An tOmbudsman Seirbhísí Airgeadais agus Pinsean
Financial Services and Pensions Ombudsman

Decision Ref:	2022-0296
Sector:	Insurance
Product / Service:	Travel
Conduct(s) complained of:	Rejection of claim Rejection of claim - late notification
Outcome:	Rejected

LEGALLY BINDING DECISION OF THE FINANCIAL SERVICES AND PENSIONS OMBUDSMAN

The complaint arises following what the Complainant has said was the failure by orthopaedic doctors in the United States, to accept her travel insurance policy as adequate insurance cover, after she sustained a wrist injury. Another issue arises from the Provider declining her "Personal Accident" insurance claim under the Policy.

The Complainant's Case

The Policy was incepted by the Complainant on **18 January 2018**. She travelled to the United States and was covered for the period **06 February 2018** to **27 April 2018**.

Whilst in the United States, the Complainant had an accident on **25 February 2018** suffering an injury to her wrist. The Complainant contacted the Provider's emergency assistance service, approximately 2 weeks later, on **13 March 2018** to notify it of her injury.

On **15 March 2018** the Provider's emergency assistance service provided authorisation to the hospital in the USA for the Complainant to have surgery on **16 March 2018** and confirmed that the surgery would be covered under the Policy.

The surgery was postponed until the **23 March 2018** due to the Complainant falling ill, and the Provider's emergency assistance service again confirmed and authorised the surgery scheduled for the **23 March 2018,** as covered under the Policy.

The Complainant never underwent the surgery. The Complainant submits that the Policy was not accepted by the orthopaedic doctors at the relevant hospital in the United States. The Complainant submits in her complaint to this Office on **01 April 2019** that:-

> *"Now after a long time of back-and-forth correspondence with [the Provider], they are still insisting that they were not in the wrong by not being there for me and that their / my travel insurance was not accepted by all 7 Orthopaedic Doctors in the Napa Valley / California. They have not taken my claim seriously at all and have avoided from the start of my claim to explain why in their policy it does not say "we cannot be held responsible for a doctor / doctors refuse our Travel Insurance. Which is exactly what happened to me much to my shock, surprise and disappointment which has left me with a permanently disabled left wrist."*

Further the Complainant states on **01 April 2019**:-

> *"I must also tell you that I have taken out [Provider] insurance twice a year for quite some years now and have always read my travel Insurance Cover details and have always felt safe and have had faith in them until now, my very first time I needed them, it didn't work. This – my first claim and letter. I don't want to go on and on and I have written so many letters since May 2018.*"

In referencing all of the medical reports and medical information the Complainant submits:-

> "*The Provider by law has to give you my file with photos and all the correspondence all the letters and emails I sent it, and all the letters and emails that it sent me – including an email and report from my GP [GP's name] a report from [doctor's name] who the Provider made me go and see and who took three months to send [the Provider] his report and the report from NHS Orthopaedic [name redacted] from [hospital name redacted]."*

In explaining the impact this dispute with the Provider has had on the Complainant, she submits:-

> *"The only reason I have been going to California twice a year since 2011 is to look after and spend time with my mother and father whom I love very much. My dad unfortunately died in 2014 but I have kept going to spend time with and look after my mother twice a year. Due to [the Provider] I was unable to see my mother the second time last year because they have kept me waiting for responses from them from the report from my GP. Then had to wait to see their Independent Orthopaedic [doctor's name] who I saw in September last year – it was booked for October but I called them and was lucky to bring forward to September and then he took 3 months to send them his report – keeping me waiting again. Then I had to see my GP again to be referred to an Orthopaedic Consultant at [hospital name] which took 4 weeks – waiting again – and all along I knew it was too late for an operation because the self-healing of my wrist was very far gone and it was no more an emergency*."

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The Provider's Case

The Provider issued its Final Response Letter on **18 February 2019** to the Complainant. In it the Provider states:-

> *"Firstly, to respond to the allegations that we "were / are the reason your wrist is the state that it is", your unfortunate accident occurred on 25 February 2018. The first contact to our Emergency Assistance Service* [Named] *to notify them of your wrist injury was not until 13 March 2018."*

The Provider in its Final Response Letter highlights the "*Emergency and medical service*" and "Medical Assistance Abroad" clauses of the Terms and Conditions of the Policy which state:

> "***Emergency and medical service clause***
> *In the event of a Serious Illness or Bodily Injury which may lead to in-patient hospital treatment or before any arrangements are made for repatriation You must contact the Emergency Assistance Service. The service is available to You and operates 24 hours a day, 365 days a year for advice, assistance, making arrangements for hospital admission, repatriation and authorisation of medical expenses. If this is not possible because the condition requires immediate emergency treatment You must contact the Emergency Assistance Service as soon as possible. Private medical treatment is not covered unless authorised specifically by the Emergency Assistance Service.*
>
> ***Medical Assistance Abroad clause***
> *The Emergency Assistance Service has the medical expertise, contacts and facilities to help should You be injured in an accident or fall ill. The Emergency Assistance Service will also arrange to transport You Home when it is considered to me medically necessary."*

The Provider in its Final Response Letter then highlights the following conditions contained within the "*Emergency medical and other expenses*" clause that is contained within Section B of the Terms & Conditions of the Policy. The specific clause referenced within Section B is the "***Special conditions relating to claims, subsection 1***" which states: -

> 1. *You must give notice as soon as possible to the Emergency Assistance Service or Us of any Bodily Injury or Serious Illness which necessitates Your admittance to hospital as an in-patient or before arrangements are made for Your repatriation. There is no cover under this policy for expenses incurred without Our approval."*

The Provider in its Final Response Letter set out a timeframe for when it was contacted about the injury and when approval for the said surgery was provided. The Provider states:-

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"Following your notification, [Emergency Assistance Service] *gathered the necessary medical information and on the 15 March 2018, authorisation was given for you to have surgery in the USA on 16 March 2018. On 16 March 2018, the hospital contacted* [Emergency Assistance Service] *to advise that the surgery had to be postponed until 23 March 2018 as you were suffering from diarrhoea and chills.* [Emergency Assistance Service] *acknowledged this information and again confirmed to the hospital that the costs of the surgery on 23 March 2018 would be covered on the policy.*

On 24 March 2018 [Emergency Assistance Service] *telephoned you to see how the surgery had gone. The call went straight to your voicemail and a message was left asking you to make contact to update* [Emergency Assistance Service] *on how you were after the surgery.*

As [Emergency Assistance Service] *had no response to their voicemail an e-mail was sent to you on 25 March 2018. Again, there was no response and so on 27 March 2018 another telephone call was made to you which again went straight to your voicemail and a message was left for you. Also, on this date* [Emergency Assistance Service] *sent an email to you asking you how your surgery had gone and if you had a follow up appointment booked."*

The Provider in its Final Response Letter then references an e-mail sent by the Complainant to [Emergency Assistance Service] on **28 March 2018** stating:-

"Thanks for asking about my surgery. Well, I saved you some money because I had to talk to the Doctor who was going to perform the surgery the day before and I told him I don't think I need surgery and he went through my notes and X-rays again and he agreed with me so yesterday Monday 26 March he put a cast on and is taking it off on Monday 16th April. So, it all worked out for the best. I suppose this will mean I will not have to pay for my next insurance with you as it turned out for the best for you and me. Best regards and thanks again!"

