DRN-4095116

The complaint

Mr A complains that Zurich Assurance Ltd has terminated an incapacity claim he made on his group income protection insurance policy.

What happened

The background to this complaint is well-known to both parties, so I'm not going to set it out in detail here. Instead, I've focused on what I think are the key events.

Mr A was insured under his employer's group income protection insurance policy. In 2016, Mr A became very unwell with neurological symptoms and was signed-off work. His employer made an incapacity claim on the policy. Zurich accepted the claim and paid monthly benefit from March 2017.

Zurich periodically reviewed the claim over the next few years. Mr A continued to have neurological consultations and tried a number of treatments. But he remained incapacitated.

On 25 August 2020, Mr A underwent a video call assessment with Dr M – an independent medical examiner (IME). Dr M is a consultant in occupational medicine. Dr M also reviewed Mr A's medical records. They concluded that based on Mr A's reported symptoms and activities, he was fit to return to work on a phased basis. Dr M considered Mr A should initially return to work for 16 hours per week, building up to full-time hours after three months. Dr M recommended that Mr A should be allocated a quieter place in the workplace.

Zurich accordingly decided to terminate Mr A's claim from December 2020, as it concluded Mr A no longer met the policy definition of incapacity.

Mr A appealed Zurich's decision. He provided evidence from a neurologist which stated that he wasn't fit for work. And he underwent an occupational health assessment with a doctor I'll call Dr S, who also felt Mr A remained unfit for work.

Zurich asked Dr M to review the further medical evidence. Dr M did so and maintained their initial opinion that Mr A had been fit to return to work on a phased basis, in August 2020, although they acknowledged that his condition may have further deteriorated since then. Based on Dr M's clinical assessment, Zurich didn't agree to reinstate Mr A's claim.

Mr A asked us to look into his complaint.

Our investigator didn't think it had been unfair for Zurich to terminate Mr A's claim. Briefly, she concluded it had been fair for Zurich to rely on Dr M's opinion to cease the payment of benefit on the grounds that Mr A no longer met the definition of incapacity.

I issued a provisional decision on 6 April 2023, which explained the reasons why I planned to uphold Mr A's complaint. I said:

'This claim has been in payment for some years. This means that there is extensive medical and other evidence and both parties have provided detailed submissions. I'd like to reassure both parties that I've read and carefully thought about all they've said and sent us. In

reaching my decision though, I haven't commented on each point that's been raised and nor do our rules require me to. Instead, I've focused on what I consider to be the key issues.

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 this income protection insurance policy and the available medical evidence, to decide whether I think Zurich treated Mr A fairly.

I've first considered the policy terms and conditions, as these form the basis of the insurance contract between Mr A's employer and Zurich. There's no dispute that Mr A's claim was assessed in line with the 'standard' definition of incapacity. This says:

'Incapacity or Incapacitated means an illness or injury that causes the Member to be unable to work and is applicable under this policy. The Incapacity definition that applies is in your policy schedule. The Member must be under the regular supervision and treatment of a Medical Practitioner. We can ask for medical evidence at regular intervals throughout a claim.

Standard

The Member cannot perform the Material And Substantial Duties of their employment and they are not doing any paid work.'

The policy terms set out for how long Zurich will continue to pay incapacity benefit. I've set out below what I consider to be the most applicable of the events which trigger termination of benefit:

'• the limited Income Benefit period ends (if this applies), or

the Member:

• returns to work or no longer satisfies the terms and conditions

• no longer satisfies the definition of Incapacity shown in your policy schedule.'

In my view, Zurich's terms indicate that subject to other conditions, it will continue to pay benefit, for as long as it's satisfied that a policy beneficiary remains incapacitated. It's clear that whilst Zurich accepted that Mr A was entitled to policy benefit for some years, it now considers that he's no longer incapacitated and is able to return to work in his own occupation. So I've thought about whether this was a fair conclusion for Zurich to reach.

It's for a policyholder to provide enough evidence to show that they have a valid claim under their policy. However, once a claim is in payment, it becomes the insurer's responsibility to show that the policyholder no longer meets the policy terms. Generally, it's fair and reasonable for an insurer to periodically review income protection claims and request medical evidence to determine whether a claim remains payable. So I think Zurich was

reasonably entitled to commission IME reports during the life of the claim.

