An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2021-0537
Sector:	Insurance
Product / Service:	Income Protection and Permanent Health
Conduct(s) complained of:	Disagreement regarding Medical evidence submitted Rejection of claim - fit to return to work Ending of benefit payment
Outcome:	Rejected

LEGALLY BINDING DECISION
OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The Complainant, an [Grade Redacted] with the Civil Service, is a member of a **Group Income Protection Scheme**, and the Trade Union she is a member of is the Policyholder. The Provider is the Insurer, responsible for assessing claims. This complaint concerns the Provider's decision to cease payment of the Complainant's income protection claim from end August 2018.

The Complainant's Case

The Complainant, then [Age Redacted], completed and sent a **Group Income Protection Claim Form** to the Provider on **23 March 2018**, as she had been medically certified as unfit to work from [Date Redacted]**, 2017**.

The Complainant's treating Consultant Psychiatrist completed and sent a **Practitioner Report** to the Provider on **13 February 2018**, wherein he advised, among other things, as follows:

> *" … **What is the exact nature and cause of disability?***
> *Depression & anxiety*
>
> ***Describe the symptoms which prevent the claimant from working.***

Low mood & anxiety …

What is your prognosis for the claimant?
Guarded …

Is the claimant in your opinion currently able to carry out <u>all of</u> the duties of their normal occupation?
☐ *Yes* ☑ *No …*

If No, please confirm the normal duties of the claimant's occupation that they are currently unable to perform.
All.

Is the claimant currently able to resume their normal occupation on a part time basis?
☐ *Yes* ☑ *No …*

When is the claimant likely to be able to resume full time work?
Unable to say".

Following its assessment, the Provider concluded that the Complainant was fit to return to work, though in order to assist with a short phased return to work, it admitted the Complainant's income protection claim from **27 January 2018** (which marked the end of the 3 month policy deferred period) to **31 August 2018** in the amount of **€7,345.03** (seven thousand three hundred and forty-five Euro and three Cent).

The Complainant appealed this decision in **December 2018** but following its review in **March 2019**, the Provider stood over its original claim decision**.**

The Complainant complains that the Provider ceased payment of her income protection claim even though her treating Consultant Psychiatrist states that she remains unfit to return to work.

In this regard, in his letter dated **8 January 2019**, the Complainant's treating Consultant Psychiatrist advised that:

> *"I confirm that* [the Complainant] *attended me with a diagnosis of severe and chronic depression/anxiety syndrome. She requires to take significant doses of psychotropic medication including anti-depressant, anxiolytic and mood stabilizing medication. She needs to attend on a 3-weekly basis and requires considerable psychotherapy also.*
>
> *She last attended on 3rd January 2019 and at consultation, I deemed her unfit to return to work. The prognosis in this case is guarded in view of the severity and chronicity of symptomatology on presentation".*

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The Complainant was subsequently granted early retirement on ill-health grounds by her employer on [Date Redacted], **2019**.

In his letter dated **26 August 2020**, the Complainant's treating Consultant Psychiatrist advises that:

> *"I can confirm that* [the Complainant] *has been under my care for a number of years suffering from severe and chronic depressive anxiety syndrome … Over the years I have been seeing her on a three-weekly basis for intensive psychotherapy and psychotropic medication. During that time, she has had periods of very severe depression with inability to cope and insomnia. Her focus, concentration and cognition in recent years have been very poor as had her short-term memory.*
>
> *I formed the opinion that she was unable to continue her work and I recommended that she consider retirement on medical grounds. I stated this because of her lack of significant recovery from the above-mentioned syndrome and continuing poor cognition.*
>
> *Her current medication is Valdoxan 50mgs at night, Priadel, 600mgs at night, Lyrica 200mgs three times a day and Circadin 4mgs at night. Thus, she needs a powerful antidepressant and augmentative agent in the form of Lithium, an anti-anxiety medication at maximum dose, and a sleeping tablet in the form of Circadin. While she has begun to improve slowly in recent months, in my opinion, she will still require regular psychotherapeutic sessions and significant amounts of psychotropic medication.*
>
> *To summarise, I have no doubt that she is not in a position to return to her previous career due to the ongoing incapacities mentioned above".*

In his letter to the Provider dated **25 October 2019**, the Complainant's husband submits, among other things, that:

> *"… The* [claim] *payment that was made to my wife was based on the ordinary scale for an[Grade Redacted]. My wife was on the higher scale since approx. November 2017. This resulted in the calculation of the* [claim] *amount that she was paid being incorrect as the incorrect rate of pay was used.*
>
> *From my understanding it is extremely rare for an employee of* [the Complainant's] *age to be granted retirement on ill health so the Chief Medical Officer would have had to be certain that she was unable to perform the material and substantial duties of her normal insured occupation as a result of her illness for the foreseeable future, in order to make such a decision.*
>
> *My wife's own Consultant's assessment does not appear to have been given any weight at all in your decision. This is a doctor that my wife has been attending every 3 weeks for the last 2 years and continues to do so to date.*

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I find it incredible that 2 x 1 hour assessments by your Consultants (who have only ever seen [the Complainant] *in a medicated state) could completely refute the findings of her own Consultant who has examined her 50 to 60 times at this stage (who has examined her un-medicated and in various states of medication) and the assessment of* [her employer's] *chief medical officer who has determined that she should be retired on grounds of ill health. You don't have to be a doctor to know that someone has to be wrong. I would suggest that it is highly unlikely that her own Consultant has been medicating her for over 2 years incorrectly and that the Chief Medical Officer has assessed her case incorrectly also after a number of assessments.*

