish the Complainant with reasonable arrangements and/or assistance to facilitate him in procuring this report as part of the appeal process.

The Provider has, as part of its post Preliminary Decision submission, reiterated that the Complainant's Consultant Psychiatrist "*provided* [it] *with a report in her capacity as* [the Complainant's] *treating specialist*" and that the report "*was written on the understanding it is from doctor to doctor for the attention of* [the Provider's] *Chief medical Officer. It would not be appropriate for* [it] *to release a copy of the* [Consultant Psychiatrist's] *report to her patient without prior consent. The content may cause unintentional harm and should only be released with the approval or directly from the attending doctor*". The Provider also restates as part of its post Preliminary Decision submission that the Complainant could "*request the report from* [the Consultant Psychiatrist] *Directly, and if* [the Consultant Psychiatrist], *as the treating specialist feels it is appropriate, the report can then be released".*

It is then detailed by the Provider that the "*mechanism and normal process is for the medical reports relied upon to be sent to the Claimant's general practitioner where the report is better interpreted by a medical professional to ensure it is appropriate to release to the claimant. This has been our practice for many years to ensure the safe release of medical reports to our claimants and has been supported by the Data Protection Commissioners office also".*

It is further detailed by the Provider that as "*the specific report in question dated 3rd August 2018 was from the Complainant's own consultant. In such a case it would be quite usual for such a report to be obtained by a claimant from their own consultant or from their consultant via their own GP as such reports are, as a rule, also usually sent by the Consultant to the GP that made the referral in the first place. This is medical Community custom and practice however and not for* [the Provider] *as an Insurer. Therefore, it would be usual for the claimant's own medical reports, either from their GP or Consultant, to be with the claimant already or to be obtained directly by them*".

The Provider's submission continues, and it details that in consideration of the above practice its' "*direction to the Complainant to request the report dated 3rd August 2018 from the claimant's own medical consultant as this may be 'quicker' was the correct and most*

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practical solution and in line with the practise for obtaining medical reports in a more appropriate manner".

It further notes that "*were it to be our obligation to provide such a report we would have to obtain permission from a consultant to release such a report and in our experience, this takes time and is usually obtained much quicker by the claimant going directly to their own consultant or GP, in line with medical practices"*.

The Provider has, as part of its post Preliminary Decision submission, detailed that it has "*no record of the Complainant raising an issue that he was having difficulty getting the medical report from his own consultant"* the Provider states that *"If this matter was brought to our attention we could and would have taken the opportunity to write to his Consultant, however a consultant may also be within their rights not to allow a sharing of such a report in that manner".* The Provider further states that in its view "*the crux, therefore, of the matter here would appear to relate to the content of the complainant's consultant report dated 3rd August 2018 rather than access to this report. It is also noted that there has been no formal detailed rebuttal of the consultant report dated 3rd August 2018 in any of the subsequent medical reports received. The Complainant, therefore, in our view, and based upon the information provided was allowed to consider all the medical information relied upon for this claim and fair procedures occurred. Whether that report was provided by us, their consultant or GP directly should not be a factual basis for a Partially upheld decision where the facts are unclear".*

While I note the submissions of the Provider, regarding what it submits is the "*normal process"* and its reasoning for not either sharing the report or requesting permissions to share the report with the Complainant, I not satisfied with the Provider's rational. Basic fairness and fair producers required that the Complainant should have had access to the material, relating to his medical condition, which the Provider was using to arrive at its decision.

The decision to end payments under the Income Protection Scheme to the Complainant is a very serious matter. While I have detailed above that the Provider was entitled, under the terms and conditions of the Policy to terminate the Period of Disability and decline the claim on the basis of the medical evidence furnished to it. Where the Provider had sought the opinion of the Complainant's Consultant Psychiatrist and then used such opinion in making a very serious determination to terminate the period of disability, I find it would have been reasonable of the Provider to then seek permission of the Consultant Psychiatrist to share this report that formed part of its decision.

While I note that the Provider has submitted it has "*no record of the Complainant raising an issue that he was having difficulty getting the medical report from his own consultant"* and that had this matter been brought to its attention *"[it] could and would have taken the opportunity to write to his Consultant, however a consultant may also be within their rights not to allow a sharing of such a report in that manner".* While the Complainant has not indicated if he has faced difficulty in obtaining the report directly from the Consultant

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Psychiatrist, I do not believe that this means the Provider acted reasonably. The Complainant had made a request to the Provider to supply the report.

In the circumstances where the Provider was relying on the report in part, and approached the Consultant for the report, it would have been, in my view, reasonable for it to seek the required permission to share the report which related to the Complainant with the Complainant.

It remains my view that the conduct of the Provider in not arranging for the Complainant to have access to a report, about him, on which it was relying in order to arrive at a decision to refuse his claim was unreasonable.

Fair procedures would require that it would allow the Complainant to consider and comment on all of the information considered and relied on by the Provider, in arriving at its decision.

For that reason, I partially uphold this complaint.

That said, I do not believe it was unreasonable for the Provider to arrive at the decision it did in relation to the Complainant's claim, given the totality of information and reports available to it.

For the reasons outlined in this Decision, I partially uphold this complaint and direct the Provider to pay a sum of €500 in compensation to the Complainant.

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)*** for its unreasonable conduct.

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 €500, 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.***

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

GER DEERING
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

28 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.