I've looked closely at Dr M's report of their meeting with Mr A in August 2020. This, taken together with their follow-up reviews of additional medical information, appears to be the evidence upon which Zurich has placed most weight. I've set out below some of the report's key content:

'(Mr A) describes himself as a house husband and carries out a full range of household tasks

and also helps to look after his two young children. He does not appear to be restricted on the majority of days; however, he does have approximately 3 or 4 days a month which he terms "bad" when he cannot do anything much. Although he informed me that his symptoms are exacerbated by noise, for example when the children are noisy in the same room as Mr A, he is able to coach a local (sports) team, which are [sic] likely to involve a fair degree of noise.

Prior to the lockdown he was going to the gym 3 or 4 times a week and on one day had a full body workout. During his exercise programme at the gym, he is able to weight train, he also cycles and walks locally…

Today he informed me that it was a good day for him and had a great deal to tell me and appeared to be a very articulate individual. He was alert, had good concentration and memory and there was no evidence of any psychological difficulties. He gave a very full and detailed description of his problems during the 1 ½ hours duration of the remote assessment.'

Dr M's report concluded:

'After considering all facets of (Mr A's) case. I find it difficult to conclude that he is totally unable to undertake his normal occupation as…. The symptoms, as he described to me are variable in degree and there are 3 or 4 days a month where they are severe and he would not be able to function in his job environment.

However, for most of the month, symptoms are not so intrusive and severe, although hinder him from leading a completely normal life. It would be preferable if he were to be allocated a quieter area in the workplace as he complained that noise made his symptoms worse. Initially, he should return on a phased basis, working 16 hours a week when he first returns to the workplace and to gradually increase his hours of attendance, dependent of course on his progress with his full-time hours after 3 months back at work.'

It's clear that Dr M, an expert in their field, concluded (and continued to maintain) that Mr A was fit for work and therefore no longer met the policy definition of incapacity. In particular, I note that Dr M placed some weight on the sports coaching Mr A conducted bi-weekly. As Dr M is a consultant in occupational medicine, I've read and thought about his report(s) very carefully, as they represent key evidence.

But in deciding what's fair and reasonable, I also need to think about any other medical evidence which has been considered as part of this claim. I am not a medical expert and my role is to assess the medical evidence provided by medical professionals who are experts in their field to decide which evidence I find most persuasive. As such then, while I've given a great deal of thought to Dr M's conclusions and rationale, I've also borne in mind additional medical evidence and Mr A's job role.

I can see from Mr A's neurologist's records (and indeed from Dr M's report) that Mr A was prescribed medication for his symptoms and had undergone various forms of treatment. In

July 2019, Mr A was assessed by another IME - a consultant clinical psychologist who I'll call Dr F. It's clear from Dr F's report that they carried out a number of neuropsychological tests on Mr A as part of that assessment.

Below, I've set out what I think are the key findings from Dr F's report:

'The results of the present assessment suggest that Mr A is experiencing cognitive problems, particularly with reference to situations whereby he is placed under more

significant demands. It is likely that his cognitive load and ability to manage demands is now limited as a result of his (illness) and that this would make it extremely difficult for him to manage situations in future whereby additional cognitive demands are placed on him.

Mr A has experienced considerable psychological difficulties with reference to adjusting to the changes that have occurred in his life as a result of the impact of (his illness) on his loss of occupation. He is adjusting somewhat to this, however, I would recommend that he is provided with twenty sessions of Cognitive Behaviour Therapy, delivered by a clinical psychologist with expertise in the area of neurological disorder or brain injury. This should be helpful in terms of improving Mr A's current symptoms, however, is unlikely to lead to any resolution which would allow him to return to work in his previous role.

Mr A is experiencing significant cognitive symptoms, particularly within the area of executive functioning. It is likely that when he is placed under more complex demands that his cognitive functioning will suffer further.

Mr A was assessed in a quiet clinic room with little distraction. Despite this, he still had difficulties with reference to more complex cognitive tests and I would consider that within a real life situation, such as his return to work, then this will result in more significant cognitive problems.

Mr A is unlikely to be able to return to his pre-accident job as…given the complex cognitive demands that would be placed on him in this position. This is unlikely to change at any point in the future, particularly given the length of time that has elapsed since his period of (illness).'

Dr F concluded, following a series of assessments, that Mr A was unlikely to be able to return to his role. They also noted that even though Mr A was assessed in a quiet room, he had difficulties with more complex tests. And, while I note this report was completed in 2019, Dr F felt Mr A was unlikely to be able to return to his own occupation and that this was unlikely to change at any point in the future.