I have also got grave reservations to some of the content in your doctors' assessments and their relevance to the assessment of [the Complainant's] *illness, e.g. in* [the Report from Consultant Psychiatrist B] *under Mental State Examination 10.1 his assessment was that she was neatly* [dressed] *with good self-care and had styled hair and nails manicured. This was not an assessment of her at all. This was an assessment of the 3 people it took to prepare her to go to the interview with* [this Consultant Psychiatrist] *as prior to the interview my wife had little or no self-care and struggled to have enough motivation to get out of bed each day. Prior to the interview 3 of her relations washed* [her]*, dressed her and got her hair and nails done so that she might have enough confidence to even attend the interview. Obviously,* [Consultant Psychiatrist B's] *assessment is flawed if he accepted her appearance at face value.*

The definition of "Disability" per your policy is "the member's inability to perform the material and substantial duties of their normal insured occupation as a result of their illness or injury". Question 10 of [the Report from Consultant Psychiatrist B] *asks "Is* [the Complainant] *fit to carry out* ***a*** *normal occupation as an [Grade Redacted]?" Firstly I would suggest that this question does not comply with the definition of Disability per the policy as it states "****a*** *normal occupation" and not "their normal occupation". "Their normal occupation: would mean the duties of the job* [the Complainant] *was doing prior to her illness. "A" normal occupation would assume that all duties are the same for each officer. This is not the case as her normal occupation would have been a quite stressful job which required a huge amount of concentration and excellent people skills. I see no evidence of a detailed review of her specific normal duties in* [Consultant Psychiatrist B's] *report to suggest that he understood what her normal duties to make an informed decision. I also see no evidence that* [Consultant Psychiatrist B] *has any idea what the normal duties of any Executive Officer is.*

[Consultant Psychiatrist B's] *answer to question 10 was* "[The Complainant] *is fit to carry out a normal occupation". This also does not answer the question asked! He does not go on to say "as an[Grade Redacted] ". This answer is also very misleading. It does not confirm that she does not have a disability in accordance with the policy. It merely states that she is fit to carry out* ***a*** *normal occupation. Dog walker may be* ***a*** *normal occupation that she may be fit for, but even if she was fit for such an*

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> *occupation, it does not break the definition of disability per the policy she is insured under.* [Consultant Psychiatrist B] *has therefore not determined that she did not meet the definition of disability as set out in the policy.*
> *In summary, you can see from the above that my wife's claim has been handled very badly from start to finish. This has led to an incorrect assessment that does not comply with the definition per the policy …"*

In addition, in his email to this Office on **27 August 2020**, the Complainant's husband also submits, among other things, that:

> *"If* [the Complainant's treating Consultant Psychiatrist's] *report was taken into account along with* [the Complainant's employer's] *Chief medical officer's report, do* [the Provider] *believe that* [the Complainant's treating Consultant Psychiatrist] *has been incorrectly treating my wife for the last 3 years or so? While I understand than an insurer would want other opinions, I find it very hard to believe that her consultant has been medically treating her with serious mood altering drugs for the last number of years wrongly. Surely his opinion would carry much more weight given that he has seen her every 3 weeks for years compared to 2 one hour assessments done by the insurer's appointed consultants. Is the* [employer's] *chief medical office also wrong? The chief medical office would have a vested interest in getting her back to work and it would have been a big decision for this officer to grant early retirement in her case given her age. I cannot see how an insurance assessor at* [the Provider] *could have come to the conclusion that my wife was fit to carry out her normal duties if all reports were taken into account …"*

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

> *"… Initially misled into thinking that payment from claim would continue until circumstances changed. The payment made was calculated on the wrong salary scale. Claim disallowed even though still being treated for condition to date and still considered to be unfit for work by own consultant, also granted early retirement by* [my employer's] *Chief Medical Officer. Doctors reports* [from medical examinations arranged by Provider] *misleading as state "*[The Complainant] *is fit to carry out a normal occupation". It does not state that* [the Complainant] *is able to perform the material and substantial duties of her normal insured occupation. While* [the Complainant] *may sometime in to future be able to do some normal occupation, she almost certainly would not in any way be fit to resume HER normal occupation, which is what she was insured for …"*

The Complainant seeks for the Provider to reinstate payment of her income protection claim from **1 September 2018**.

The Provider's Case

The Provider says that the Complainant completed a **Group Income Protection Claim Form** on **23 March 2018** in which she advised that her first date of absence was **6 November 2017**.

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The Complainant's treating Consultant Psychiatrist completed a **Practitioner Report** to the Provider on **13 February 2018**, advising among other things, as follows:

> *" … **What is the exact nature and cause of disability?***
> *Depression & anxiety*
>
> ***Describe the symptoms which prevent the claimant from working.***
> *Low mood & anxiety …*
>
> *… **how long is the expected duration of absence as a result of this disability?***
> ☑ *0-3 months …*
>
> ***Have you discussed returning to work with the claimant?***
> ☐ *Yes* ☑ *No …*
>
> ***If No please provide an approximate date when these discussions are likely to occur.***
> *06/03/18 … "*

The Provider notes that the Complainant's treating Consultant Psychiatrist advised in his **Practitioner Report** of 13 February 2018, that the expected duration of the Complainant's absence as a result of the illness was 0-3 months from the date of that report, and that return to work discussions were likely to take place in **March 2018**.

