An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0522
Sector:	Insurance
Product / Service:	Payment Protection
Conduct(s) complained of:	Claim handling delays or issues Rejection of claim - fit to return to work
Outcome:	Partially upheld

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

Background

The complaint relates to the maladministration and discontinuance of payment on a claim and subsequent appeal under an Income Protection Plan.

The Complainant's Case

The Complainant states that the Provider was appointed by her employer to offer and administer a work based illness income protection plan. The Complainant states she was claiming from the plan, and that her claim was stopped without fair cause. The Complainant says that this is so, given that she was deemed unfit by her GP, but the Provider's appointed doctor disagreed. The Complainant states that she had not been told that there was any time frame on her claim, and submits that she had previously declined a redundancy offer received from her employer, in the belief that her income protection would continue to be paid for the duration of her illness.

The Complainant states that the Provider appointed a Cognitive Behavioural Therapist whom she met with for nearly ten sessions, through which she gained a clear insight and understanding of her situation and illness. The Complainant states that the Therapist said she would recommend that the Complainant was unfit for work until such time as certain issues were resolved within the Complainant's personal life. The Complainant contends that this report should have been *front and centre* of the Provider's assessment. She queries how the Provider gave preference to a separate specialist who had no real insight into her situation or illness. The Complainant further contends that her claim was

cancelled on the basis that the Provider placed a preference of one opposing opinion over the other.

The Complainant states that when the Provider first notified her that it was stopping her claim payments it advised that her GP did not supply a report as had been requested. The Complainant contends that this is not the case and is untrue. The Complainant states that the report was issued to the Provider in **May 2018** and the GP's report is also referenced in a summary document the Provider issued to her within its response to a data access request that she made. The Complainant adds that her GP contacted the Provider on **10 May 2018**, requesting a consent form from the Provider so as to process the report, and on **19 June 2018** her GP contacted the Provider again as the consent form had not been issued as previously requested. The Complainant states that it is also recorded on the Provider's summary that her GP was informed that her report was no longer required.

The Complainant submits that prior to her claim payments being stopped, her employer offered her redundancy in **February 2018** and that the departure dates for those taking redundancy ran up to July 2018. The Complainant states that correspondence between her GP and the Provider were ongoing between **May 2018** and **June 2018** and the fact that the Provider informed her GP that a report was no longer required, suggests that the Provider had already at that point reached the decision to end her claim. The Complainant contends that had the Provider informed her at that time that it was going to decline her claim, then she would have accepted the redundancy package previously offered to her. The Complainant states that the Provider issued the correspondence rejecting her claim on **1 August 2020** and she therefore lost out on the opportunity to accept the redundancy.

The Complainant says that the Provider, when arranging a consultation with an independent Consultant, stated in the referral documentation that she was an '*Engineering Technician'* as opposed to her correct position as a '*Senior Technology Specialist'*. The Complainant states that this error is indicative of the lack of care and attention that the Provider gave to her claim. The Complainant also states that there is a significant difference between the two job roles with a Senior Technology Specialist being a highly responsible position that directly affects the value of the company, whereas an Engineering Technician is a role that maintains machine equipment. The Complainant contends that the error in relation to her job role is misleading adding that:

> '*My role is one that requires full attention, full capability and competency, directing and engaging in all site functions and globally on high level, high value activities. Any lapse of attention would be directly detrimental to the [details redacted] product made by the company, to the safety of other employees, to the [customer] and to the company'.*

The Complainant contends that once the Provider wrongfully informed the Consultant Doctor that she was an Engineering Technician, it gave the wrong impression and misled the Consultant in terms of the competencies that were required, for her to do her job.

The Complainant states that she received a letter from the Provider on **1 August 2018** to advise that her claim had been stopped. The Complainant states that this letter also set

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out the appeal process and she issued her appeal on **8 August 2020**. The Complainant contends that her appeal was not given a full and fair hearing by the Provider.