Personal Accident Claim

Regarding the Personal Accident claim made by the Complainant, the Provider in its Final Response Letter advised: -

"Turning to your comments regarding the Personal Accident benefit on your policy, we have taken on into account all of your comments and reviewed them together with the policy terms and conditions however we cannot agree that your circumstances, unfortunate as they clearly are, meet all three of the "Special conditions relating to Personal accident claims":

1. *Our Medical Practitioner may examine You as often as We deem necessary in the event of a claim.*

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2. *Under Permanent Total Disablement, You need to be in receipt of the applicable disability benefit from Your local government body.*
3. *Under Permanent Total Disablement, You need to be certified by Our Medical Practitioner that there is no likelihood of an improvement in Your condition."*

The Provider references two medical reports / letters, the first from an Independent Orthopaedic Surgeon appointed by the Provider where it states:

> *"that having assessed your injury he recommends that you be assessed further by way of up to date x-rays as well as a CT scan with 3D reconstruction views. [Doctor's name] has stated that the benefit of such imaging would be to "delineate indeed quantify the nature of the injury to the wrist and, in particular, the status of the radiocarpal joint", [doctor's name] believes that this would help to advise with regards to further potential treatment.*
>
> *[Doctor's name] advises that the two potential options surgically would be either a corrective osteotomy of the wrist or alternatively a formal wrist fusion. [Doctor's name] has suggested that there may be an improvement in your condition following one of the suggested surgical options above."*

The Provider also referred to a second report/letter (from a separate Consultant Orthopaedic Surgeon with whom the Complainant attended of her own accord) This was dated **07 December 2018,** referred to a clinic date of **04 December 2018,** and stated:-

> *"Clinically the deformity is very obvious. In fact functionally she is getting better and better with it. She is starting to use it more now and the range of movement of the wrist is starting to come back as is the strength. It is obviously some way from normal but clinically she doesn't seem to have a great deal of pain from it…….*
>
> *……. In view of her functional improvement over the last few months she is a bit hesitant about taking the risk of surgery which is not unreasonable. I have suggested to her that she carries on with her rehab and use of the hand and see how much trouble she gets from it. I have booked her appointment for six months' time so that we can reassess the situation. The surgery, if she does wish to proceed could be performed at any stage."*

The Provider in its Final Response Letter concluded by referring to both medical reports / letters and stating:-

> *"as you have not been certified that there is no likelihood of an improvement in your condition, I regret that the decision previously communicated in this matter remains unchanged."*

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The Complaint for Adjudication

The first complaint is that the Provider's Policy was not accepted by the orthopaedic doctors at the relevant hospital in the United States when the Complainant first suffered her wrist injury. The Complainant claims that the Policy was therefore inadequate and failed to provide her with the cover she had expected from the Provider.

The second complaint is that the Provider wrongfully refused to admit the Complainant's Personal Accident claim, for payment of benefit.

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 **5 August 2022**, outlining the preliminary determination of this office in relation to the complaint. The parties were advised on that date, that certain limited submissions could then be made within a period of 15 working days, and in the absence of such submissions from either or both of the parties, within that period, a Legally Binding Decision would be issued to the parties, on the same terms as the Preliminary Decision, in order to conclude the matter. Following the consideration of additional submissions from the parties, the final determination of this office is set out below.

I note that the Provider submitted a copy of its Insurance Schedule which displays the date of purchase by the Complainant on **18 January 2018** and clearly outlines the period of cover from **06 February 2018** to **27 April 2018**.

The Provider also supplied a copy of the Terms and Conditions of the Policy that was given to the Complainant when the Policy was purchased. The Provider specifically references the following sections and clauses of the Policy. The "*Emergency and medical service*" clause and the "*Medical assistance abroad"* clause, on **page 21** of the Terms and Conditions. Both clauses have been outlined in full above.

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Further the Provider specifically references the "*Special conditions relating to claims, subsection 1*" clause contained within Section B on **page 24** of the Terms and Conditions. This clause has also been outlined in full above.

The following key correspondence and interactions between the Complainant, [Emergency Assistance Service] and the Provider during the period between **15 March 2018** and **26 February 2019** are noted: -

15 March 2018 – An e-mail from [Emergency Assistance Service] to the Provider outlining the details of the Policy, details of the accident and interactions it had with various hospitals in the United States. In this e-mail [Emergency Assistance Service] stated: -

> *"On the 13th March we received a call from* [Complainant] *asking for authorisation for her to undergo surgery on her wrist on the 16th of March. We confirmed with [*Complainant] *that on the 25th of February, she suffered a fall on to her right arm whilst out on a walk due to icy conditions.* [Complainant] *attended the emergency room in* [Hospital 1*] where she underwent an x-ray and the diagnosis was confirmed to be a displaced left distal radius fracture. When* [Complainant] *was questioned as to why she did not call us initially at the time of her incident, she stated that* [Hospital 1] *had accepted all of her insurance paperwork and she believed they would get in touch with us, we have had no contact from them to date.*
>
> *[Complainant] stated that after her visit to the emergency room she was referred to an orthopaedic doctor, who she could not tell us the name of, for further treatment and a review for surgery, but he would not accept her insurance policy. [Complainant] stated that she struggled to find an orthopaedic doctor for further treatment until the 12th March where she was seen in* [Hospital 2] *and referred to have surgery, it was at this point that she made us aware as the hospital would not carry out her surgery without our pre-authorisation.*
>
> *We immediately made contact* [Hospital 2] *… we have confirmed that medically the injury is coverable as a trauma. We are not as yet in a position to cover the entirety of the claim, due to the costs going above our delegated authority, and by her not contacting us sooner we feel she had prejudiced your position on the claim.*
>
> *Our Doctor has reviewed all the medical information and is in agreement with the treating Doctor that the surgery should take place abroad. This decision is largely due to the late notification that we received from* [Complainant] *by not alerting us sooner she has missed the two week surgical window in which we would have brought her back to the UK to undergo further treatment. By missing this window* [Complainant] *has increased her risk of malunion, and it is no longer medically reasonable or logistically possible to consider bringing her home for surgery.*
>
> *We would advise that as soon as the* [Complainant] *is fit to fly that she return to the UK, due to her higher risk of injury and further claim as a result. We would advise that she travel in a business class seat with a possible non-medical escort for assistance.*

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The medical information confirmed that [Complainant] *had difficulty finding an orthopaedic Doctor after her injury on the 25th February, so much so that she went back to* [Hospital 1] *on the 6th March and then was referred to* [Hospital 2]. *We have acknowledged* [Complainant's] *reasons for not initially calling us on the 25th, as she thought that the hospital was going to make contact with us, but have specifically asked why she did not call us in the two week interim when she was looking for further treatment.*

[Complainant] *has not answered this question and is being uncooperative, and hard to contact, in providing us with any information to move the case forward, as she does not see the need to provide us with explanations and information and she has paid for an insurance policy, even though it has been clearly stated to her that this is detrimental to moving her case forward and considering authorisation for her surgery, I am still chasing her response."*

16 March 2018 – An e-mail from [Emergency Assistance Service] to the Provider, providing an update on some of the Complainant's medical information. At the end of the e-mail it states: -

"I will update you as soon as we know how the surgery went today."