The Provider says that in order for an income protection claim to be payable, a member of the **Group Income Protection Scheme** must satisfy the policy definition of disability, as follows:

> *"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"*.

As part of its claim assessment, the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist A on **23 May 2018**, who in his ensuing **Report** stated:

> *"**Structured Inventory of Malingered Symptomatology (SIMS):***
>
> *This is a 75 item, multi-axial scale assessing exaggeration of psychiatric symptoms. A total score above 14r suggests the possibility of exaggeration of symptoms.*
>
> [The Complainant] *scored 24 on the SIMS.*
> ***Mental State Examination:***
>
> [The Complainant] *looked well and was very stylishly groomed. She was friendly and cooperative throughout. Her mood was good. She was not anxious. Her attention and*

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> *concentration were very good. The examples of forgetting she gave were all examples of everyday normal forgetting. She was not overtly distressed or upset at any point during the interview …*
>
> *It is my opinion that that* (sic) [the Complainant] *is currently fit to carry out her normal occupation on a part time basis. She is fit to work half time and this could be gradually increased over a period of eight weeks to full time"*.

The Provider says that having assessed the claim, the medical evidence suggested that the Complainant had sufficiently recovered from her illness and was fit to return to work. As a result, the Provider wrote to the Policyholder's broker on **10 July 2018** to advise that:

> *"*[The Complainant] [recently] *attended an Independent Medical Examination. The outcome of the examination was that she is fit to return to her normal occupation on a phased basis. To allow this phased return we are paying the claim in full up to the 31 August 2018. The gross payment for the period 27 January 2018 – 31 August 2018 is for €7,345.03. This payment will be issued on 25 July 2018. Please note as* [the Complainant] *has been deemed fit to return to work there will be no further payments on the claim".*

In this regard, the Provider admitted and paid the Complainant's claim for the period from **27 January 2018**, the end of the policy deferred period, to **31 August 2018** in the amount of **€7,345.03** (seven thousand three hundred and forty-five Euro and three Cent).

The Provider says that the Complainant appealed this decision in **December 2018** by submitting a letter from her treating Consultant Psychiatrist dated **17 December 2018**, which advised that the Complainant had been diagnosed with severe depression/anxiety and needed to take significant doses of psychotropic medication, and he deemed her unfit to return to work. A subsequent letter was received from this Consultant Psychiatrist dated **8 January 2019** reiterating the same. The Provider notes that there was no objective testing provided with either letter, nor did the Consultant offer any explanation as to the reason why he felt that the Complainant could not make an attempt to return to work, having previously indicated that she would be fit to return circa May 2018.

The Provider says that as part of its appeal review and to further consider the matter, it arranged for the Complainant to attend for a medical assessment with Consultant Psychiatrist B on **5 February 2019**, who in his ensuing **Report** of the same date stated:

> *"**Mental State Examination***
> [The Complainant] *was a neatly* [dressed] *lady with good self-care. She was wore* (sic) *make-up, her hair was styled and her nails manicured. She was accompanied to the appointment by her brother-in-law.*
>
> *She was cooperative and was not anxious or tense. Objectively, she was not depressed and she had no evidence of psychomotor retardation.*

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She reported cognitive problems, but these were not evident during the assessment. She maintained good attention and concentration throughout. Her memory was good in terms of recounting her history and current problems. She was not psychotic. She was future orientated and not suicidal.

Some of her reported of (sic) *symptoms were vague such as her fear of dying and not being able to watch certain TV adverts or seeing people she knows grow older. Her elevated scoring on the SIMS (as per IME with* [the Consultant Psychiatrist A] *on 23/05/2018) was noted testing was not repeated today.*

MoCA
This measure of cognitive functioning assesses areas such as executive function, memory, attention, delayed recall and orientation. It is measured out of 30 and scores of greater than 26/30 are considered normal.

[The Complainant] *scored 29/30.*

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

[The Complainant] *scored 11/15.*

***Conclusion** …*
[The Complainant] *is fit to carry out a normal occupation. I could not find evidence of disabling psychiatric symptoms or a disorder that would prevent her from working. She reports cognitive problems, but these were not evident on objective testing. She is independent in many ways and is fit to return if she so wishes. However, her motivation to return seems low. Further, the longer she is on sick leave, the more deconditioned from working she will become and the more difficult it will be for her to return in the future"*.

As a result, the Provider wrote to the Complainant on **4 March 2019** to advise that it was standing over its original claim decision.

The Provider received further communication from the Complainant's husband on **29 October 2019** and this was fully addressed in its **Final Response** letter to the Complainant dated **20 December 2019**.

The Provider says that payment of income protection benefit is conditional on the claiming member continuing to satisfy the **Group Income Protection Scheme** definition of disability. In this case, the Provider says the Complainant did not continue to satisfy the definition of disability, therefore her claim was retrospectively admitted from the period **27 January 2018** up to **31 August 2018**, at which point it ceased, because the Provider concluded from the weight of objective evidence before it that the Complainant had been found fit to return to work following the claim assessment.