The Complainant submits that the Provider did not follow the appeals process as set out within its own appeal guidelines, citing that the Provider did not acknowledge her appeal letter, nor was she advised on what grounds the appeal would be heard and neither was she informed of how long the appeal would take. The Complainant states that when it was apparent that it had failed to comply with its own appeal procedures, she e-mailed the Provider on **2 September 2018** and attached the original appeal letter and requested a response to confirm receipt. The Complainant states that this also went unanswered.

The Complainant states that she e-mailed the Provider on **10 September 2018** to request that her previous correspondence be acknowledged. The Complainant states that the Provider responded on the **17 September 2018**, and submits that her letter of Appeal was not actually acknowledged by the Provider. The Complainant adds that the Provider's response also failed to advise on the next steps of the appeal.

The Complainant states that she wrote to the Provider on **26 October 2018** when it became apparent her payments had ceased. The Complainant asserts that she did not receive any correspondence from the Provider in advance to advise her that the payments were to be withheld during the appeal process. The Complainant contends that she should have received payment during the appeals process as to do otherwise removes any incentive for the Provider to process her appeal in a timely manner.

The Complainant states that she received two letters from the Provider dated **7 November 2018,** the first of which confirmed that it had declined her appeal. The Complainant submits that the Provider referenced that the Complainant's GP report was not received, however she asserts that this was sent to the Provider in **May 2018** and as part of her appeals application she enclosed a copy of the cover letter issued with the report dated **4 May 2020**. The Complainant states that she noted in her appeal application that if the Provider had issues with access to the report, then it should contact her, or her GP, however the Provider did not request this at this time.

The Complainant states that in declining her appeal the Provider says that it based its decision on all the medical evidence available. The Complainant contests the accuracy of this, on the basis that her GP's report was not considered and submits that it was her GP's position that the Complainant was not fit to return to work. The Complainant further contends that the appointed professionals see only a moment in time when meeting with a claimant, and they cannot have an insight into the daily effects of one's illness, whereas a GP is 'best placed to give an opinion and guidance in relation to a patient's illness.

The Complainant states the Provider also addressed the behaviour of one of the independent Consultants that the Complainant met with. The Complainant states that she had indicated in her appeal that this Doctor was inattentive and took a telephone call during their consultation and it became apparent that he was required elsewhere. The Complainant states that the Doctor ended the meeting and hurried away from the office and left the consultation before her. The Complainant states that the Provider's position

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was that the doctor is a practicing clinician in a busy hospital. The Complainant contends that the Provider's response to this was not acceptable and disrespectful.

The Complainant states that the Provider's appeal process document states that all appeals will be considered by the Technical Claims Executive with any additional medical evidence to be examined by its Chief Medical Officer and that the claim will also be referred to the Provider Claims Committee. The Complainant states that the Provider did not appear to follow this process and instead noted in the letter dated **7 November 2018**, that it's Claims Manager had carried out a full review of her claim, with no mention of the Technical Claims Executive, Chief Medical Officer or the Claims Committee and as such the Complainant again contends that the Provider did not adhere to its own procedure.

The Complainant states that in a second letter received from the Provider dated **7 November 2020**¸the Provider agreed that it did not acknowledge her appeal letter, provide advice on the next steps nor advise how long it would take. The Complainant submits that the letter also states that the Provider maintained that despite these issues, it refused her claim on the basis of the medical evidence it had to hand. The Complainant once more submits that the report issued by her GP does not appear to have been considered and this report was critical to her claim.

The Complainant states that on **23 September 2020**, the Provider supplied her with a copy of the applicable policy document which she states she has not seen before nor is she convinced whether it existed in **2018**. The Complainant contends that she should have been furnished with the policy document at the outset of her claim and adds that, had she known of the implications within the policy, she would have taken the redundancy offer made by her employer.