Following the termination of the claim, Mr A's employer arranged for him to see Dr S, an occupational health doctor. Again, I've set out below what I think are their key findings:

'There is no clear date for a return to work and further absence over a number of months is required. There is also a question as to whether he would be able to return to the extended hours of working which have been described for his position.

Recommendations

What is this employee's current state of fitness to work?

My findings based on my assessment today is that Mr A is not yet fit for work.

What effect will this illness have on the employee's ability to carry out his current

occupation?

His affects on his function with headaches, dizziness, fatigue and triggers with light from computer based work, limit his ability to carry out his current occupation.

Are there any work modifications which would alleviate the condition or facilitate rehabilitation?

At a time of increased health and a suitable level of function, modifications such as a phased return to work is an example of one that would assist. There are no work modifications I can identify at present to enable a return to his position in the foreseeable future.'

Dr S' report did not identify their qualifications. However, from my own research, I understand that Dr S is also a consultant occupational physician. I appreciate Dr M has referred to the fact that Dr S' report was based on Mr A's reported symptoms, rather than a review of his medical records. But I'm satisfied that Dr S is also an expert in the field of occupational medicine and reached a clinical opinion that Mr A remained unfit for work.

I've looked closely too at letters from Mr A's neurologist. One letter, dated 5 March 2021, (post-dating the termination of the claim) followed a remote consultation. The neurologist said:

'You are certainly not fit to work and the psychological stress of returning to work would lead to a relapse of your migraine to serious levels, which would make you incapacitated.'

Zurich's chief medical officer wrote to the neurologist to ask for further information. I'm mindful that in July 2021, in response to that request, the neurologist said:

'I agree that Mr A is able to work 90 minute coaching sessions twice a week. This would indicate that he would be able to return to the workplace for 90 minutes twice a week. I am not sure that is compatible with normal work patterns.

Physical symptoms like this are generally improved by physical activity and I encourage all my patients to increase their level of physical activity as much as possible.

I have not ever said that he should not return to work or be supported in a phased return to work. That is very much a matter for an Occupational Health Physician to provide an opinion on, rather than a Neurologist.

I would definitely support engagement of an Occupational Health Physician and rehabilitation support. With most physical and mental illnesses, physical activity is good for patients, and employment has also proven to be beneficial. If Mr A can be got back to work, this would certainly be in his long-term health interests.'

It's evident there is conflicting medical evidence, most of which I think is broadly supportive of Mr A's position. I accept that the neurologist later clarified that he hadn't said that Mr A shouldn't return to work. However, his comments on 5 March 2021 did explicitly state that Mr A wasn't fit for work and that a return to work could exacerbate his condition. The neurologist has, at times, been involved in Mr A's care over the life of his illness and so I think his clinical opinion as to Mr A's symptoms is important. Taking together Dr F's, Dr S' and the neurologist's evidence, I think the majority of the medical evidence points to Mr A remaining incapacitated from carrying out the material and substantial duties of his occupation at the time the claim was terminated.

I have to weigh up whether I am more persuaded by Dr M's conclusions, or the totality of Dr F's, Dr S' and the neurologist's evidence. And currently, on balance, I am less persuaded by Dr M's conclusions than the combination of the other specialist evidence. I've looked carefully at Mr A's job description. It doesn't appear to me that Mr A's role could be carried out in a quiet area, given the nature of it. It may well be that a different role could be done in such a way – but it doesn't seem that Mr A could carry out the material and substantial duties of his role were his office location moved. Dr F carried out neurological tests which indicated that Mr A wouldn't be able to carry out his own occupation. However, I've seen no evidence that Dr M undertook such neurological assessments during their call with Mr A. I'm

also not persuaded that bi-weekly sports training sessions are commensurate with a return to work – especially given Mr A says this is a volunteer role and he simply doesn't take part if he's too unwell.

Overall, I don't think there's enough medical evidence from the point the claim was terminated to show that Mr A's symptoms had improved to the point he was no longer incapacitated, in line with the policy terms.

This means that currently, I don't think Zurich has shown, on balance, that Mr A no longer met the policy definition of incapacity when the claim was terminated. So I currently find that it needs to reinstate the claim with effect from December 2020 and pay Mr A backdated benefit, together with interest. I should add that Zurich remains entitled to periodically request further medical evidence or IME assessment to determine whether Mr A's claim still satisfies the policy definition of incapacity. If Mr A is unhappy with any future, further reassessment of his claim, he may be able to bring a new complaint to us about that issue alone.'

I asked both parties to provide me with any further evidence or comments they wanted me to take into account.

Mr A accepted my provisional findings.