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The Provider says that if the **Claim Form** it received on **29 March 2018**, some 4½ months after the first date of absence, had been submitted before the end of the policy deferred period on **27 January 2018**, it may have been in a position to make a decision on the claim before the end of the policy deferred period. In that regard, the Provider says that in that event it is possible that if the Complainant had been found fit to return to work at that time, no payment would have been made and the claim would have been declined, without payment of benefit.

However, given the late submission of the **Claim Form**, the Provider says it was unable to deduce that the Complainant was fit for work during the period from **27 January 2018** up to the date of the medical assessment with Consultant Psychiatrist A on **23 May 2018**. The Provider says that on balance, it made a retrospective claim payment for that period and also paid the claim up to **31 August 2018,** to allow the Complainant time to make arrangements to return to work on a phased basis, building up to full time hours. The Provider notes that the Complainant did not however attempt to return to work in 2018.

The Provider notes that both Consultant Psychiatrists A and B were advised that the Complainant worked as [role redacted] and have previously been provided with the details of thar role. Therefore the Provider is satisfied that its assessments were benchmarked against that role. In addition, both Consultant Psychiatrist A and B were furnished with copies of the claim documentation to include the **Claim Form**, which outlined the duties of the Complainant's role specifically.

The Provider says that the Complainant's treating Consultant Psychiatrist's report dated **13 February 2018** was taken into consideration and was provided to Consultant Psychiatrist A prior to his medical examination with the Complainant on **23 May 2018**. In addition, the Complainant's treating Consultant Psychiatrist's reports dated **13 February 2018**, **19 December 2018** and **8 January 2019** were taken into consideration and were provided to Consultant Psychiatrist B prior to his medical examination with the Complainant **on 5 February 2019**. The Provider also confirms that a further medical report addressed to the Provider's Chief Medical Officer dated **10 June 2019**, but not received until **29 October 2019**, was taken into consideration prior to the issuing of the **Final Response** letter on **20 December 2019**.

The Provider acknowledges the contents of the medical reports submitted by the Complainant's treating Consultant Psychiatrist. Whilst he offered his opinion in his letters that the Complainant was unfit for work, the Provider says that the Consultant Psychiatrist provided no objective evidence or detailed reasons explaining why the Complainant was unfit for work, or any great insight into her illness. He merely stated that she has a condition for which she is being treated with medication and remains unfit for work. In this regard, in order for it to decide if a claimant does or does not meet the definition of disability in terms of mental health, the Provider says that medical reports should be supported and backed up by objective evidence, which in this case, they were not. In that regard, the Provider notes that Consultant Psychiatrist A, during his appointment with the Complainant on 23

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May 2018, and Consultant Psychiatrist B, during his appointment with her on 5 February 2019, both carried out objective testing and a comprehensive report on her overall mental health, and both concluded that the Complainant was fit to carry out her occupation.

The Provider says it is generally accepted that a disabling condition impedes not just an individual from working, but also adversely impacts their ability to perform normal every-day tasks and activities. In this regard, the Provider notes that both Consultant Psychiatrists A and B have outlined in their respective reports that the Complainant can carry out most of the activities of daily living when she has to. While also noting the level of medication that she was taking; both Consultant Psychiatrists still felt that the Complainant was fit to return to her normal occupation.

In addition, the Provider says it is also accepted that working is an integral part of everyday life and resumption of occupational functioning is proven to have therapeutic benefits and promotes overall health and wellbeing. As both Consultant Psychiatrist A and B were of the opinion that the Complainant was fit to resume her normal occupation, the Provider therefore believes that a return to occupational functioning should have been the next natural step as the Complainant moves forward with her life.

In relation to the fact that the Complainant was granted ill heath early retirement in June 2019, the Provider says this is a separate process to its assessment of her income protection claim. The Provider is not aware of the criteria needed to qualify for ill health early retirement and cannot comment on this. The Provider says that moreover, the fact that the Complainant applied for ill health early retirement, and that she now has no job to return to, cannot be factor in its assessment of her claim.

The Provider notes that the claim benefit of **€7,345.03** was calculated based on the Complainant's actual salary, immediately prior to the period of disability, which was confirmed by her employer to be €46,616, and separately by the Complainant herself in the **Claim Form** she completed. The Provider says it has since come to its attention, when reviewing the file in July 2020, as part of this complaint process, that in calculating her claim benefit from 27 January 2018 to 31 August 2018, it had failed to take into account that the Complainant was in fact on full pay with her employer until 16 April 2018, half pay from 17 April to 9 August 2018 and only on nil pay from 10 August 2018. As a result, the Provider says the actual claim benefit should have been **€4,421.72** (four thousand four hundred and twenty-one Euro and seventy-two Cent) based on revised calculations and therefore the Complainant's claim was overpaid by **€2,923.31** (two thousand nine hundred and twenty-three Euro and thirty-one Cent). The Provider says that as a gesture of goodwill, it will not be seeking reimbursement of this overpayment.

Having reviewed all aspects of her file, the Provider is satisfied that the objective evidence obtained, clearly indicates that the Complainant did not meet the **Group Income Protection Scheme** definition of disability and that she was medically fit to return to her normal occupation. In addition, the Provider says that as the insurer, the decision on work disability rests with the Provider alone and having considered her claim, the Provider is not satisfied that there is sufficient evidence to suggest that the Complainant is medically disabled from working.

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Accordingly, the Provider it is satisfied that its decision to cease payment of the Complainant's income protection claim from 31 August 2019 was correct.