The Complainant states that the Provider's position that: *"It's important to note that this claim was initially accepted for a work related stress issue, which seems to have all but resolved during the course of this claim"* is incorrect. The Complainant states that she did not leave work on sick leave on the basis of a work related stress issue. The Complainant states that she left work on sick leave because she was suffering from extreme stress, anxiety and depression. The Complainant states that this was brought on due to being pursued relentlessly by the bank regarding their family home. The Complainant says it is due to real fears about being made homeless by the bank foreclosing on their home as she could not pay the mortgage alone and that this is still the case.

The Complainant states she left work on sick leave as a result of having been through many court proceedings (with respect to family situation and mortgage). The Complainant states this left her in a state of realisation that she had no control over the situation, and in a state of despair and hopelessness.

The Complainant states she left work on sick leave because she was suffering from grief due to family bereavements. The Complainant states she had assisted in the care of two family members, while they were sick and dying. The Complainant states that these two deaths in her close family left her traumatised and at the time she did not receive any support for her grief.

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The Complainant states she left work on sick leave because she was suffering from the trauma of a difficult marriage.

The Complainant states she left work on sick leave because she had no support from anyone except one of her parents during all of this and then that parent was diagnosed with a medical condition, rendering her parent unable to offer the Complainant support of any kind and finding herself in a situation where very difficult decisions had to be made and the onus was on her to make them.

The Complainant states she left work on sick leave because of issues within the home.

The Complainant states that stress, anxiety and depression she is suffering is due to all of the above and to ongoing court proceedings around some of these matters. The Complainant states that to date she has been to court on some of these matters 35 times.

The Complainant is adamant she did not leave work on sick leave because of a work related stress matter.

The Complainant says she never cited "Marital disharmony" as the reason for her leaving work on sick leave. But the effects of her marriage breakdown and all the other issues she has described led to her suffering from stress, anxiety and depression. The Complainant's position is that this is ongoing for her and she continues to be certified as sick by her GP and continues to receive payments from the Department of Social Protection. The Complainant states that these issues continue to be the source of her illness.

The Complainant states that while on sick leave, she has attended therapy and counselling. The Complainant says that through this therapy and counselling, she came to a realisation with the help of various therapist that her workplace, which had once been a place of respite, had become a hostile environment through various buy outs and changes in management, where people were dismissed on the spot for making a mistake. The Complainant states that she came to realise that it was misogynistic in style and finally admitted to herself that she had been sexually assaulted twice in her workplace, by two different colleagues on two separate occasions.

The Complainant's position is that she was encouraged by her therapists to include this information when being interviewed by the doctors appointed by the Provider. The Complainant states that she thinks their intention was that this should illustrate that her therapy was ongoing and was still uncovering issues for her, which she needed to work on to recover from. The Complainant's position is that it was not intended to suggest that this was the reason for her leaving work, although it would be a barrier in returning to work until she had recovered from these issues and been provided with the necessary assurances and support on these matters when returning to her workplace.

The Complainant states that to give the Cognitive Behavioural Therapist the benefit of the doubt she thinks she wrote what she did because her instruction was to get her back to work, so she focused on work related issues. The Complainant however, states she thinks the reports do show that while she had all these others issues live and ongoing, it was just not possible for her mind to focus on anything requiring good attention, focus and clarity, (like Cognitive Behavioural Therapy) while it was so consumed by the issues she was facing

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and continue to face. The Complainant states that the specialist's final report supports this, so she questions how could she have been found fit for work.

The Complainant wants the Provider to reinstate her claim under the original payment terms for as long as she is certified sick by her GP.

The Provider's Case

The Provider states that at no time was correspondence issued to the Complainant by the Provider stating payments would be paid indefinitely throughout the period of illness.

As regards the Complainant's position that she missed the opportunity to accept a redundancy package from her Employer, the Provider states that the issue of redundancy is a separate issue between employer and employee. The Provider says that payment of benefit would cease upon a redundancy, as an employee would no longer be a member of the scheme. It is the Provider's position that it was not consulted nor was any information requested by the Complainant in respect of a potential redundancy.

