

The complaint

Mrs K complains that Legal and General Assurance Society Limited (L&G) has turned down an incapacity claim she made on a group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties, so I've set out a summary of what I think are the key events.

Mrs K is insured under her employer's group income protection insurance policy. The policy provided cover for her own occupation and included a deferred period of 28 weeks.

In January 2022, Mrs K became absent from work. In May 2022, her employer made an incapacity claim on the policy. Mrs K completed a member statement which said that she was absent from work due to work-related stress and pressure, which had led to stress, depression and anxiety.

L&G looked into Mrs K's claim. One of its clinical vocational specialists (VCS) spoke to Mrs K and carried out a telephone assessment with her. The VCS concluded that Mrs K was suffering from work related stress, leading to depression and anxiety. They also felt that Mrs K was fit to return to work, as they considered her absence had been triggered by work-related stressors. On that basis, L&G turned down Mrs K's claim, as it didn't feel the claim met the policy definition of incapacity.

Mrs K was unhappy with L&G's decision and she appealed. Her GP provided a letter in support of Mrs K's claim. The GP said that Mrs K had been consulting with them since August 2021 with stress at work and subsequent development of anxiety and depression. The GP said that Mrs K now had moderate depression and severe anxiety. The GP stated that as they weren't an occupational health specialist, they couldn't comment directly on whether Mrs K was fit to work in her profession – but they said they felt Mrs K's symptoms would make this difficult.

L&G's Medical Office (MO) reviewed the GP's evidence. However, the MO wasn't satisfied that there was evidence of pervasive or persistent symptoms of mental illness which would preclude Mrs K from working. The MO felt Mrs K could perform her own occupation with a similar employer. So L&G maintained its decision to turn down Mrs K's claim.

Mrs K remained unhappy with L&G's position and so she asked us to look into her complaint.

Our investigator felt it had been reasonable for L&G to rely on the information it had been provided with at the outset to turn down Mrs K's claim. However, she felt that Mrs K's GP's letter was suggestive that Mrs K may have developed an impairing mental health condition. So therefore, she felt that L&G ought to have requested further medical evidence to assess whether or not Mrs K now met the policy definition of incapacity. She recommended that L&G should obtain further medical evidence and to allow it to further consider Mrs K's claim.

L&G disagreed. It didn't think the investigator had considered its MO's evidence. The MO was occupationally qualified. And it said the MO had written to the GP following the GP's letter with practical steps to move things forwards. There'd been no response to this letter. And L&G didn't agree that the onus should be placed upon it to continually try and obtain evidence.

The complaint's been passed to me to decide.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I've concluded that L&G must obtain further medical information and reassess Mrs K's claim. I'll explain why.

First, I must make it clear that this decision will only consider whether it was fair for L&G to turn down Mrs K's claim. I appreciate Mrs K has also complained about the way that L&G handled her claim and the service she received. However, L&G has told us that this didn't form part of Mrs K's original complaint to it and it didn't address these issues within its final response to her complaint. Under our rules, a financial business must be given an opportunity to look into a complaint before we can potentially help with it. L&G has told us that it will be assessing Mrs K's service concerns separately.

The relevant regulator's rules say that insurers must handle claims promptly and fairly. And that they mustn't turn down claims unreasonably. So I've considered, amongst other things, the terms of the policy and the available medical and other evidence, to decide whether I think L&G handled Mrs K's claim fairly.

I've first considered the terms and conditions of the policy, as these form the basis of Mrs K's employer's contract with L&G. Mrs K's employer made a claim on her behalf for incapacity benefit, given she wasn't fit for work. So I think it was reasonable and appropriate for L&G to consider whether Mrs K's claim met the policy definition of incapacity. I've turned then to look at L&G's definition of 'incapacity'. This *'means the insured member is incapacitated by illness or injury that prevents him from performing the essential duties of his occupation immediately before the start of the deferred period.'*

This means that in order for L&G to pay incapacity benefit, it must be satisfied that it's a policyholder's illness which prevents them from carrying out the essential duties of their own occupation.

The policy says that L&G will pay incapacity benefit the day immediately after the last day of the deferred period. This means that in order for benefit to be paid, a policyholder must've been incapacitated in line with the policy terms, for the entire deferred period and afterwards.