The Complaint for Adjudication

The complaint is that the Provider wrongly or unfairly ceased payment of the Complainant's income protection claim from 31 August 2018, notwithstanding that she remained unfit to return to work.

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 **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. In the absence of additional submissions from the parties, within the period permitted, the final determination of this office is set out below.

I note that the Complainant, who was absent from work on a medical certificate from [Date Redacted] **2017**, completed and submitted a **Group Income Protection Claim Form** to the Provider on **23 March 2018.**

I note the Complainant's GP completed a **Practitioner Report** for the Provider on **13 February 2018**, wherein he advised, among other things, as follows:

> *" … **What is the exact nature and cause of disability?***
> *Depression & anxiety*
>
> ***Describe the symptoms which prevent the claimant from working.***

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Low mood & anxiety …

What is your prognosis for the claimant?
Guarded …

Is the claimant in your opinion currently able to carry out <u>all of</u> the duties of their normal occupation?
☐ *Yes* ☑ *No …*

If No, how long is the expected duration of absence as a result of this disability?
☑ *0-3 months* ☐ *3-6 months* ☐ *6-12 months* ☐ *1-3 years* ☐ *3+ years*

If No, please confirm the normal duties of the claimant's occupation that they are currently unable to perform.
All.

Is the claimant currently able to resume their normal occupation on a part time basis?
☐ *Yes* ☑ *No …*

When is the claimant likely to be able to resume full time work?
Unable to say.

Have you discussed returning to work with the claimant?
☐ *Yes* ☑ *No …*

If No please provide an approximate date when these discussions are likely to occur.
06/03/18 …"

I note that following its claim assessment, the Provider concluded that the Complainant was fit to return to work, though in order to assist with a short, phased return to work, it admitted the Complainant's income protection claim from the end of the policy deferred period on **27 January 2018**, to **31 August 2018** and paid a total of **€7,345.03.**

I note that in December 2018, the Complainant appealed this decision to cease payment of her income protection claim but following its review, the Provider wrote to the Complainant on **4 March 2019** to advise that it was standing over its decision to cease benefit. In the meantime, the Complainant had retired from work on ill health grounds in [Date Redacted] 2018.

The Complainant complains that the Provider ceased payment of her income protection claim in circumstances where she remained unfit to return to work.

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I note the Provider says, however, that it is satisfied from the weight of objective evidence before it that its decision to cease payment of the Complainant's income protection claim from **31 August 2019** was correct.

It is not the role of this Office to adjudicate in conflicts of medical evidence. Rather, it is the role of this Office to examine the totality of the medical evidence which was before the Provider to determine whether the decisions made by the Provider in **July 2018** to admit the Complainant's income protection claim but cease payment of it from **31 August 2018**, and to stand over this outcome upon appeal in **March 2019**, were reasonable decisions based upon the medical evidence that was available to the Provider at those times, when it made those decisions now complained of by the Complainant.

I am satisfied that this is in accordance with the views of the High Court in *Baskaran v. FSPO* [2016/149MCA], where the Court confirmed that:

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

The **Group Income Protection Scheme** which the Complainant is a member of, like all insurance policies, does not provide cover for every eventuality. Rather the cover will be subject to the terms, conditions, endorsements and exclusions set out in the policy documentation.

Section IV, '**Claims**', at pg. 10 of the applicable **Policy Conditions** states:

> *"The benefit shall be payable to the claiming member at the end of the deferred period once we are satisfied that the member meets the definition of disability"*.

As a result, in order for income protection to be payable, a claimant must satisfy the policy definition of disability. In this regard, the 'Interpretation' section of the **Policy Conditions** defines '**Disability**' at pg. 4, as follows:

> *"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"*.

In addition, Section IV, '**Claims**', of the **Policy Conditions** states at pg. 11, as follows:

> *"**THE CLAIMS PROCESS** ….*
>
> *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".*

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As part of its claim assessment, I note the Provider arranged for the Complainant to attend for a medical examination with Consultant Psychiatrist A on **23 May 2018**, who in his ensuing **Report** stated:

> *"**History Leading to Absence:***
> [The Complainant] *noticed a gradual onset of depression and anxiety symptoms in 2017. She went to her GP with symptoms in September 2017 and was referred to* [her treating Consultant Psychiatrist]*. By [Date Redacted] she could not cope at all. She said it was a Friday and she just completely fell apart. She said she was not just a bit down, she was extremely upset, crying and afraid. She had a weariness. She said this had had a gradual onset and that the subsequent dark, gloomy winter exacerbated all this. She said it was the longest winter ever.*
>
> ***Psychiatric Symptoms:***
> *… She said her energy crashed. She wonders could the menopause be contributing to all this. Her symptoms were depressed mood, anxiety, sleep disturbance, poor appetite, fear, anxiety, she had great difficulty sleeping, she had a fear of dying. She was hoarding things. Her worst phase was in February and March 2018 where her symptoms, plus change in medication led to her eat almost nothing for the whole month and to have an exacerbation of her symptoms. She felt extremely down, had no energy, could hardly walk, she needed help getting dressed. She was tired, could not sleep, could not even watch television as if she saw an ad for a funeral or for over fifties she would become distressed. She could not concentrate. From March onwards she felt some improvement and has made significant progress but is not back to her old self yet.*
> *She has no obsessional checking and no obsessional thoughts and no phobias.*
>
> ***Current Treatment:***
> *She is not on any psychotherapy yet as* [her treating Consultant Psychiatrist] *told her that she was too unwell to engage in talk therapy. Her current medication in Valdoxan 50mg at night time, Lithium 800mg at night time, Circadian 2mg at night, Lyrica 125mg three times daily.*
>
> ***Psychiatric History:***
> *She had postnatal depression 21 years ago and had some episodes of depression treated with antidepressants but never anything as severe as her current depression and anxiety …*
>
> ***Patient's Perception of what's stopping her from Working:***
> *She said she cannot focus and cannot remember things. She gave an example of being unable to remember the tablets she was on some years ago. But she did recall after an effort that it was Cipramil. She said she might go upstairs to get something and forget what it was, or she might go up to get things to put in the washing and forget to bring them down. She has to make notes to remember things.*

