DRN-4235942

The complaint

Mr F has complained that Legal and General Assurance Society Limited (L&G) declined a claim he made under his employer's group income protection policy.

What happened

The details of this complaint are well known to both parties. In summary Mr F became absent from work in June 2022 (although his symptoms had started some months earlier). In August 2022 he made a claim for income protection benefit under his employer's policy. He wrote that he was suffering from depression, insomnia, stress and anxiety.

L&G assessed Mr F's claim, appropriately seeking medical input from its Chief Medical Officer (CMO), but it didn't find that he met the policy definition on incapacity. It said that the disability definition was one of suited occupation, therefore the policy criteria require the member to have a physical or mental health condition of sufficient severity to preclude them from working in their own or suited occupation. It added that the policy focus was on functional ability, rather than medical diagnosis /diagnoses.

Our investigator sent L&G a further report from an Occupational Health Physician - Dr JM - in order to comment. L&G didn't find the report provided medical evidence material to the time of the claim, so didn't change its original conclusion.

When our investigator didn't recommend that the complaint be upheld, Mr F appealed. I issued a provisional decision on 26 June 2023. I explained the reasons why I was minded to come to a different conclusion to our investigator. These were:

- *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 insurance contract and all the available medical evidence, to decide whether I think L&G treated Mr F fairly.*

- *The onus is on Mr F to show that he meets the policy definitions for his claim to be payable. His policy has a deferred period of 26 weeks – that means that he needs to show he met the policy definition of incapacity for that period and beyond in order for benefit to be payable.*

- *Having carefully considered all the evidence I'm provisionally satisfied that the medical evidence does show that Mr F met the policy definition of incapacity during the deferred period and until and including January 2023. I haven't disregarded the input from L&G's CMO. I didn't find it was partial – as Mr F has suggested. I appreciate too that that the case is finely balanced. Nevertheless, I'm minded to find that the medical evidence, including the Occupational Health Report dated 27 January 2023, does tip the evidence in his favour.*

- *I appreciate that L&G is of the opinion that Mr F's depression fell into the 'less severe category' – whilst Mr F believes it should be categorised as 'severe'. Mr F is supported in this by his psychiatrist at the Community Mental Health Team who*

confirms that Mr F is having treatment for the management of one of the major mental disorders, having been referred in October 2022. But as the policy focuses on functional ability rather than diagnosis (or categorisation) I find that the evidence regarding functional ability is of greater importance than categorisation. I say this as the fact that Mr F was suffering with a mental illness is not in dispute. His GP also confirmed he was treated for a persistent episode of depression and anxiety. So I have carefully considered the evidence regarding Mr F's functional ability during the relevant period.

- *Mr F himself reported sleeping for only 2-3 hours per night, a feeling of anxiousness, exhaustion and poor concentration. The trigger was work related stress but Mr F was signed off work, prescribed medication and referred for therapy. I don't accept that because Mr F did engage in some social activities this supports a conclusion that he was able to engage in his own or a suited occupation.*

- *L&G concluded that Mr F's treatment had been effective – it does appear that this is so to some degree and the prognosis is positive. But I'm not provisionally minded that to agree this meant Mr F's absence from work was due to difficulties in the workplace. I say this as the impact on his functional ability was ongoing. This is clear from the evidence of his GP, with whom Mr F was engaging on a regular basis and who didn't consider he was fit to work. I note too the evidence of the psychiatrist Mr F saw in November 2022 having been referred by his GP. I don't find that this was at odds with the treatment given by Mr F's GP and the conclusion that he reached.*

- *In reaching this provisional decision I should make clear that I have not disregarded the assessment of the of the Vocational Clinical Specialist in August 2022 which concluded that Mr F was fit to return to his own or a suited role. But I don't find that the weight of all the evidence supports this early conclusion. Likewise I note the CMO's opinion that the symptoms of clinical depression triggered by work related stress should settle once the person isn't at work. In this case however although Mr F wasn't at work the medical evidence doesn't support the conclusion that his symptoms abated to the extent that he was able to return to a work environment.*

- *In their Occupational Health Report dated 27 January 2023, Dr JM found that Mr F was unfit for work and would require another 8-10 weeks sickness absence. They did not believe that Mr F had the concentration to be able to render reliable and sustainable service and attendance at that time but felt that he had an excellent prognosis and it was just a matter of time – they anticipated three months or so.*

- *In all the circumstances therefore, I am minded to conclude that Mr F did meet the policy definition of incapacity – and was unable to work even in a suited occupation for the duration of the deferred period and beyond. I recognise that in similar cases it will be possible for someone to return to work whilst on appropriate medication and undergoing therapy. Although, like his GP, I'm not minded to find that was the case here or that Mr F could have continued working with the symptoms he was experiencing.*