As regards the difference in job title, the Provider states that the term Engineering Technician was a system generated job title that best matched the job title provided by the Complainant and it was the job description that was relevant, and not the title. The Provider states that the Complainant's job description of Senior Technology Specialist was considered throughout the claim, in accordance with the description provided in the initial claim form.

As regards the specialist being interrupted during the medical examination, the Provider states that Dr C clarified that he had to take a phone call as a practicing clinician in a busy hospital and he acknowledged that the interview with the Complainant was interrupted and unfortunately, this happens from time to time.

The Provider states that Dr C saw the Complainant on three separate occasions and that his opinion and findings of his third report are consistent with the opinion in February 2019 of Dr K Consultant in General Adult Psychiatry.

As regards whether the correct appeal's process was followed, the Provider states that the Risk Claims Manager reviewed the file on **19 October 2018** and the Chief Medical Officer reviewed the file on **21 August 2018** prior to the decision on the claim appeal. The Provider states that an appeal would only be referred to the Claims Committee if necessary, that is, if the liability was above the Claims Manager's authority limits or if the Claims Manager had approved the initial decision to cease the claim, and say that the correct process was followed.

As regards whether payments should have continued during the appeal, the Provider states that payments are not reinstated when an appeal is made, but may be reinstated and backdated if a successful appeal outcome transpires. The Provider says that here the

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payments were extended to **31 January 2019** from **17 October 2018** in acknowledgement of service issues as set out in letter of **10 December 2018**.

As regards the furnishing of the policy document, the Provider states that as this is an employee benefit scheme, the benefits and details of the policy are referred to in the employee handbook or in a scheme handbook (if available). The Provider says that a copy of the policy conditions were always available from the Provider, but it would usually be requested through the scheme owner or scheme broker.

The Provider states that the Complainant attended Dr C on three separate occasions in the course of her claim. The Provider states that in 2016 Dr C was of the opinion that the Complainant was unfit for work. The Provider says that in the follow up review in 2017 the Complainant reported that she was considerably better than when previously seen, however Dr C was of the opinion that the Complainant had not fully recovered. The Provider states that at the third review in 2018 Dr C was of the opinion that the claimant was now fit to return to work. The Provider's position is that all three reports detailed the history of the Complainant's circumstances and provided specialist opinion on her fitness to return to her pre-disability role.

The Provider submits that a medical examination was arranged with a separate psychiatrist Dr K for the claim appeal. The Provider says this gives a fresh and independent medical review of the claim and is part of the normal process for an appeal case. The Provider states that a second psychiatric medical examination was also suggested by the Provider's Chief Medical Officer.

The Provider submits that Dr K's report of 2019 furnished a comprehensive and detailed history of the case together with a specialist opinion on fitness to return to work. The Provider states that a significant Industrial Relations / Human Resources issue was identified as a major barrier to returning to work as opposed to a health issue.

The Provider states that the reports from the GP state ongoing anxiety / depression with the opinion that the Complainant is unfit for work. The Provider's position is that there was very little information provided in support of ongoing disability either in respect of medication, ongoing treatments or consultations to support a claim as being totally unable to do the previous occupation. The Provider says that the specialist medical reports from Dr C and Dr K are consistent in their opinion and had sight of the Complainant's GP's medical reports at each examination date. The Provider submits that there has also been no medically substantiated rebuttal of Dr C's 2018 report and Dr K's 2019 report.

The Provider says that in considering the medical evidence, it is noted that separate and independent specialist opinions were received from two consultant psychiatrist. That these reports were substantial and provided a comprehensive account of the claimant's situation with full sight of the medical reports furnished by the Complainant.

The Provider submits that its Chief Medical Officer and Risk Claims Manager both reviewed the claim appeal and are of the opinion that the claim is no longer medically supported.

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The Provider says that a full medical assessment was carried out and its normal process was followed.

The Provider states that Dr K had sight of the full medical file at the medical examination on 17 January 2019 as did its Chief Medical Officer and claim assessors at each stage of the claim assessment. The Provider says Dr K's 2019 medical claim assessment was consistent with Dr C's medical opinion from 7 June 2018 and the Provider's view to cease the claim without a GP report in 2018.