/Cont'd…

> ***Structured Inventory of Malingered Symptomatology (SIMS):***
> *This is a 75 item, multi-axial scale assessing exaggeration of psychiatric symptoms. A total score above 14r suggests the possibility of exaggeration of symptoms.*
>
> [The Complainant] *scored 24 on the SIMS.*
>
> ***Mental State Examination:***
> [The Complainant] *looked well and was very stylishly groomed. She was friendly and cooperative throughout. Her mood was good. She was not anxious. Her attention and concentration were very good. The examples of forgetting she gave were all examples of everyday normal forgetting. She was not overtly distressed or upset at any point during the interview …*
>
> [The Complainant] *has a diagnosis of major depressive disorder with anxiety, currently in partial remission …*
>
> *The prognosis is good. She has made significant progress towards recovery.*
>
> *It is my opinion that that* (sic) [the Complainant] *is currently fit to carry out her normal occupation on a part time basis. She is fit to work half time and this could be gradually increased over a period of eight weeks to full time"*.

In that regard, I note that Consultant Psychiatrist A concluded that the Complainant was able to perform the material and substantial duties of her normal insured occupation, albeit that he recommended she return to performing these duties full time, on a phased basis, over an eight week period. I accept that such a phased return to full time hours is a typical and suitable plan, where the employee has been absent for a prolonged spell.

Following its claim assessment, I note the Provider wrote to the Policyholder's broker on **10 July 2018** to advise, as follows:

> *"*[The Complainant] [recently] *attended an Independent Medical Examination. The outcome of the examination was that she is fit to return to her normal occupation on a phased basis. To allow this phased return we are paying the claim in full up to the 31 August 2018. The gross payment for the period 27 January 2018 – 31 August 2018 is for €7,345.03. This payment will be issued on 25 July 2018. Please note as* [the Complainant] *has been deemed fit to return to work there will be no further payments on the claim".*

In this regard, I note the Provider admitted the Complainant's claim for a period of 7 months, from 27 January 2018 (being the end of the policy deferred period) to 31 August 2018 in the amount of **€7,345.03**, with no further payments thereafter. I note the Provider advises that it paid the claim up to 31 August 2018 to allow the Complainant time to make arrangements to return to work on a phased basis, building up to full time hours, in line with the return to work time frame recommended by Consultant Psychiatrist A.

/Cont'd…

I note from the documentary evidence before me that the Complainant appealed the claim decision to cease payment of her income protection claim by submitting a letter from her treating Consultant Psychiatrist dated **17 December 2018**, which stated:

> *"I confirm that* [the Complainant] *attends me with a diagnosis of severe & chronic depression/anxiety syndrome. She requires to take significant doses of psychotropic medication including anti-depressant, anxiolytic and mood stabilizing medications. She needs to attend on a 3-weekly basis and requires considerable psychotherapy also. She last attended on 11/12/18 & at that consultation I deemed her unfit to return to work. The prognosis in this case is guarded in view of the severity & chronicity of symptomatology on presentation".*

I note that in his short letter dated **8 January 2019**, the Complainant's treating Consultant Psychiatrist similarly stated that:

> *"I confirm that* [the Complainant] *attended me with a diagnosis of severe and chronic depression/anxiety syndrome. She requires to take significant doses of psychotropic medication including anti-depressant, anxiolytic and mood stabilizing medication. She needs to attend on a 3-weekly basis and requires considerable psychotherapy also.*
>
> *She last attended on 3rd January 2019 and at consultation, I deemed her unfit to return to work. The prognosis in this case is guarded in view of the severity and chronicity of symptomatology on presentation".*

I note that no further details were offered at that time as to the Complainant's current symptoms, but instead the letter referred only to her ongoing medication and psychotherapy.

I note that as part of its appeal review, the Provider arranged for the Complainant to attend for a medical assessment with Consultant Psychiatrist B on **5 February 2019**, who in his **Report** of the same date stated:

> *"**Current Symptoms and Stressors***
> [The Complainant] *said she feels "anxious…scared at times". She gets nervous meeting others and avoids her neighbours. She puts off leaving her house for any reason and is not as "outgoing" as before.*
>
> [The Complainant] *said her confidence is low and her concentration in poor. She said she loses her train of thought in conversation and reports word finding problems. She does not phone people in case she cannot follow the conversation.*
>
> *She cooks for her son who has* [redacted*] and eats a restricted range of food types. She rarely cooks for herself and her own diet is limited. However, she reports no weight loss. She watches television but said she gets upset seeing adverts about life insurance or planning for death. She also gets "freaked out" by seeing others ageing …*