16 March 2018 – An e-mail from the Provider to [Emergency Assistance Service] where the e-mail states: -

"The extent of our cover is the operation and the follow up physiotherapy (subject to the applicable policy excess). We are currently of the view that this customer has prejudiced our position by not contacting us in a timely manner so that we could manage the loss. I would remind the customer that there is an onus on her to mitigate our loss and she has failed to do so by her actions."

23 May 2018 – An e-mail was sent from the Complainant to the Provider stating that there was a letter attached (there was no letter attached to the e-mail) and also included photos of the Complainant's injured wrist.

23 May 2018 – The Provider replied to the Complainant's e-mail of the same date and attached a claim form for the Complainant to complete and return. The Complainant was also asked for the following documentation:-

- *"Receipts of any medical expenses claimed.*
- *Signed travel insurance certificate.*
- *Copy of your private health insurance (if applicable). "*

24 May 2018 – The Complainant e-mailed the Provider stating:-

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"Can you please tell me what exactly you are going to do about getting compensation. I want the Doctors to pay me compensation. I really am in a lot of stress after my GP told me that there is nothing he can do about it and that my hand will be permanently deformed angulated for the rest of my life. My life is totally different now that I don't have my left hand anymore. I really appreciate your help and have confidence in whatever you decide to do about it."

25 May 2018 – The Provider by e-mail responded to the Complainant's e-mail of **24 May 2018** stating: -

"In respect of your request to take action against the doctors / orthopaedic consultants in [Hospital 1] *California, I would draw your attention to Section J of your Policy, "Overseas legal expenses and assistance" where it states:*

What is not covered
We shall not be liable for:

2. Legal costs and expenses incurred in pursuit of any claim against a travel agent, tour operator, carrier, airline, medical establishment, US, Emergency Assistance Service or their agents, someone You were travelling with, a person related to You, a Travelling Companion or another Insured Person.

Therefore I regret to advise you that any action that you may choose to take against [Hospital 1] *would be a personal matter and would be excluded from cover under your travel insurance contract. Upon receipt of your completed claim form and the supporting documentation I will be in a position to review your medical expenses claim."*

25 May 2018 – A copy of the claim form signed by the Complainant on this date.

31 May 2018 – A letter was sent from the Provider to the Complainant reiterating the message almost word for word contained in the e-mail sent by the Provider to the Complainant of **25 May 2018**.

13 June 2018 – The Complainant wrote a letter to the Provider stating:

"I have gone through a solicitor in [UK city]. *I am enclosing a copy of their final letter to me. So, I have tried even through a USA Attorney to get some kind of compensation – I was pursuing this because I just wanted compensation so that I could try and get an Orthopaedic Doctor to fix my left wrist/hand. I am also enclosing a letter (e-mail) from my GP over here so that you can know for sure that I have lost the use of my left hand permanently. It is deformed and angulated and has changed everything in my life. Bathing, showering, dressing and so many more things have become painful and difficult……My GP here (NHS) has told me that there is nothing he can do because the healing process had advanced too much.*

/Cont'd…

I have read again and again through all the fine print in my Insurance Policy and I can't find anywhere where it says that I am not insured for all doctors or any doctors or any hospitals. It does not say anywhere that doctors or hospitals don't take your insurance.

Why have I paid out a lot of money for Insurance for nothing. Because of [the Provider's name] I am now disabled. This is not something trivial……I expected, at the least, to get compensation from the Orthopaedic Doctors who refused to take Your Insurance, but I won't. So now I have no option but to get compensation from my Insurance Company [the Provider]."

Attached to the Complainant's letter of **13 June 2018** was a letter from a US lawyer dated **06 June 2018** and the Complainant's GP dated **14 May 2018**. The letter from the US Lawyer states:-

"Unfortunately, the U.S. Attorney does not feel your claim has significant prospects of success and regrettably does not wish to take the matter on. The U.S Attorney has explained that in relation to your circumstances you have two potential claims.

The first is in relation to the fall you had on the grass. Given the circumstances and your comments on the fall, there does not appear to be any blame for what occurred and therefore there is no one to bring this claim against.

The second is in relation to a potential medical negligence claim. The standard of proving this is extremely high. You would be under an obligation to prove that the refusals to treat you were unjustified and that you were not warned about the dangers of delay. You would also be required to prove via expert medical evidence that had you seen an Orthopaedic expert when first sent to one, the outcome in relation to your injury would have been different. This is very difficult to establish."

The e-mail from the Complainant's GP dated **14 May 2018** states: -

"I can confirm that you suffered a wrist fracture in the USA. The fracture was not operated on at the time. I can confirm that there is significant angulation and deformity at the wrist which is likely to be permanent."

15 June 2018 – The Provider wrote by letter to the Complainant. In this letter the Provider states:

"I believe from your recent correspondence that you wish to claim a compensation payment under the Personal Accident section of your Travel Insurance Contract. The compensation payment sought is because you view your personal medical circumstances, as befitting to the contractual definition of Permanent Total Disablement."