- *I am not able to say however if or when Mr F would have been ready to return to a suited occupation. And although L&G has commented on Dr JM's report, it hasn't had the opportunity to assess the claim following this. Accordingly, I'm provisionally minded to require L&G to admit the claim paying benefit until end January 2023 and assess whether benefit was still payable after that date.*

- *For completeness I would say that Mr F had complained about a breach of confidentiality. Our investigator didn't recommend that this was upheld – she didn't*

find that L&G had done anything wrong by writing to Mr F's employer – the policyholder. I agree. As Mr F accepted the investigator's findings I won't comment further as this aspect of his complaint is resolved.

For these reasons my provisional decision was that I intended to require L&G to admit Mr F's claim and pay benefit in line with the policy terms until the end of January 2023, adding interest. I intended to require it to then assess Mr F's claim from end January 2023.

Both parties responded. Mr F accepted the provisional decision. He attached further evidence regarding his ongoing incapacity from January 2023. Additionally he asked that consideration be given to the stress caused by the claim not being met when it should have been. In summary he said that this exacerbated his condition and severely impacted his financial circumstances. Finally he said that he had been caused embarrassment by L&G sharing information with his employer, which led to his employer trying to force him back to work too early and against his doctor's advice. He felt L&G had caused him reputational damage by sharing information with his employer – he referenced in particular a communication sent in August 2022.

L&G strongly disagreed with my provisional decision and highlighted a number of concerns. In summary these included:

- The term 'major mental disorder' is non specific and L&G would expect clear justification that it can be evidenced from a treating psychiatrist to dispute it's CMO's medical opinion. Without such specialist information it asked how the categorisation highlighted by its CMO can be justified.

- It didn't consider that objective 'satisfactory evidence' had been demonstrated by Mr F in order to prove his claim.

- It felt that the recommendation to stop benefits in January 2023 indicated that the medical evidence was unclear/finely balanced. But it felt that my provisional recommendation to assess this further demonstrated that there was insufficient satisfactory evidence to prove that the claim was valid. It reiterated that it was from Mr F to prove the claim was valid and not L&G.

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'm not persuaded to change my provisional findings, which I adopt here. I'll explain why.

There is clearly a medical disagreement about how Mr F's mental health condition should be categorised. I referenced this in my provisional findings. I said: *But as the policy focuses on functional ability rather than diagnosis (or categorisation) I find that the evidence regarding functional ability is of greater importance than categorisation. I say this as the fact that Mr F was suffering with a mental illness is not in dispute.* I didn't find that it was helpful in the circumstances here to reach any firm conclusion on this categorisation point. As I said I took into account the CMO's opinion as well as that of Mr F's treating physicians. I preferred to look at all the evidence holistically and, as I said, focus on Mr F's functional ability. There is no doubt that this was impaired. I was satisfied by the evidence, and remain so, that the impairment was such that he was unable to work in his own or any suited occupation. I found that the evidence that I had referenced allowed me to draw this conclusion.

That said, I did consider, and have reconsidered, all the evidence and I recognise that when L&G first declined the claim in August 2022 it was on the basis of the evidence it had at that time. I understand that Mr F feels that it shouldn't have written to his employer at that time setting out its findings. His employer is the policyholder, and I don't find that it erred in corresponding with his employer in the way it did when it did.

Mr F feels his claim should have been admitted earlier and so compensation is due. I fully accept that he has experienced a very difficult time both emotionally and financially. But I'm satisfied that there was persuasive evidence on both sides – some coming in at a later stage. In these circumstances I don't require L&G to compensate Mr F, other than to pay his claim with interest, as I direct below.

I didn't feel that L&G had the opportunity to assess the evidence submitted Mr F's claim post the report of January 2023. I reached the conclusion that there *was* sufficient satisfactory evidence prior to that date – and therefore that Mr F had proved his claim to the required standard. Mr F has submitted further new evidence – and I'm pleased to note that he hopes to be back at work soon – but he will need to submit that evidence to L&G for its consideration of his ongoing claim. For completeness I would say it is for him to show he continued/continues to meet the policy definition of incapacity.

My final decision

My final decision is that I uphold this complaint. I require Legal and General Assurance Society Limited to:

- Admit Mr F's claim and pay benefit in line with the policy terms until the end of January 2023.

- Add interest to the settlement at the annual rate of 8% simple from the date the benefit payment was due until the date of settlement.

- Assess Mr F's claim from end January 2023.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mr F to accept or reject my decision before 8 August 2023.

Lindsey Woloski
Ombudsman