/Cont'd…

She is separated from her husband, but they still live together. She said she cannot afford to get a place of her own. She worries about her son who is [redacted]. *He is resistant to going out and meeting friends. He has a dislike of noise and people and his self-care is modest. She worries what would happen to her son were she to become unwell to care for him. She hoarded groceries and clothes in the past, but said this is not an issue now. She is future orientated and not suicidal.*

Treatment

[The Complainant] *attends…Consultant Psychiatrist every three weeks. She is prescribed Pregabalin (for anxiety) 200mg three times daily, Agomelatine (antidepressant) 50mg at night, Lithium (mood stabiliser) 800mg at night and Melatonin 2mg at night for sleep.*

[The Complainant] *meets an Employee Assistance Officer on a monthly basis. Her officer felt she needed regular counselling and she has her first appointment with a Counselling Service…tomorrow.*

Daily Routine

[The Complainant] *said she gets up by 10:30 most mornings. She lets her dog out into the garden and has a light breakfast. She has no set routine to her day. She might do some light house work and watched TV in the afternoon.*

She depends on her sister who takes her to the shops or delivers her groceries to her. [The Complainant] *said she has not driven for over a year now as she feels her concentration is not good enough. Her sister is about to go on holidays to USA for six weeks and* [the Complainant] *is not sure how she will manage when she is away.*

She likes to sit in her garden, but does not take an active interest in maintaining it. She said her sister took care of her garden all last year. She said she cannot concentrate enough to read and this has been a longstanding problem for her.

She sometimes talks to friends over the phone. Once every few months, she might meet her friend for a cup of tea. She chats to her, watches TV in the evening and usually goes to bed about 01.00 hours.

Work Issues

[The Complainant] *has worked for* [her employer] *for over 30 years. She lives close to her work (5-minute drive) and said she liked her job and colleagues. She hopes to return "at some stage". She does not feel ready at the moment and said her concentration is too poor for her to work. She said family and friends have remarked that she regularly drifts out of conversations.*

[The Complainant] *also feels that changes will have happened at work and that she will need to up skill on current work practices. She also feels less connected with her colleagues as she has not worked for over a year now. She said "everybody has moved*

/Cont'd…

on" and she lacks confidence to return. She feels she will not be able to follow phone conversations [due] *to her problems with concentration.*

An officer from her Employee Assistance Programme and her Company Doctor both feel she is too unwell to return to work. She has no back to work plan at present …

Mental State Examination

[The Complainant] *was a neatly* [dressed] *lady with good self-care. She was wore* (sic) *make-up, her hair was styled and her nails manicured. She was accompanied to the appointment by her brother-in-law.*

She was cooperative and was not anxious or tense. Objectively, she was not depressed and she had no evidence of psychomotor retardation.

She reported cognitive problems, but these were not evident during the assessment. She maintained good attention and concentration throughout. Her memory was good in terms of recounting her history and current problems. She was not psychotic. She was future orientated and not suicidal.

Some of her reported of (sic) *symptoms were vague such as her fear of dying and not being able to watch certain TV adverts or seeing people she knows grow older. Her elevated scoring on the SIMS (as per IME with* [the Consultant Psychiatrist A] *on 23/05/2018) was noted testing was not repeated today.*

MoCA

This measure of cognitive functioning assesses areas such as executive function, memory, attention, delayed recall and orientation. It is measured out of 30 and scores of greater than 26/30 are considered normal.

[The Complainant] *scored 29/30.*

Rey Test

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

[The Complainant] *scored 11/15.*

Conclusion *…*

Q1 *Diagnosis*
Depression …

Q3 *Current mental state*
… [The Complainant] *reports cognitive problems, however, she scored fine on objective testing of cognition (MoCA). She has no evidence of psychosis and objectively she was not depressed on mental state examination.*

/Cont'd…

Q4 *Current symptoms*
… [The Complainant] *reports depressive symptoms and she has become dependent on her sister. However, she is able to look after herself and carry out most normal daily activities when she has to. Any current depressive symptoms are mild and not disabling.*

Q10 *Is* [the Complainant's] *fit to carry out a normal occupation as an Executive Officer?*
[The Complainant] *is fit to carry out a normal occupation. I could not find evidence of disabling psychiatric symptoms or a disorder that would prevent her from working. She reports cognitive problems, but these were not evident on objective testing. She is independent in many ways and is fit to return if she so wishes. However, her motivation to return seems low. Further, the longer she is on sick leave, the more deconditioned from working she will become and the more difficult it will be for her to return in the future …"*

Consultant Psychiatrist B thus concluded that the Complainant was fit to carry out the role of an Executive Officer, which I accept is, in the context of the relevant **Group Income Protection Scheme** policy conditions, the *"normal insured occupation"* of the Complainant.

Having completed its appeal review, I note the Provider wrote to the Complainant on **4 March 2019** to advise that it was standing over its decision to cease payment of benefit.

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

The Complainant's income protection claim is governed by the terms and conditions of the **Group Income Protection Scheme**, which forms the basis of the contract of insurance between the Provider, the Policyholder and the Complainant. In order for an insured person to be eligible for income protection, he or she must satisfy the policy definition of disability. I am satisfied that the Provider, as an insurer, is entitled to form its own reasonable views on a claimant's fitness or otherwise for work and to arrive at its own conclusions on the basis of the medical evidence available to it, when making decisions on claims.