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The Provider references "*Permanent Total Disablement*" as defined in the Terms and Conditions of the Policy as outlined under Section D **page 26** where it states: -

> *"**Permanent Total Disablement***
>
> *Means a physical or mental impairment that has a substantial and long-term adverse effect on Your ability to carry out any form of employment and at least three of the following normal day to day activities:*
>
> - *Dressing and undressing.*
> - *Personal hygiene.*
> - *Getting up and down a flight of stairs.*
> - *Getting in and out of bed or chair.*
> - *General household duties including cleaning, ironing or shopping.*
>
> *We will consider You are unable to perform an activity when the following applies:*
>
> - *You are unable to perform the activity even with the use of equipment and;*
> - *You always need the help of another person to perform the activity."*

The Provider in the same letter of **15 June 2018** references the "*Special conditions relating to Personal accident claims"* clause contained in the Policy's Terms and Conditions on **page 27:**

> *"Special conditions relating to Personal accident claims":*
>
> 1. *Our Medical Practitioner may examine You as often as We deem necessary in the event of a claim.*
> 2. *Under Permanent Total Disablement, You need to be in receipt of the applicable disability benefit from Your local government body.*
> 3. *Under Permanent Total Disablement, You need to be certified by Our Medical Practitioner that there is no likelihood of an improvement in Your condition.*
>
> ***Provisions***
>
> 1. *Benefit is not payable to You:*
>
> a) *Under more than one of items 1., 2., or 3.*
> b) *Under item 3. Until one year after the date You sustain Bodily Injury*
> c) *Under item 3, if You are able or may be able to carry out any relevant employment or relevant occupation."*

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The Provider in its letter of **15 June 2018** then states:

> *"I would like to draw your attention to the provisions mentioned above, whereby, it advises that any payment under the personal accident section of your policy is not payable until one year after the date that you sustained the injury.*
>
> *At this juncture I have written to your General Practitioner [Doctor's name and practise location] for additional information in support of your claim. Upon receipt of this additional medical information, if we deem it necessary, we may arrange for you to be examined by an independent medical practitioner."*

15 June 2018 – the Provider wrote to the Complainant's GP seeking copies of medical records including consultation dates, treatments and medications prescribed from **27 April 2018** to date.

21 June 2018 - The Complainant wrote a letter to the Provider. This letter was not received by the Provider until **12 July 2018**. The letter states:

> *"I have to rely on friends to help me. Luckily, I share a bungalow with a good friend. She helps me get in and out of the bath because I can't do it on my own with the use of only one hand and I am worried about falling in the bath and doing myself more harm…….*
>
> *I automatically use my left arm sometimes and it just causes more pain. I wear a brace most of the time but take it off occasionally to try and exercise or use my left hand……*
>
> *It is very difficult to come to terms with the fact that I have lost a hand. Everything I do takes so much longer. It is very frustrating and very depressing. I love to cook, which now I am not able to do…….*
>
> *I would like to consult an Orthopaedic Doctor outside of the NHS to see if someone can fix my hand…….I need this compensation to afford an Orthopaedic Doctor. Leaving it for a year is like torture to me. I have recently applied for disability allowance and you should know that it takes time to hear back from them…….*
>
> *So the 5 things you want to know about my daily activities:*
>
> 1. *Dressing and Undressing – takes me longer and can be painful.*
> 2. *Personal Hygiene – I need help with which I have explained.*
> 3. *Up and down stairs – there are no stairs in a bungalow and I avoid stairs if I can. If I do have to use stairs I am very careful. I use a handrail with my right hand.*
> 4. *In and out of bed. I use my right arm carefully.*
> 5. *General Household Duties – I can't cook, I can't iron, I can do some cleaning with my right hand, but not as much as I used to do. I can't move the lawn. Shopping is difficult, I need to ask people to pack my shopping. I only do small shops. At least I have my legs."*

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26 June 2018 - A follow up letter was sent from the Provider to the Complainant's GP seeking the information as outlined in the letter of **15 June 2018**. On the same date, the Provider wrote to the Complainant informing her that her GP had yet to respond.

02 July 2018 – The Complainant wrote to the Provider thanking it for keeping her updated and informing it that her GP was away on holiday. In this letter the Complainant states:

> *"I am more than willing to see one of your Medical Practitioners."*

16 July 2018 – The Complainant wrote to the Provider seeking a copy of its **2018** Insurance Policy as the Complainant understood that a new booklet containing new Terms & Conditions had been brought out.

17 July 2018 – The Complainant wrote a letter to the Provider outlining all of her day to day difficulties she was suffering as a result of the injury she sustained and queried at length the time it was taking the Provider to process her claim.

18 July 2018 – The Provider wrote to the Complainant acknowledging her letter of **21 June 2018**, not received until **12 July 2018** by the Provider.

19 July 2018 – The Provider responded to the Complainant's letter of **16 July 2018**, confirming that its most recent policy document was released in **March 2017** and a copy of this including the current Terms & Conditions would have been supplied to the Complainant when she purchased the Policy.

20 July 2018 – The Provider wrote to the Complainant confirming that it had spoken to a person in the office of her GP, and that person confirmed that her GP was dealing with the Provider's request.

26 July 2018 – The Provider wrote to the Complainant, acknowledging her letter of the **17 July 2018**, which was not received by the Provider until **24 July 2018**. The Provider again outlined the need for the Complainant's GP to provide the medical information that was requested, and that this information would be required to move the Complainant's claim along.

29 July 2018 – The Complainant wrote to the Provider and enclosed a copy of an invoice received from [Hospital 1] for $5,253.00 USD. The Complainant's letter queried why this bill had not been paid given the Hospital at the time had confirmed that the Policy covered the procedures and treatments performed at the time of the Complainant's visit. Further in the letter the Complainant states: -

> *"I am sorry but I can't cope with this and I know that you are the Insurers and experts so I will have to send you the original copy. I can't believe all of this and how very long everything seems to be taking. I am sure that you will be able to sort this out. I am getting so weary and distressed and upset about all of this. I just want this to end."*

/Cont'd…

03 August 2018 – An e-mail from the Provider to [Emergency Assistance Service] discussing the outstanding invoice issued from [Hospital 1] in respect of certain treatment costs. The e-mail states: -

> *"Please see attached an invoice in respect of treatment received by the Complainant at* [Hospital 1] *… According to this correspondence there is an outstanding sum of $5,253.00 USD. Our customer* [Complainant] *is quite distressed after receiving this. Can you confirm if this invoice is outstanding or if it has in fact been paid? If it is outstanding, please make contact with* [Hospital 1] *as a matter of urgency to confirm that the invoice will be settled by the insurance and please request that no further invoices be sent to our Customer."*

03 August 2018 – The Provider wrote to the Complainant responding to her letter of **29 July 2018** and confirming that the outstanding invoice was paid. The Provider also in this letter states: -

> *"I would also like to advise you that we have now had a response from [Complainant's GP's office address] and the information they have provided is currently under review."*

13 August 2018 – An e-mail from [Emergency Assistance Service] to the Provider responding to the e-mail of **03 August 2018** confirming that the outstanding invoice was paid.