It's a general principle of insurance that it's for a policyholder to show they have a valid claim on their policy. This means it was Mrs K's responsibility to provide L&G with enough evidence to demonstrate that her illness had led to her being unable to carry out the essential duties of her own occupation for the full deferred period and afterwards.

L&G first assessed and turned down Mrs K's claim in May 2022. At that point, it hadn't received the letter from Mrs K's GP. So I think it's appropriate for me to assess whether it was fair for L&G to initially turn down the claim in May 2022. I'll then move on to consider whether it was fair for L&G to maintain the claim decline once the GP's evidence was received.

Was it fair for L&G to turn down the claim in May 2022?

L&G assessed the evidence Mrs K provided in support of her claim, including with clinical staff. And it concluded that she wasn't suffering from a mental illness which prevented her from carrying out her role. Instead, it felt that Mrs K was suffering with a reaction to work-related stressors. So I've next looked at the available evidence to assess whether I think this was a fair conclusion for L&G to reach.

There is very little medical evidence available from the time of Mrs K's claim. L&G relied on the member statement Mrs K completed, along with the VCS' findings, following their conversation with Mrs K. I've looked carefully at both pieces of evidence.

Mrs K was asked to describe the reasons why she was absent from work and to provide a diagnosis. She stated:

'Work related stress and pressure leading to anxiety, stress and depression.'

The VCS report is dated 6 May 2022. It too provides a diagnosis of work-related stress leading to depression and anxiety. The VCS recorded:

'Member advises she has been absent since 5 January due to work related stress. She reports that she was stressed at work for the last couple of years, but it got worse in the last year. She reports that there is a huge amount of pressure in the role, to meet deadlines and targets and had to work late to meet deadlines. She started to become overwhelmed and anxious at work. She would get dizzy and panic. She reports that she would try hard to work through it and work through how she was feeling and doing breathing exercises. She states she has tried several self-help things that only worked in the short term. She reports that when she was off work, she would be worried about cases at work and could not switch off. She took three days off in December when she was not able to continue with work as she was feeling anxious and feeling like a failure. She spoke to her employer, and they agreed to reduce her workload, she went back to work but was still not able to continue with work even with the reduced workload. She had sought help from the GP before she went off sick. She sought further help from the GP again and she was referred to (a) local mental health trust and she has been assessed in April. She was referred to CBT and has been put on waiting list. She was told that the waiting list is eight months.'

The VCS concluded:

'In my opinion the member is fit to return to work. Her current absence does not appear to be clinical and was triggered by work related stressors...Member reports that her main barriers are her anxiety, she has difficulty with having phone calls. Her job is demanding and has to have difficult discussions with colleagues at work. As she still anxious and overwhelmed she does not feel she would be unable to do this.'

Ultimately, the VCS' report concluded:

'In my opinion this case is not primarily medical. The member is suffering from stress type symptoms which are directly related to work related issues and personal stressors. This has caused her to experience stress. It may be worth noting that "stress" in itself is not a clinical illness but instead is used in general parlance to describe an adverse reaction (which can manifest as physical and/or psychological symptoms e.g. disturbed sleep, anxiety, anger etc.) to particular situations due to incompatibility between the person and the situation for non-medical reasons.'

Although the member is exhibiting clinical signs of anxiety and depression, if the work-

related factors were removed, there should be no reason why she could not return to work in some capacity. The member has reported ongoing symptoms and an inability to return to work due to her anxiety, this is not consistent with the reported level of her day-to-day function. She appears to be managing her activities of daily living and has a reasonable typical day function.'

It seems that L&G didn't request any further medical evidence from Mrs K's GP at this point, as it relied on the clinical opinion of the VCS and Mrs K's testimony. I don't think it was unfair for L&G to do so here. Taking into account the evidence which was available to L&G in May 2022, I don't think it was unreasonable for L&G to conclude that the evidence showed that the main reason for Mrs K's absence was likely the workplace stress she was experiencing as opposed to a mental health condition. It also appears, from the VCS' report, that Mrs K would be in a position to return to work if the workplace issues had been resolved.