Evidence

Policy Provisions

Condition 1.2 Definitions – Period of Disability

> *"A period throughout which a Member is totally unable to carry out his Normal Occupation due to a recognized illness or accident and during which the Member is not involved in carrying out any other occupation .."*

Condition 4.1 Disability Benefit

> *"Disability Benefit will be payable from the end of the Deferred Period if, in the opinion of [the Provider] having regard to all of the information available to it, the Member is suffering a Period of Disability. [The Provider] will continue to pay benefit until:*
>
> *(i) The Member, in the opinion of [the Provider], having regard to all of the information available to it, is no longer suffering a Period of Disability .."*

4.4 Medical Evidence

> *"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 a [the Provider] may require, (which includes "the completion and submission by the Member of signed initial claim form .." and "attendance at any medical doctor, consultant .. other relevant professional person nominated by the Provider")".*

Condition 4.5 Other Evidence and Enquiries

> *"..*
>
> *This list of requirements is not exhaustive and [the Provider] reserves the right at all times to request any additional evidence as it considers necessary to complete the full assessment and / or review of a Member's claim.*
>
> *The payment of benefit is at all times subject to regular review. The claim will at all times be assessed on the member's ability to carry out his Normal Occupation, notwithstanding that his Normal Occupation may no longer be available to him to return to".*

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4.9 Direct Payment of Claims

> *"..*
> *The claim will at all times be assessed on the member's ability to carry out his Normal Occupation, notwithstanding that his Normal Occupation may no longer be available to him to return to".*

<u>Some Medical Evidence and Claim Correspondence</u>

26 November 2015 – Occupational Physician:

> *"In my opinion, [the Complainant] current remains unfit to return to work due to symptoms that have arisen due to factors outside of the workplace. However, should her symptoms continue to stablise, then I expect she should be fit to return to work in approximately the next 6 to 7 weeks, in early January 2016. Furthermore, I believe that [the Complainant] should be fit to return to her normal duties within [employer] . In addition as discussed following the consultation, due to circumstances outside of the workplace, I recommend she continue to work only her core hours for the present".*

18 May 2016 - Dr C – Consultant Psychiatrist:

> *"[The Complainant has] moderate anxiety and depression. Although is slightly better than had been she still remains significantly symptomatic and is unfit for work".*

15 February 2017 - Dr C - Consultant Psychiatrist

> *"There has been considerable improvement in [the Complainant] since she was seen here in May 2016. Her mood symptoms are largely remitted but I would not say that she has fully recovered and I think that allowing the cognitive behavioral therapy to progress further in addition to her making contact with HR would allow her to start to initiate the process of a return to work. This would probably have to be on a phased basis and she is not sure whether they would even have the facility for her to have part time work rather than full time. That is a separate question to some extent. I think at this point she is well enough to start exploring the possibilities in relation to a return to work over the next three months which would allow her to compete her CBT and her programme of focus on her wellbeing that she could initiate this process".*

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21 February 2017 – Cognitive Behavioural Therapist

> *"[The Complainant] does not feel able at present to engage in a focused psychotherapy to facilitate her return to work".*

4 May 2018 – Complainant's GP

> *"She was diagnosed with anxiety and depression. … I would say she may be able to return to work over the next 1-2 years".*

7 June 2018 - Dr C - Consultant Psychiatrist.

> *"[The Complainant] ... has improved by own account from when she was last seen in 2017. Things are better but she would feel that she is unfit for work as result of ongoing distress and anger at the circumstances that she finds herself in. However, although these circumstances are obviously very difficult and challenging she is functioning and doing all that she has to do. At this point I would consider that she is well enough to make a decision as to whether she wants to return to her job with [Employer] as opposed to a health issue primarily. Given that she has been out of work for this length of time a return to work on a phased basis would be appropriate over a period of two to three months".*