17 August 2018 – The Provider wrote to the Complainant and the letter states:

> *"We are currently in the process of instructing an independent medical professional who will assess your injury, at a time and date that suits you. When we have the name and address of this professional I will forward same to you for your records and they will contact you to arrange a suitable appointment.*
>
> *In the interim, it would be useful if you could forward copies of any additional documentation that you may have received from the Department of Work and Pensions (DWP) in respect of your request for Disability Living Allowance (DLA)."*

23 August 2018 – The Complainant wrote to the Provider responding to the Provider's letter of **17 August 2018**. In the letter the Complainant states: -

> *"I wrote to you – letter dated 21st June – 2 months ago saying that I was more than happy to see any Medical Practitioner of yours and as many times as they would like to see me because my wrist is not going to change and it hasn't. I really don't understand why you didn't instruct an Independent Medical Professional to see me then. You have already received a Professional Report from my Doctor. Now, so much later I have to see this other professional and have to wait again. Why?....."*

/Cont'd…

I wrote to the DWP on 11 June 2018 and am still waiting for them to reply. I don't understand why you are so interested in respect of any Disability Living Allowance I might get! What has that got to do about my claim for a compensation payment from [the Provider's name]. I have been waiting every day to get a response from DWP, but nothing yet."

27 August 2018 – The Provider wrote to the Complainant responding to her letter of **23 August 2018.** The Provider expressed sympathy that the Complainant felt the matter was taking longer than it should but reminded the Complainant of the *"Special conditions relating to Personal accident claims"* clause. And in particular highlighted the following:-

"Provisions

1. *Benefit is not payable to You:*

   b) *Under item 3. Until one year after the date You sustain Bodily Injury"*

and

2. *Under Permanent Total Disablement, You need to be in receipt of the applicable disability benefit from Your local government body.*

Further in the letter of **27 August 2018** the Providers states:-

"At this point an Independent Orthopaedic Specialist [name redacted] has been appointed to carry out an assessment of your injury. A letter has been sent to you by [Company name redacted], confirming this and providing you with a date and time for assessment."

27 August 2018 – The Complainant e-mailed the Provider twice that day again expressing disappointment at the length of time the claim process was taking, and queried again why it had to take a year as outlined in the Policy's Terms and Conditions.

28 August 2018 – The Provider responded to the Complainant and in that e-mail the Provider states: -

"The first contact to our emergency assistance service [Named] *on this matter was 13th March 2018. I understand you believed that the hospitals had made contact on your behalf after your accident on 25th February 2018.* [Emergency Assistance Service] *approved cover and authorised the surgery that was initially scheduled for 16th Match 2018. This surgery was postponed until 23rd March 2018, as you were unwell. After this it was decided by the Orthopaedic Surgeon in the USA, that surgery was not necessary. Our* [Emergency Assistance Service] [Named] *has settled your hospital bill from the USA. Taking all of the above into account I believe that* [Emergency Assistance Service] *provided all of the appropriate assistance, once they were made aware of your accident"*

/Cont'd…

31 August 2018 – The Complainant wrote to the Provider confirming that she had arranged a time to meet with the Independent Orthopaedic Surgeon sometime in early **September 2018.**

18 September 2018 – The Complainant wrote a letter to the Provider again reiterating the daily difficulties she was having with her wrist and how this was impacting her life.

12 October 2018 – The Provider by e-mail wrote to the Complainant informing her that they were still awaiting the final report from the Independent Orthopaedic Surgeon.

12 October 2018 – The Complainant replied to the Provider's e-mail of the same date and expressed her disappointment at the length of time the Independent Orthopaedic Surgeon was taking to produce the report.

17 October 2018 – The Provider by e-mail wrote to the Complainant informing her that the Independent Orthopaedic Surgeon as a matter of urgency would be providing the report.

26 October 2018 – The Provider by e-mail wrote to the Complainant informing her of further delays with the report as the Independent Orthopaedic Surgeon was requesting *"copies of the Complainant's full medical records".* The Provider confirmed that it made it clear to the Independent Orthopaedic Surgeon that

> *"I again explained that the unfortunate incident occurred in February 2018 and the medical information provided to [Independent Orthopaedic Surgeon's name] together with his examination of your injury, should enable him to provide the relevant report."*

26 October 2018 – The Complainant responded to the Provider's e-mail of the same date, thanking it for the update and expressing her extreme disappointment with the length of the delay.

06 November 2018 – The Complainant wrote a follow up e-mail to the Provider seeking an update on the status of the Independent Orthopaedic Surgeon's report. On the same date the Provider responded stating that it was still trying to obtain the report, but as at that date still did not have it.

16 November 2018 – The Complainant sent a follow up e-mail to see if the Independent Orthopaedic Surgeon's report was finalised.

20 November 2018 – The Provider responded to the Complainant's e-mail of the **16 November 2018** stating:-

> *"Unfortunately, we have still not received the report from [Independent Orthopaedic Surgeon's name] however [Company name] have advised me that [Independent Orthopaedic Surgeon's name] was chased by their manager and their expert Liaison Manager, and they now advised that they expect to receive the report this week."*

/Cont'd…

23 November 2018 – The Provider wrote to the Complainant confirming that they had now received the Independent Orthopaedic Surgeon's report.

30 November 2018 – The Complainant wrote to the Provider seeking a copy of the Independent Orthopaedic Surgeon's report.

04 December 2018 – The Complainant wrote to the Provider stating:-

> *"I went to [Hospital name] today 4/12/18 and had an x-ray and saw [Doctor's name Orthopaedic Consultant – not the Independent Orthopaedic Consultant] after and we had a long chat and he decided an operation would be too risky. I now have an appointment with him in six months' time. I just thought that you should know as it is pretty important to me. I have to keep living with this deformity and angulation and difficulty and pain for the rest of my life."*

04 December 2018 – The Provider wrote to the Complainant regarding the Independent Orthopaedic Surgeon's report and her Permanent Total Disablement claim of £30,000.00 under the Personal Accident section of the Policy. In the letter the Provider states: -

> *"When incepting the insurance policy on 18th January 2018 you signed the Customer Declaration to confirm:*
>
> *I have read and understood the Important Information, in particular relating to Existing Medical Conditions as set out in the policy document provided to me. I am aware that the policy is a contract of insurance and by purchasing the insurance I am entering into a contract which has terms, conditions, exclusions and limits which I must accept for all persons to be covered by the policy. If the circumstances of anyone insured by the policy changes, I undertake to contact the location at which I purchased the insurance without delay. "*

Further in the letter the Provider states:-

> *"[Independent Orthopaedic Surgeon] has stated that in his independent report that having assessed your injury he recommends that you be assessed further by way of up-to-date x-rays as well as a CT scan with 3D reconstruction views. [Independent Orthopaedic Surgeon] has stated that the benefit of such imaging would be to delineate indeed quantify the nature of the injury to the wrist and, in particular, the status of the radiocarpal joint. [Independent Orthopaedic Surgeon] believes that this would help to advise with regards to further potential treatment.*
>
> *[Independent Orthopaedic Surgeon] advises that the two potential options surgically would be either corrective osteotomy of the wrist or alternatively a formal writs fusion."*

The Provider then set out the "*Permanent Total Disablement*" and the "*Special conditions relating to Personal accident claims*" clauses contained in the Policy's Terms and Conditions. Further the Provider stated: -

/Cont'd…

"[Independent Orthopaedic Surgeon] has suggested that there may be an improvement in your condition following one of the suggested surgical options above. At this juncture we do not believe that your circumstances qualify for the Permanent Total Disablement compensation payment under the Personal Accident section of your Travel Insurance contract. I have not arrived at this decision lightly as I fully appreciate the implications of this decision on you.