This means I don't think L&G acted unfairly in May 2022 when it decided that Mrs K wasn't suffering from a significant mental health condition during the deferred period, which prevented her from carrying out the material and substantial duties of her occupation.

Did L&G fairly assess the new evidence?

Following L&G's decision to decline the claim, Mrs K's GP provided a letter dated 12 July 2022. I've set out what I think are the key points below:

'I can confirm that I have been consulting with (Mrs K) since 2 August 2021 regarding stress at work and subsequently development of anxiety and depression...

Despite time off, making sensible changes to her lifestyle and exploring help from the local Wellbeing service, (Mrs K) continued to struggle with low mood and anxiety. Due to significant waiting times locally for help from mental health services, she had her initial assessment with the Wellbeing team...At the time of the assessment, her score was...indicating moderate depression...and her score on the anxiety scale was...indicating severe anxiety.

Although it would seem the precipitant for (Mrs K's) depression and anxiety was initially work, unfortunately it seems that her low mood and anxiety has now become more pervasive and affects her in other areas of her life.

As I am not a trained occupational health physician, I cannot comment directly on whether (Mrs K) is able to continue in her current profession. However, I would suggest the symptoms she has experienced would make this difficult. I think it would only be fair in terms of ongoing assessment for (Mrs K), if she has not already, to have a formal occupational health assessment to assess this further.'

L&G's MO assessed the GP's letter. They concluded:

'This is a work-related stress claim, with no evidence of pervasive or persistent symptoms of mental illness that would fully preclude work, in my view. The member would be able to perform her own occupation with a similar employer, in my opinion. The member remains high functioning and is driving, cooking, hoovering, cleaning and reading books, which is reassuring.

The MO wrote to Mrs K's GP with some suggestions as to how Mrs K might be supported and I've considered that letter carefully. It's clear the MO felt that work could be beneficial for Mrs K and that they suggested Mrs K should seek occupational health support from her employer. It isn't clear to me though that the MO's letter naturally invited a response from the

GP, as it seemed to be based on their own opinion and understanding of Mrs K's clinical situation.

I've thought very carefully about the GP's letter and L&G's response to it. I'm mindful that the MO is an expert in their field and in their clinical opinion, Mrs K is fit for work. However, it seems to me that whilst the GP accepts Mrs K's symptoms were originally down to stress at work, both the Wellbeing service and the GP had concluded, in April 2022, that Mrs K was suffering from moderate depression and severe anxiety. Depression and anxiety can both be impairing mental health conditions, which could *potentially* affect Mrs K's ability to carry out her own occupation. And in my view, L&G didn't have enough medical evidence to fully assess whether the definition of incapacity had gone on to be met. I asked L&G if it could provide me with copies of the fit notes Mrs K was given in January 2022, so that I could consider Mrs K's likely diagnosis at that point further, but these notes were not forthcoming.

It seems to me that L&G ought to have requested further medical evidence from Mrs K's treating practitioners in July 2022. I think it would've been reasonable for L&G to request a copy of Mrs K's full medical records, from January 2022 onwards, together with copies of any notes of her CBT therapy. In my view, this may have given L&G a clearer picture of Mrs K's overall clinical position during the deferred period and afterwards and could have determined its next steps with the claim. While the MO's evidence is undoubtedly helpful, I don't think it's enough to counteract the GP's findings that Mrs K's original work-related stress had developed into depression and anxiety.

So I find that the fair and reasonable outcome to this complaint is for L&G to now obtain Mrs K's full medical records from January 2022 and other medical evidence it may think necessary and to reconsider Mrs K's claim based on that evidence and in line with the policy terms and conditions. It's important that I make it clear that I'm not directing L&G to accept and pay Mrs K's claim – I'm simply directing it to obtain further medical evidence to decide whether it's sufficient to show that the claim meets the policy definition of incapacity. If Mrs K is unhappy with the outcome of the claim reassessment, she may be able to make a new complaint about that issue.

My final decision

For the reasons I've given above, my final decision is that I uphold this complaint.

I direct Legal and General Assurance Society Limited to obtain Mrs K's full medical records and to reassess her claim in light of that evidence and in line with the policy terms and conditions.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs K to accept or reject my decision before 7 July 2023.

Lisa Barham
Ombudsman