19 June 2018 – Chief Medical Officer's Decision

> *"Fit to work. Terminate claim".*

1 August 2018 – The Provider regarding claim decision

> *"In order to claim benefit you must be "totally unable by reason of sickness or accident from following the occupation of Senior Technical Specialist" as required by the scheme conditions.*
>
> *I regret to advise that as the definition of disability under the terms of the scheme is no longer satisfied we must cease your claim.*
>
> *In line with our claims philosophy and as suggested by Dr C we will be making a further payment of 12 weeks benefit to assist you in preparations to return to your full time duties, bringing final benefit payment up to 17/10/2018."*

8 August 2018 – GP Notes

> *"Patient feels she is too anxious to go back to work. She is attending her counsellor weekly. Patient is taking her BP meds according to herself. She has had a significant anger outburst recently. She states she is currently unable to work" "Anxious++ BP 157/113" "Acute on chronic anxiety Hypertension moderate"*

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14 November 2018 – GP Notes

> *"Anxiety persists. Patient has ongoing anxiety+++ … anxiety significant with inability to return to work".*

3 January 2019 – GP Notes

> *"Anxiety and depression – In my opinion this patient is unfit for work at this time".*

17 January 2019 – Dr K – Consultant in General Adult Psychiatry

> *"The Complainant] is not suffering from a disabling psychiatric illness. She has significant emotional problems and I readily acknowledge this. However, these do not amount to disabling psychiatric illness. Her mood symptoms are reactive to difficulties in her life and are proportionate and therefore not pathological.*
>
> *There are significant work-related issues in this case which are a real and definite impediment to [the Complainant] returning to work in [Employer]. Clearly these are of a human resources / industrial relations nature and would need to be addressed by the appropriate cannels if she is to return successfully to work with [Employer]".*

5 February 2019 – Provider's Chief Medical Officer

> *"IR / HR issues + Personal Stress*
> *No evidence debilitating psych illness*
> *"Fit for work – Terminate"*

11 December 2018 – Provider's proposal:

"

- *Obtain full medical records from GP*
- *Obtain comment on Dr C's June 2018 report*
- *A further psychiatric Medical Examination*

Reinstate benefit payments to 31 January 2018 as a gesture of goodwill"

The Complaints for Adjudication

The complaint is that the Provider failed to adequately administer a review and subsequent appeal of the Complainant income protection payments which has resulted in her payments being unfairly stopped.

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

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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 **25 November 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.

A Submission dated **26 November 2021** from the Complainant was received by the Financial Services Ombudsman and Pensions Ombudsman after the issue of a Preliminary Decision to the parties. This submission was exchanged with the Provider and an opportunity was made available for any additional observations arising from the said additional submission. I have considered the contents of this additional submission for the purpose of setting out the final determination of this office below.

Analysis

In the Complainant's post Preliminary Decision submission of **26 November 2021**, the Complainant submits that it is testimony to how ill she was at the time, that she did not even question if her income would be continued to be paid. The Complainant states she believed it would be continued to be paid and she had this belief from all involved. The Complainant says that this much is obvious, had she been given the correct information, she would have opted to take the redundancy, that was being offered by her employer. The Complainant states that through the inaction of the Provider she has lost €180,000.

I accept that the issue of redundancy is a separate issue to income protection and redundancy would be an issue between employer and employee. I also accept that there is no evidence of the Provider being made aware by the Complainant of the offer of redundancy, or that the Complainant was contemplating taking redundancy.

I accept that at no time was correspondence issued to the Complainant by the Provider stating payments would be paid indefinitely throughout the period of illness. Income

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Protection benefit by its very nature is subject to review to establish whether, on health and income grounds, the claimant continues to qualify for payment of the benefit. That said, I accept that a claimant would have to be furnished with information on the income protection cover and of the processes regarding a review of the income benefit, to better understand how this cover operates.