Zurich did not accept my provisional findings and provided detailed further comments, and, upon my request, further medical evidence from a rehabilitation consultant (RC). I've summarised its key response points below:

- It felt it was unclear whether I'd considered why it'd placed more weight on Dr M's report, rather than Dr S' report. It said it was its firm belief that once Mr A's claim had been terminated; his symptom reporting had changed to allow Dr S to reach a different conclusion and recommendation around a return to work. It said there'd been no medical explanation for the change in symptoms and sudden deterioration;

- Dr M had been asked to comment on Dr S' report and he specifically noted that while Mr A had reported word finding difficulties and memory problems to his employer, these were not evident during the 90 minute consultation which had taken place with him. Dr M stated that all times, Mr A had been focused, with good concentration;

- It didn't agree that a return to work shouldn't have been attempted. It felt that if the neurologist had felt so strongly that a return to work shouldn't have been trialled, they wouldn't have deferred to an occupational health specialist. The neurologist had also specifically stated that a return to work could be beneficial;

- Zurich said it wasn't just considering whether Mr A met the policy definition of incapacity when the claim was terminated. The policy also states:

  '*The member must be under the regular supervision and treatment of Medical Practitioners and must be taking reasonable steps to manage their condition or help their recovery.*'

  It considered that taking reasonable steps to manage Mr A's condition would include full engagement in the return to work process;

- It had engaged an RC to help Mr A to return to work, but that he'd refused to engage with the process. This was in clear breach of the policy terms and conditions. And under the Equality Act 2010, an employer has a duty to make reasonable

adjustments at work;

- Dr M believed that dependent on the return to work progress, Mr A could've achieved full-time hours after three months back at work. If Mr A could coach a rugby team, it felt he should've at least attempted a return to work;

- If a successful return to work had been achieved, which Dr M had felt was possible, there would've been no debate about whether the definition of incapacity had been met, but establishment of this point had been denied to it by Mr A.

I asked Zurich to send me a copy of the RC's report it had referred to. The consultation between Mr A and the RC appears to have taken place on 30 July 2020 – shortly before the engagement of Dr M by Zurich. I've set out the key findings from that report below:

'*Mr A informed me that he remained symptomatic with constant persistent headaches that have variable intensity on any given day. He explained that his symptoms include dizziness, forgetfulness, fatigue, nausea, visual disturbance. He said he experienced sleep disturbance and poor energy levels.'*

Return to work initiatives:

Mr A has not attempted a return to work since becoming absent and does not believe that he is in a position to do so. His contact with his employers is infrequent.

The claimant's perceived barrier for returning to work is his persistent symptoms.

Summary and Recommendations

Mr A has been absent from the work place for a significant number of years, realistically a return to his insured occupation with or without fitness to work is consider (sic) *poor.*

Points to consider/ establish:

1. The CM (claims manager) may consider writing to the claimant's current specialist in a bid to understand whether in his opinion Mr A could be considered for a phased supported return to work. The CM would need to focus on the fact that there is a level of functionality, (driving, caring for children, travelling, domestic chores etc that supports day to day activities and that the only exception of his functionality is a return to work. The CM would need advocate that if the specialist feels that a return to work is not appropriate they would need to offer clear rational as to why the claimant is not fit and work and what the longer term prognosis is.

2. Alternatively the CM could consider an IME with occupational health physician, (whom as we know is a specialist around the occupational capacity and considers this as well as the reported diagnosis.

3. Another option would be to obtain an opinion from a psychologist who can help determine as to whether the barriers for not returning to work are more functional than medical, the issue with this is that the claimant is likely to contest the medical qualifications and validity of this opinion.

4. I note that the claim expiry is 2022 and possibly the most achievable option is to discuss with the employer's reasonable exit strategies and to explore why these were discussed but not pursued.

5. The challenge with this case is the subjective nature of the claim, the length of time we have already being paying it and the lack of medical opinion that is likely to support a return to work, however it is clear that this claimant does have an apparently ordinary lifestyle with the exception of work and this in itself is a concern and should be further explored.'

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 still don't think it was fair for Zurich to terminate Mr A's claim and I'll explain why.

I'd like to thank Zurich for its detailed response to my provisional decision and for the further medical evidence it's provided. I'd assure Zurich that I have considered its submissions in detail and very carefully weighed up all that I've been presented with. As I explained in my provisional decision, I'm not required to comment on each specific point that Zurich has raised. Instead, I've focused on what I think are the key issues.