Notwithstanding all of the above, I note that you were seen at [Hospital name] today where you had an up-to-date x-ray and say [Orthopaedic Consultant's name – not the Independent Orthopaedic Surgeon]. You have advised that both you and [Orthopaedic Consultant] felt that an operation would be too risky and that you have a further appointment with [Orthopaedic Consultant] in six months.

I will be happy to further review this matter if you or [Orthopaedic Consultant] can provide me with evidence which may impact on our above decision."

05 December 2018 – The Complainant responds to the Provider's letter of **04 December 2018.** In the e-mail the Complainant states: -

"I am so very surprised and so disappointed in your email. Your outcome is completely unacceptable ... It is your fault that your insurance was not accepted by any Orthopaedic Doctor in the Napa Valley California ...."

11 December 2018 – The Complainant wrote a letter to the Provider stating:

"I am a reader and writer and from the start I have read your booklet and have been happy with it because it seemed to cover all I needed when going to the USA …

I was so disappointed when none of the 7 Orthopaedic Doctors in the Napa Valley would accept my/your travel insurance. And then found out that even the ER wouldn't accept it and I ended up with a Plastic Surgeon and the self-healing had already begun …

I thought about coming home and then I knew by the time I could have changed my flight the self-healing would be well on its way and it would take time to get to see a Consultant on the NHS and the bones in my wrist would just become more parted so I stayed …

I re read your policy booklet, all the fine print and even the pages that were not relevant to me. Again, as I said in my first letter to you, there is nowhere in your booklet that says that you can't be held responsible if ER or any Doctors refuse your insurance ...

/Cont'd…

I had a long talk with [Orthopaedic Consultant] after the x-ray…the fact that I will be on a waiting list and after the operation it will take 3 to 4 months to find out if it has worked or not ...

I have still not heard from DWP about disability allowance ...

Today 13 December 2018 I received the letter from [Orthopaedic Consultant]. I feel assured you will take this seriously."

12 December 2018 – The Complainant wrote to the Provider by e-mail

"*Wait until I send you copy of the most recent report from [Orthopaedic Consultant] who is more likely to be the one to take more seriously."*

21 December 2018 – The Provider acknowledged receipt of the Complainant's letter of **11 December 2018** together with the outpatient clinic advice of the [Orthopaedic Consultant].

25 January 2019 – The Provider wrote to the Complainant and in that letter states:

"Following receipt of the additional information from [Orthopaedic Consultant] we have again reviewed your case. We have considered your claim in detail taking into account all of the documentation received on this matter however I regret to advise that our decision on this matter remains unchanged."

02 February 2019 – The Complainant wrote a letter to the Provider in the letter states:-

"I have obviously not made it clear enough about the reason I am claiming for the Permanent Total Disablement compensation payment. My left wrist is angulated and deformed permanently. If however the Orthopaedic Doctors in the Napa Valley had accepted [Provider's] insurance, my wrist would have been operated on as a matter of emergency and my wrist would have been normal in a matter of a couple of weeks……

I am enclosing the appropriate part of my letter that I received today 06 February 2019 to show that I am on disability income."

The letter the Complainant attached is in fact dated **31 January 2019** and not **06 February 2019** and relates to an "Employment and Support Allowance" (rather than a disability allowance) and demonstrates how that allowance is calculated.

18 February 2019 – The Provider issued its Final Response Letter.

/Cont'd…

26 February 2019 – The Complainant responded by letter to the Provider's Final Response Letter. In it the Complainant states:-

> *"My injury needed an EMERGENCY OPERATION". Emergency to me means immediate treatment. How would it have helped to contact your "Emergency Assistance Service" when I needed an immediate operation as a matter of Emergency. So by the time you made any repatriation it would have been too late. What don't you understand about the fact that Emergency means NOW ...*
>
> *"*[Emergency Assistance Service] *authorised my surgery for Friday 16th March. Unfortunately I became ill … on the Monday after the Friday when I was to have the surgery the nurse called to say that [Doctor's name] thought it was too late for surgery and he called me and said the same – so just in 2 days the Doctor changed his mind – and said he did not want to do the surgery because he thought that he may make it worse and he didn't want to mess with it …*
>
> *As to what was too late that* [Emergency Assistance Service] *had called me and went to voicemail. I use my mother's phone when I am there, and she has it most of the time. She does not answer the phone if it's an unknown number …*
>
> *As for my e-mail dated 28th March 2018, you took this friendly humorous e-mail completely out of context. The girl that I did speak to at* [Emergency Assistance Service] *was very friendly (and at the same time very professional). So, I just sent a friendly and a humorous e-mail because she was so very nice. I meant when I spoke to [Doctors name] was – I asked him if I really needed the surgery. I was worried because I in any case would have preferred an Orthopaedic Surgeon to perform the surgery instead of a Plastic Surgeon. Again, your fault they would not accept your insurance. The answer to if I really needed the surgery, he just agreed with me. So that e-mail was mainly in jest, but it was true, it was too late for surgery. I did not suggest that I did not need surgery then – I just asked him and he agreed. And if the Emergency Assistance Service had found a facility that would have accepted the Policy, where would that have been? Without a doubt outside of the Napa Valley far away from my mother which would have been unacceptable. It should have been done as you must by now know as a matter of emergency in Napa where no Doctor would accept my / your travel insurance …*
>
> *My circumstances meet all 3 of the "Special Conditions relating to personal accident claims". I have already answered all 3 more than once …*
>
> *Under Permanent Total Disablement I have sent you a copy from the DWP showing that I am on disability allowance.*
>
> *Read the first paragraph of [Orthopaedic Consultant] again. I still do get pain in my wrist but I don't talk about it because I have a very high pain threshold … I did not complain about the pain to [Orthopaedic Consultant] because I could handle it."*

/Cont'd…

Medical Reports

Paragraph 21 of the Independent Orthopaedic Surgeon's report issued on **10 November 2018** states: -

> *"Were the Complainant to receive no further input with regards to her left wrist, then in my opinion, her wrist will remain as it is in terms of appearance and in terms of functional disability going forwards. Having considered the Complainant's current significant functional restrictions, I take the view that as a result of the index accident, in her left wrist, she has been left with permanent total disablement and that she still required ongoing assistance with personal care and with regards to general household day to day tasks."*

At paragraph **22** the report states:

> *"Having assessed the Complainant today, I would recommend that she be assessed further by way of an up to date plain X-Ray of her left wrist – anteroposterior and lateral views – as well as a CT Scan with 3D reconstruction views. The benefit of the above imaging would be to delineate indeed quantify the nature of the injury to the wrist and, in particular, the status of the radiocarpal joint. This I believe would help advise with regards to further potential treatment. The two potential options surgically would be either a corrective osteotomy of the wrist or alternatively a formal wrist fusion. Once I have had sight of the images and radiology report, then I would be happy to prepare a Supplemental Report in which, if it is felt appropriate, I would be pleased to make the necessary recommendations."*

A letter issued from the Orthopaedic Consultant on **07 December 2018**. In that letter it states:-

> *"Clinically the deformity is very obvious. In fact functionally she is getting better and better with it. She is starting to use it more and more and the range of movement of the wrist is starting to come back as is the strength. It is still obviously some way from normal but clinically she doesn't seem to have a great deal of pain from it ...*
>
> *I think the only realistic way to improve the situation would be osteotomy. This inherently carries some risk associated with it ...*
>
> *In view of the functional improvement over the last few months she is a bit hesitant about taking the risk of surgery which is not unreasonable. I have suggested to her that she carries on with her rehab and use of the hand and see how much trouble she gets from it. I have booked her an appointment for six months' time so that we can reassess the situation. The surgery, if she does wish to proceed could be performed at any stage."*

/Cont'd…

Analysis

Medical Cover

The first element of the complaint is that the Provider's Policy failed to provide adequate cover to the Complainant and was not accepted by certain orthopaedic surgeons in the United States.

I note that the Complainant purchased the Policy on **18 January 2018,** and it covered her for her trip to the United States during the period **06 February 2018** to **27 April 2018**. I note also that this was not the first time the Complainant purchased such a policy of this type from the Provider, as in her submission to this Office on **01 April 2019** she states: -

> *"I must also tell you that I have taken out [the Provider's name] insurance twice a year for quite some years now and have always read my travel Insurance Cover details"*

I note therefore that the Complainant was familiar with the Provider's Policy Terms and Conditions and that the Complainant had read and familiarised herself with the said Terms and Conditions, a point she reiterated in a letter to the Provider on **11 December 2018**.

I note the following Policy clause highlighted by the Provider, the "Emergency and medical service" clause. The clause has been outlined in full above under the "Provider's Case" section. I note the following extract from the clause: -

> *"If this is not possible because the condition requites immediate emergency treatment You must contact the Emergency Assistance Service as soon as possible. Private medical treatment is not covered unless authorised specifically by the Emergency Assistance Service"*

I further note that in the Provider's Terms and Conditions on **page 2** in a prominent box in the middle of the page in large font, a contact phone number is specified headed "*For oversees emergency assistance*".

I further note the "*Special Conditions Relating to Claims"* subsection 1 clause contained within section B of the Policy which states: -

> *" 1. You must give notice as soon as possible to the Emergency Assistance Service or US of any Bodily Injury or Serious Illness which necessitates Your admittance to hospital as an in-patient or before arrangements are made for Your repatriation. There is no cover under this policy for expenses incurred without Our Approval."*

Unfortunately, the Complainant suffered a wrist injury on the **25 February 2018**. From the evidence presented it is not clear exactly when the Complainant first attended a hospital in the United States.

/Cont'd…

I note that the [Emergency Assistance Service] in its correspondence to the Provider on **15 March 2018** and having spoken to the Complainant, states:

> "*The Complainant stated that after her first visit to the emergency room she was referred to an orthopaedic doctor, who she could not tell us the name of, for further treatment and a review for surgery, but he would not accept her insurance policy. The Complainant stated that she struggled to find an orthopaedic doctor for further treatment until the 12th March."*

I note that the Complainant returned to the Emergency Room in [Hospital 1] on **06 March 2018** and was referred to [Hospital 2] from there. I note also that [Emergency Assistance Service] acknowledged and understood why on the date of the accident, the Complainant did not immediately contact them; in its correspondence to the Provider on **15 March 2018** [Emergency Assistance Service] states: -

> *"the Complainant's reasons for not initially calling us on 25 February 2018, as she thought that the hospital was going to make contact with us*"

It is acknowledged by both parties that the first contact the Complainant had with the Provider, regarding the accident of the **25 February 2018,** was over two weeks later on **13 March 2018**. In all of the correspondence from the Complainant to the Provider, and to this Office, no significant reason has been put forward by the Complainant as to why she delayed contacting the Provider in circumstances where it seems that her policy cover was initially refused by orthopaedic surgeons in [Hospital 1] the first hospital she attended after the accident. No opportunity was given by the Complainant to the Provider, to assist her with this issue.

I note that when [Emergency Assistance Service] was contacted on **13 March 2018** for the first time by the Complainant, authorisation was given to have the surgery two days later on **15 March 2018,** with the surgery scheduled in an insured facility the following day on **16 March 2018**.

I am satisfied accordingly, that the precise cover which the Complainant needed was confirmed for her at that time, two days after making contact.

Unfortunately, due to illness, the Complainant's operation was cancelled but I note that [Emergency Assistance Service] reapproved the same surgery for **23 March 2018**. [Emergency Assistance Service] phoned the Complainant on **24 March 2018** to enquire as to how the surgery had gone but could only get the Complainant's voicemail.

The next contact from the Complainant was by e-mail on **28 March 2018** when the Complainant stated: -

> *"I had to talk to the Doctor who was going to perform the surgery the day before and I told him I don't think I need surgery and he went through my notes and x-rays again and he agreed with me*"

/Cont'd…

The Complainant in her response to the Provider on **26 February 2019** in addressing the delay in contacting the Provider states: -

> *"My injury needed an EMERGENCY OPERATION". Emergency to me means immediate treatment. How would it have helped to contact your "Emergency Assistance Service" when I needed an immediate operation as a matter of Emergency."*

I note that when the Complainant first presented to the Emergency Room of [Hospital 1] she underwent several x-rays and other procedures to assess the nature and severity of the initial injury. The expenses for these procedures were covered under the terms of the Policy and were subsequently paid by the Provider.

It seems that what was not covered in [Hospital 1] was the cost of the orthopaedic surgery. Rather than immediately contacting the Provider / [Emergency Assistance Service], as was required under various terms of the Policy outlined above, it appears the Complainant tried to contact various hospitals and surgeons herself.

The Complainant has admitted that she read and was familiar with the Terms and Conditions of the Policy, however for reasons unknown, she waited more than two weeks to make first contact with the Provider about her injury. As a result, I am satisfied that the Provider has no responsibility for that particular period of delay.