I accept that it was important that the Complainant's correct job title was considered, and that there is a distinct difference between the roles of an Engineering Technician and a Senior Technology Specialist. That said, I accept that from a review of the appointed specialist's reports the Complainant's job description of Senior Technology Specialist was considered throughout the claim, as per the description provided on the initial claim form.

As regards the specialist being interrupted during the medical examination, I accept that the Complainant would reasonably consider that this was not an ideal situation. That said, I accept that the Provider did correctly have the specialist comment on the matter. It is noted that Dr C clarified that he had to take a phone call as a practicing clinician in a busy hospital and he acknowledged that the interview with the Complainant was interrupted and he explained that unfortunately this is something that happens from time to time. I accept that the Provider acted correctly in having the matter clarified by the specialist. I cannot comment on the ability or expertise of a medical practitioner acting in that capacity in particular in their examination of a patient / claimant and submission of medical opinion. If a patient or claimant has any issues with a doctor there is another body (Medical Council) who may investigate such matters.

I accept that with regard to the appeal process the Provider could have been timelier in its responses and acknowledgment of the Complainant's communications. I note the Complainant raised her concerns with the overall appeal process and I note that the Provider did respond to those concerns, by: (i) obtaining the full medical records from the Complainant's GP (ii) obtaining a comment on Dr C's June 2018 examination / report (ii) arranging a further psychiatric Medical Examination with a different appointed specialist and (iv) reinstating benefit payments to **31 January 2019** as a gesture of goodwill.

I accept that this was a correct response from the Provider to the matters raised by the Complainant.

I accept that the policy provisions do not state that payments are reinstated when an appeal is made, and I accept that it is the general position that payments would only be reinstated and backdated if a successful appeal was achieved. In that regard I note that payments continued for a time after the Complainant had been advised that payments were to cease, and that the Provider extended payments to **31 January 2019** from **17 October 2018** in acknowledgement of service issues raised by the Complainant.

As regards the furnishing of the policy document, the Provider states that as this is an employee benefit scheme, the benefits and details of the policy are referred to in the employee handbook or in a scheme handbook (if available). The Provider says that a copy of the policy conditions were always available from the Provider, but it would usually be requested through the scheme owner or scheme broker.

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While I accept that the employer and scheme broker had a role as regards the information that should have been furnished to the Complainant, I would have expected to see a more structured process or procedure in place concerning the respective parties' roles as to the communication of information to the claimant (the Complainant). I would also have expected to see some specific information available to the parties from the Provider (for onward communication to the claimant) as to the position that no payment would be made during an appeal.

While the contractual parties are the Employer and the Provider, I accept that it is reasonable to expect where a claim arises and benefit becomes payable to an employee, that the employee should be given access to as much information to assist with their understanding of what they are entitled to under the scheme. That information ideally should include the policy documentation or relevant extracts from the policy dealing with the claim process, and appeal process. While the Provider is correct that such information and advices should come from the Broker to the Scheme, I accept that the Provider should also ensure that the fullest information is made available to the member upon a claim under the policy, regarding such access.

As regards the claim itself and the Provider's cessation of benefit the following is noted:

Following an examination of the Complainant by the Provider's appointed Consultant Psychiatrist (Dr C) the claim was accepted by the Provider and payments commenced from **6 April 2016**.

The Provider's first review of the claim took place in 2017 and the Provider continued payments to the Complainant based on its appointed Consultant Psychiatrist's report (Dr C's report).

A second review took place in **April 2018**, and an appointment was made with the Provider's appointed Consultant Psychiatrist (Dr C) for **7 June 2018**.

The Provider ceased the Complainant's claim from **1 August 2020**, but allowed for payments up to **17 October 2018** to assist a phased return to work. Payment of the claim benefit was later extended by the Provider to **31 January 2919**.

The Provider's claim decision was appealed on **31 October 2018**. The GP report that was received on **10 August 2018** was reviewed as part of the claim appeal where it was considered by Dr K the Provider's newly appointed Consultant Psychiatrist, the Chief Medical Officer, and the Risk Claims Manager.