It's clear that Zurich feels strongly that Mr A changed his reported cognitive symptoms in response to its decision to terminate his claim. And that it was that change in symptom reporting which resulted in Dr S' conclusions that Mr A wasn't fit for work. I've borne in mind Dr M's comments on that point.

But I don't think the totality of the medical evidence does indicate that Mr A changed his reported cognitive symptoms in response to the termination of his claim. As I set out above, in 2019, Dr F specifically stated the following, which I think it's important I repeat:

'Mr A is experiencing significant cognitive symptoms, particularly within the area of executive functioning. It is likely that when he is placed under more complex demands that his cognitive functioning will suffer further.

Mr A was assessed in a quiet clinic room with little distraction. Despite this, he still had difficulties with reference to more complex cognitive tests and I would consider that within a real life situation, such as his return to work, then this will result in more significant cognitive problems.

Mr A is unlikely to be able to return to his pre-accident job as […], given the complex cognitive demands that would be placed on him in this position.'

Dr F also carried out neurological assessments on Mr A, which informed his conclusions about Mr A's fitness to work.

It seems to me then that the symptoms Mr A reported to Dr S are the same symptoms he reported to Dr F. As such, his symptom reporting appears consistent. I note that the symptoms of a difficulty in word-finding were reported to another consultant neurologist in January 2020. And I'd add that Mr A also clearly reported cognitive symptoms to Dr M (and the RC), even if Dr M didn't conclude that Mr A did show signs of a lack of concentration during that particular assessment. I remain mindful though that Dr M doesn't appear to have carried out any neurological assessment on Mr A, despite his reported symptoms and despite Dr F's findings. Based on what I've seen, I'm not persuaded that Zurich has shown that Mr A deliberately changed his symptom reporting following its decision to terminate the claim.

I've considered too whether Zurich has demonstrated that Mr A breached the policy term

requiring him to engage in his recovery. I don't think it has. The available evidence indicates that Mr A was under the care of consultant neurologists; underwent a range of treatments and remained on medication. It also appears that he was prepared to engage fully with the IMEs and other occupational health specialists Zurich asked to review his claim. I haven't seen enough evidence to persuade me that Mr A declined to engage with medical experts – he simply disagreed with Dr M's conclusions regarding his fitness to work, which had contradicted the medical opinion of Dr F (and also later, Dr S and Mr A's neurologist). Indeed, I note that while the RC had concerns about whether Mr A did remain medically incapacitated, they also referred to the lack of medical opinion which would support a return to work.

Zurich has referred again to Mr A's ability to coach a rugby team. As I explained, I don't think that this is enough to demonstrate that Mr A is fit to return to work in his own occupation. This is a voluntary role, which Mr A says he simply doesn't take part in if he's feeling unwell. It's also a markedly different role to Mr A's own occupation. Zurich has referred to the employer's duties under the Equality Act. However, I'm not persuaded these have any bearing on my decision, as that's a matter between Mr A and his employer. But it still appears that given the nature and duties of Mr A's own occupation (rather than a new role), it would be extremely difficult for him to undertake the material and substantial duties of it within the quiet area Dr M recommended.

I acknowledge that Mr A's neurologist did defer to the medical opinion of an occupational health specialist, following his earlier view that Mr A wasn't fit to work. I also accept that the neurologist agreed that a return to work could be beneficial. But it remains the case that they did initially conclude that Mr A wasn't fit for work. And taking together that opinion, alongside the conclusions of Dr F and Dr S, who are both consultant specialists in occupational medicine, I am not persuaded, on balance, that Zurich has shown that Mr A no longer met the policy definition of incapacity when the claim was terminated.

It follows then that I still find that the fair and reasonable outcome in all the circumstances of this complaint is that Zurich should reinstate Mr A's claim and pay him backdated incapacity benefit, together with interest. I'd add that as I set out previously, Zurich is entitled to periodically review the claim to decide whether Mr A's claim remains payable.

My final decision

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

I direct Zurich Assurance Ltd to reinstate Mr A's claim from the point it was terminated. It must calculate and pay Mr A any backdated benefit payments due, and it must add interest at an annual rate of 8% simple from the date each backdated payment was due until the date of settlement.

If Zurich considers that it's required by HM Revenue & Customs to take off income tax from that interest it should tell Mr A how much it has taken off. It should also give Mr A a certificate showing this if he asks for one, so he can reclaim the tax from HM Revenue & Customs if appropriate.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr A to accept or reject my decision before 30 May 2023.

Lisa Barham
Ombudsman