In my opinion, the Provider/[Emergency Assistance Service] acted quickly when first informed of the injury, approving and scheduling the surgery in an insured hospital in the United Stated, in a period of just two days. When the first surgery was cancelled, the Provider / [Emergency Assistance Service] again acted quickly again in re-approving and scheduling the second surgery for **23 March 2018**. I do not accept the Complainant's assertion that the surgery was required to be performed immediately, and that this was the reason for her failure to contact the Provider, on the date of the accident.

A surgical procedure was scheduled for **16 March 2018** some **2.5** weeks after the accident, presumably on the assumption that the surgery would benefit or improve the Complainant's injury. It is not clear to me whether the Complainant decided not to proceed with the surgery of her own accord, or if the Doctor advised the Complainant not to proceed on **23 March 2018**. What is clear to me that the Provider played no role in that decision to cancel the surgery on **23 March 2018**, and it phoned the Complainant on **24 March 2018** to enquire as to how the surgery had gone.

However, during this period, the Complainant unfortunately proved difficult to contact, as she was not using her phone but rather, she says that she was using her mother's phone. Again, the difficulty in making contact was not of the Provider's making and I am satisfied that it has no case to answer in that respect, and I take the view that it was reasonable for the Provider to seek to make contact with the Complainant using the phone number that she had supplied.

/Cont'd…

I am satisfied that the evidence shows that the Complainant delayed in contacting the Provider and failed to adhere to the Policy's Terms and Conditions, that she says she was familiar with. Had the Complainant contacted the Provider sooner (as required under the terms of the Policy) the Provider could have directed the Complainant to a hospital where the Policy would offer full cover and the Complainant could have had the benefit of the treatment she required, sooner.

On the basis of the evidence before me, I am satisfied that the policy provided cover for the Complainant's surgery in Hospital 2, but the Complainant ultimately reached a decision, in consultation with her medical advisors at Hospital 2, not to proceed with the surgery. In my opinion, there is no evidence of any wrongdoing on the part of the Provider in its interactions with the Complainant regarding her medical care, once the Provider was notified by the Complainant on 13 March 2018, that she had suffered an accident and required medical care. Accordingly, in the absence of any wrongdoing by the Provider, I take the view that it would not be reasonable to uphold this element of the complaint.

Claim

With regard to the second complaint that a claim made under the Personal Accident section of the Policy was wrongfully refused by the Provider, I note the following: -

The Provider specifically references the "*Permanent Total Disablement*" and the "*Special conditions relating to Personal Accident Claims*" clauses, both outlined in Section D of the Policy's Terms and Conditions.

The "*Permanent Total Disablement*" clause is outlined above, and states that this term:

> "*Means a physical or mental impairment that has a substantial long-term adverse effect on Your ability to carry out any form of employment and at least three of the following normal day to day activities.*
>
> *We will consider You are unable to perform an activity when the following applies:*
>
> - *You are unable to perform the activity even with the use of equipment and;*
> - *You always need the help of another person to perform the activity."*

I note also that the Complainant in correspondence to the Provider dated **21 June 2018** and again in correspondence dated **02 February 2019,** specifically articulates her struggles with the day-to-day tasks referenced in the clause and specifically states that she does need the help of her roommate, for at least three of the five daily tasks listed.

I note also the "*Special conditions relating to Personal accident claims*" clause under Section D of the Policy. The Complainant was referred to an Independent Orthopaedic Surgeon who produced and issued his report on **10 November 2018**. Separately the Complainant attended a different Orthopaedic Consultant of her own accord and independent of the claims process, and that Consultant issued a letter on **07 December 2018**.

/Cont'd…

I note that in the Provider's Final Response Letter of **18 February 2018** in addressing and relying on this clause, the Provider states: -

> *"[Doctor's name] has suggested that there may be an improvement in your condition following one of the suggested surgical options above."*

A key criterion to meet the definition of Permanent Total Disablement is that there is no likelihood of improvement of the condition. Having reviewed the Independent Orthopaedic Surgeon's report of the **10 November 2018** it is clear to me that the Independent Orthopaedic Surgeon concluded that there could be an improvement in the Complainant's condition, after it was further assessed and treated.

With reference to Paragraph **21** of the report quoted above, I note that the doctor used the term "*permanent total disablement*", but it is clear to me that the use of this phrase was with reference to the overall reduction in the function of the Complainant's wrist, rather than a suggestion that she met the specific definition of "*Permanent Total Disablement*", within the meaning of the policy provisions. It is a matter for the Provider alone, to make a reasonable decision, on the basis of the totality of medical reports available to it, as to whether the Complainant met the criteria of that particular policy definition.

It is also clear to me from Paragraph 22 of the report that the medical advisor recognised the potential for treatment to improve the Complainant's situation. The Independent Orthopaedic Surgeon clearly stated that he would recommend additional tests to be carried out with a view to determining further potential treatments.

I take the view that in mid to late 2018, it was not entirely clear, at that point, whether there was a likelihood of improvement in the Complainant's condition, post future treatments, but certainly I accept on the evidence that it seemed that there was potential. I note that the letter of **07 December 2018** produced by the Orthopaedic Consultant whom the Complainant attended of her own accord, does suggest the likelihood of an improvements to her wrist, and at that time the report was that "*the range of movement of the wrist is starting to come back, as is the strength."*

Whilst I note that the Complainant was somewhat frustrated that no benefit was payable in the event of a successful claim, until at least one year had elapsed from the date of the injury, I consider this to be a reasonable period to assess the level of disability, so as to assess the treatment undergone, and any potential treatment into the future.

I also note that another key condition of the Personal Accident claim is that any claimant must be in receipt of a disability benefit from a government body. The Complainant did produce a letter dated **31 January 2019** detailing an "*Employment and Support Allowance Award*" purporting to be disability benefit from a government body. It is not clear to me that this constituted a disability allowance, but given the nature of the medical evidence considered by the Provider in mid to late 2018, this issue did not require further examination, at that time.

/Cont'd…

On the basis of the evidence available, I am satisfied that at the point when the Provider declined the Complainant's claim, it did so on a reasonable basis, based on the information which was before it. If, thereafter, in the period which has since intervened, the Complainant has found herself with a "*Permanent Total Disablement*" within the meaning of the policy provisions, it will of course be open to her to further pursue that claim with the Provider, on the basis of up-to-date medical reports.

I appreciate that the Complainant is very disappointed by the events that have led to this complaint, but on the basis of the evidence before me, I take the view that in 2018/2019 the Provider acted reasonably and accordingly I do not consider it appropriate to uphold this complaint.

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
FINANCIAL SERVICES AND PENSIONS OMBUDSMAN (ACTING)

30 August 2022

PUBLICATION

Complaints about the conduct of financial service providers

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.

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Complaints about the conduct of pension providers

Pursuant to *Section 62* of the *Financial Services and Pensions Ombudsman Act 2017*, the Financial Services and Pensions Ombudsman will **publish case studies** in relation to complaints concerning pension 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.