The appeal decision letter issued to the Complainant on **13 February 2019** advising that the claim was declined based upon the medical assessment.

From the above I note that the Complainant attended the Provider's appointed Consultant Psychiatrist (Dr C) on three separate occasions in the course of the claim. In 2016 Dr C was of the opinion that the Complainant was unfit for work. In the follow up review in 2017

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the Complainant reported that she was considerably better than when she had previously been seen. However, the Provider's appointed Consultant Psychiatrist (Dr C) was of the opinion that the Complainant had not fully recovered. The Provider therefore continued to pay the claim. At the third review in 2018 the Provider's appointed Consultant Psychiatrist (Dr C) was of the opinion that the claimant was now fit to return to work. I accept that all three reports detailed the history of the Complainant's circumstances and provided specialist opinion on the Complainant's fitness for her pre-disability role.

When the Complainant appealed the Provider's decision to stop her payments, the Provider arranged a medical examination with a newly appointed Consultant Psychiatrist (Dr K). I accept that this gave a fresh medical review of the claim, which would be the normal process for an appeal.

I accept that Dr K's report of 2019 gave a full and detailed history of the Complainant's claim together with his specialist opinion on the Complainant's fitness to return to work.

I accept the Complainant's position that it was not only the Industrial Relations / Human Resources issue that prevented her returning to work, but encompassed her entire circumstances which were causing her health issues.

I note that the reports from the Complainant's GP state ongoing anxiety / depression with the opinion that the Complainant is unfit for work. The Provider's position is that there was very little information provided in the GP reports supporting ongoing disability either in respect of medication, ongoing treatments or consultations indicating the Complainant as being totally unable to do her previous occupation. I accept that the specialist medical reports from Dr C and Dr K are consistent in their opinion and Dr K had sight of the Complainant's GP's medical reports at his examination.

I accept the Provider's position that there has been no medically substantiated rebuttal of Dr C's 2018 report and Dr K's 2019 report. I accept that while the Complainant relies on her GP's assessment of her illness, the medical assessment of income protection claims is based primarily upon specialist medical reports.

In the above regard I note that the Provider has suggested (letter of **22 February 2021**) that should the Complainant wish to submit additional medical evidence from a specialist such as a psychiatrist, the Provider would be happy to have its Chief Medical Officer review it. The Provider suggested that the Dr C's and Dr K's reports would be furnished to this specialist for comment. I also note that the Provider stated that in the circumstances it would pay for any such psychiatrist medical report within the reasonable costs for similar reports. The Provider suggested that an appointment with her GP may be the right place to initiate this if the Complainant wished to furnish further medical evidence.

The Complainant's response (of **1 March 2021**) to the Provider's offer to pay for, and review, a specialist report from the Complainant was that she had seen many doctors at this stage and did not feel that seeing another doctor would help her, or her case. She expressed the view that the specialist would be ultimately working for the Provider. The

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Complainant states that she simply does not have the energy to meet another doctor, as she is so exhausted by the whole process.

Having regard to all of the above, I accept that the Provider's decision that the definition of disablement under the policy has not continued to be met in this particular claim, was reasonable, and that it was therefore entitled to decline to admit the Complainant's claim for further payment of benefit.

That said, I do consider that a compensatory payment is merited for the poor communication by the Provider to the Complainant from the outset in relation to where she could access information in relation to how the policy operated relative to a claim, the review of claims, and about how matters progress upon any appeal that would be made by a claimant. I accept that, if as the Provider states, this information is available from the employer / broker to the scheme, that this position should itself be set out for a claimant by the Provider from the outset upon receipt of a claim. Likewise, I accept that a Provider should make it known to an applicant from the outset that the policy terms and conditions can only be obtained by way of request to the employer.

I believe the Provider's conduct in this regard was unreasonable. Therefore, I partially uphold this complaint and I direct that the Provider pay the Complainant €800 (eight hundred euro) for the inconvenience caused as a result of its conduct.

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 €800, 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

16 December 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.