Whilst it is clear and I accept that the Complainant had been diagnosed with and was continuing treatment for depression and anxiety, I take the view that the diagnosis and treatment of a medical condition, be it chronic or otherwise, is not, in and of itself, sufficient to validate an ongoing income protection claim. Neither does it automatically equate to "disability" within the policy definition. In this regard, there are many people who have been diagnosed with an illness or a condition and who receive ongoing treatment but who, at the same time, and often as a result of the medication that they are taking, are fit to work and do work.

/Cont'd…

Instead, for a valid income protection claim to arise or to continue in payment, I am satisfied that it is the role of the Provider, as the insurer, to determine from the weight of the objective medical evidence before it, whether the claimant's symptoms are of such severity that they render him or her unable to perform the material and substantial duties of his or her normal occupation, as a direct result of that diagnosis and/or treatment, as required by the **Group Income Protection Scheme** terms and conditions.

On the basis of the medical evidence available, I am of the opinion that it was reasonable for the Provider to conclude from the medical evidence before it, and which I have cited from at length above, that the Complainant no longer satisfied the **Group Income Protection Scheme** definition of disability from 31 August 2018. I accept that in those circumstances, the Provider was entitled to cease payment of her income protection claim from that date.

I note the Complainant was granted early retirement on ill-health grounds by her employer on **15 June 2019**. In his letter to the Provider dated **25 October 2019**, I note the Complainant's husband submits that:

> *" … From my understanding it is extremely rare for an employee of* [the Complainant's] *age to be granted retirement on ill health so the Chief Medical Officer would have had to be certain that she was unable to perform the material and substantial duties of her normal insured occupation as a result of her illness for the foreseeable future, in order to make such a decision … "*

In this regard, an ill-health retirement application will be determined according to the specific criteria of the employer's pension/ill-health retirement scheme. Any decision made by the employer's Chief Medical Officer is not a matter for this Office. Income protection claims must be assessed according to the insurer's specific policy definition of disability. There can be differences between those criteria and a person may be eligible and accepted for ill-heath retirement but yet not meet the specific policy criteria for continuation of income protection benefits. Indeed the reverse can also be true

As a result, I accept that the fact that the Complainant has retired on ill-health grounds, does not directly impact on the assessment by this Office of the Provider's decision to cease payment of income protection benefit to the Complainant, as those decisions by the Provider can only be assessed against the medical evidence which was available to the Provider at the times when it made those decisions.

In relation to the pay scale the Provider used in calculating the claim benefit paid, I note the Complainant's employer completed a **Request for Information from Employer** form to the Provider on 7 March 2018 wherein it advised:

> *"**Actual annual salary immediately prior to the last period of disablement €**46,616".*

In addition, in the **Claim Form** she completed, the Complainant advised:

> *"**What was your pre-disability salary?***

/Cont'd…

€46,616.00".

I am therefore satisfied, in the absence of any clarifying documentation from the Complainant's employer, that it was reasonable for the Provider to use this salary amount as the basis for its claim benefit calculations.

I note the Provider has advised that it has since come to its attention, when reviewing its file in July 2020 as part of this complaint process, that in calculating her claim benefit from 27 January 2018 to 31 August 2018, it had failed to take into account that the Complainant was in fact on full pay with her employer until 16 April 2018, she was on half pay from 17 April to 9 August 2018 and was on nil pay, only from 10 August 2018.

In this regard, I note the **Request for Information from Employer** form that the Complainant's employer completed to the Provider on 7 March 2018 advised:

> *"**Date on which full salary ceases to be paid:** 26.01.2018*
>
> ***Date on which half salary commences:** 27.01.2018*
>
> ***Date on which half salary ceases to be paid:** 19.02.2018*
>
> ***Date on which TRR** [Temporary Rehabilitation Remuneration] **will commence:** 20.02.2018"*.

However, I note from the documentation before me that the Complainant's employer subsequently confirmed to the Policyholder's broker by email on 17 May 2018, which the broker then confirmed to the Provider by email on 18 May 2018, the following revised dates:

> *"Full Pay:[Date redacted],17 – 16.04.18*
>
> *Half Pay: 17.04.18 – 09.08.18*
>
> *TRR: 10.08.18 – ongoing"*.

It is regrettable that the Provider failed to use these revised dates when later calculating the claim benefit due to the Complainant, instead relying upon the dates previously furnished by the employer in March 2018, thereby resulting in a claim benefit overpayment of **€2,923.31** to the Complainant. I note, however, that the Provider has confirmed that it is not seeking the repayment of this overpayment, which in my view is a fair and appropriate approach for the Provider to adopt in this matter.

Having regard to all of the above, I am satisfied that the evidence does not support the complaint that the Provider wrongly or unfairly ceased payment of the Complainant's income protection claim from August 2018. I take the view that on the basis of the medical available to the Provider at the time of its decision, and its subsequent decision on appeal, this was a reasonable position for the Provider to take.

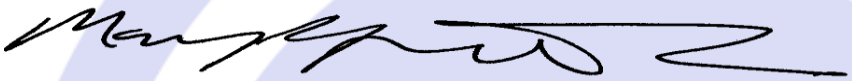
/Cont'd…

It is my Decision therefore, on the evidence before me that this complaint is not upheld.

Conclusion

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

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



MARYROSE MCGOVERN
Deputy Financial Services and Pensions Ombudsman

17 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.